West Virginia Medicaid

Qtr 2. 2011
Provider Update Bulletin
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Provider Update Bulletin

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Helpful Resources

- Provider Relations at 888-483-0793 -- (Claims Resolution Assistance)

- www.dhhr.wv.gov/bms -- Provider Manuals, Drug Information, HIPAA Remark and Reason Codes
- www.wvmmis.com -- Billing Instructions, Claims Status Option, Newsletters, Forms

Inside This Issue:

West Virginia Medicaid Regional Training Sessions
Provider Re-Enrollment, Provider Incentive Plan,
5010 Updates/Changes

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<thead>
<tr>
<th>LOCATION</th>
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<th>TIME</th>
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<tbody>
<tr>
<td>Martinsburg – Comfort Inn</td>
<td>June 6, 2011</td>
<td>9:00 – 12:00 or 1:30 – 4:30</td>
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<tr>
<td>Morgantown – WVU Health Science Center 1st floor, Oakey Patteson Auditorium</td>
<td>June 7, 2011</td>
<td>9:00 – 12:00 or 1:30 – 4:30</td>
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<tr>
<td>Wheeling- Oglebay Park, Pine Room</td>
<td>June 8, 2011</td>
<td>9:00 – 12:00 or 1:30 – 4:30</td>
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<td>Parkersburg- Blennerhassett Hotel</td>
<td>June 9, 2011</td>
<td>9:00 – 12:00 or 1:30 – 4:30</td>
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<td>Beckley – Tamarack</td>
<td>June 13, 2011</td>
<td>9:00 – 12:00 or 1:30 – 4:30</td>
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<td>Charleston Municipal Auditorium</td>
<td>June 14, 2011</td>
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<td>Huntington- Big Sandy Arena</td>
<td>June 15, 2011</td>
<td>9:00 – 12:00 or 1:30 – 4:30</td>
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<tr>
<td>Flatwoods-Days Hotel</td>
<td>June 17, 2011</td>
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Molina Medicaid Solutions and the WV Bureau for Medical Services (BMS) will be conducting eight (8) Provider Workshops throughout the State of WV June 6 – 17, 2011. In an attempt to accommodate as many provider offices as possible, we are offering these workshops at various locations.

Sign-in for each session will begin at 9:15am and 1:00pm. Once you have decided which session is most convenient for you, please complete the registration form below. Please try to limit your registration to two (2) people per office. Registration forms for the Workshops must be returned by *Friday, May 27, 2011*.

For questions and more information, please contact Provider Relations Department at 1-888-483-0793.

PLEASE SEND REGISTRATION FORM VIA MAIL OR FAX TO:
Molina Medicaid Solutions, 1600 Pennsylvania Avenue, Charleston, WV 25302
Fax: 304-345-3380 or 304-345-3211
Adm. 2011 Provider Workshops

<table>
<thead>
<tr>
<th>Person(s) Attending:</th>
<th>Name of Provider Office or Facility you are representing:</th>
<th>Session Location:</th>
<th>Morning or Afternoon Session</th>
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|                      |                                                          |                   | Morning or Afternoon Session |
|                      |                                                          |                   | Morning                     |
|                      |                                                          |                   | Afternoon                   |

Helpful Resources

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Maternity Room and Board Revenue Codes

Molina is finding that some maternity claims have either denied or paid zero. Upon researching the claims, Molina discovered that the claims in question were billed without maternity room and board revenue codes. Please keep in mind that although there may be some circumstances when you do not need a maternity revenue code, the claims will process more efficiently if you are billing the appropriate maternity room and board revenue code when applicable.

NDC Billing Instructions

Molina EDI Help Desk is reporting claims are being rejected because more than one NDC code is being billed on one service line. Below you will find instructions on billing multiple NDC codes for the same drug on a claim. For more detailed information on billing NDC codes, please see the BMS website at www.wvdhhr.org/bms. On this site, you will find a listing of drug codes and whether or not they require a NDC, Frequently Asked Questions, a provider notice and a list of manufacturers that participate in the rebate program.

Multiple NDCs

At times, it may be necessary for providers to report multiple NDCs for a single procedure code. For codes that involve multiple NDCs (other than compounds, see BMS website), providers must bill the procedure code with KP modifier and the corresponding procedure code, NDC qualifier, NDC, NDC unit qualifier and NDC units. The claim line must be billed with the charge for the amount of the drug dispensed for the NDC identified on the line. The second line item with the same procedure code must be billed utilizing KQ modifier, the procedure code units, charge and NDC information for this portion of the drug.

Split Billing

Reminder: Molina updates the hospital contracts every July 1st and October 1st. If you are billing an outpatient claim that extends from June to July or September to October, it is important for you to split the claim into two claims, one date ending on June 30th or September 30th, and the next claim beginning on July 1st or October 1st. Please Note: Inpatient acute care claims cannot be split billed; must be billed upon discharge only.

C Codes

BMS has added HCPCS codes for defibrillators and pacemakers for outpatient hospital coverage retroactively to 2009. Procedure codes C1721, C1722, C1777, C1785, C1786, C1882, C1895, C1896, C1898, C1899, C1900, C2619, C2620, C2621 are now reimbursable for services. C codes will be paid to the hospital at their cost-to-charge ratio. Denied claims have been reprocessed. The surgical procedures, which are to be billed in 15 minute time units, were already covered however procedure code 33224 has been added for coverage.
WV NURSING HOME PRE-ADMISSION SCREENING (PAS) NOW ONLINE

APS Healthcare and its subcontractor (West Virginia Medical Institute--WVMI) are pleased to announce that as of February 22, 2010 PAS can be submitted through direct data entry on a secure website. WVMI will continue to provide clinical review and support; APS Healthcare will manage provide and user registration, support, training and technical assistance. Features of the system include:

Direct Data Entry
- Fast – with save features, confirmation of submission, immediate availability of response for view and printing once the review is complete, and search features;
- Secure – meets all security requirements for safeguarding PHI;
- Provides validation before submission to reduce errors and missing data;
- Submitted PAS moves directly to the Nurse Review queue for faster response;
- Printable forms with signature lines for medical record;
- Meets all BMS requirements for PAS submission and notifies PC&A of LEVEL II referrals.

Eligibility Determination (Page 6) Results Retrieval Online
- While fax submissions are accepted, fax submissions require data entry by WVMI clerical staff and will not be submitted to the Nurse Review queue until all data is entered. Fax submissions are data entered in the order in which they are received and clinical review timelines do not begin until fax submissions have been entered in the system. ALL REQUIRED INFORMATION MUST BE COMPLETE AND LEGIBLE BEFORE PAS CAN BE ENTERED.
- All Eligibility Determinations (Page 6) will need to be retrieved online AND WILL NO LONGER BE SENT BY FAX TO THE PROVIDER(S).

Provider and User Registration
- Provider registration forms are available upon request from APS Healthcare
  dthomas@apshealthcare.com or shjackson@apshealthcare.com or call 304-343-9663 or 800-461-0655.
- Providers may elect to have as many users as they wish – user request forms will be sent upon provider registration with APS Healthcare.

Training and Technical Assistance
- Go to the APS-WV website www.apshealthcare.com/wv for a list of upcoming webinar trainings on the direct data entry web application. All providers and staff are welcome;
- Technical assistance to discuss provider specific issues is available upon request;
- User Manual/Desktop Guide is available to enrolled provider. Please contact APS Healthcare at either the emails or phone numbers listed above.

Reminder:
Each organization/facility MUST REGISTER as a Provider with APS Healthcare. If you have not registered, or if you are unsure of your registration status with APS, please contact APS Healthcare at 304-343-9663 or 800-461-0655.

While fax submission of PAS is accepted, all providers who complete PAS forms need to register with APS in order to view and print their eligibility determination (formerly referred to as Page 6.)

A Web User Request Form should be completed for each person your organization or facility wants to access the APS PAS website either to submit or check on the status of a PAS.
Podiatrists

Certification to perform surgical procedures
and/or services

As the fiscal agent for West Virginia Medicaid, Molina is required to maintain a copy of your active license and any certifications in your provider file. If you are a Podiatrist that is certified by the Board of Medicine to perform surgical procedures and/or services, please forward a copy of your certification to:

WV Medicaid Provider Enrollment
P.O. Box 625, Charleston, WV 25322-0625

PAAS Referral Numbers

The PAAS Referral Number is the Legacy Medicaid Group number unless the provider is in a solo practice. There are many instances where claims are denying because the Physician's individual number is given in place of the group numbers. The PAAS approval number is to be billed as follows:

- CMS1500: PAAS number in field 19
- UB04: PAAS number in field 78

The provider must also use the appropriate qualifier when entering the PAAS number:

- Legacy Number: 1D qualifier
- NPI Number: XX qualifier

Electronic Health Record (EHR) Incentive Program

The Electronic Health Records (EHR) Provider Incentive Program (PIP) is a federal program offering financial support to assist eligible providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), or upgrade (expand functionality or interoperability) certified EHR technology. The program goals are to improve outcomes, facilitate access, simplify care, and reduce costs of health care nationwide by:

- Enhancing care coordination and patient safety
- Reducing paperwork and improving efficiencies
- Facilitating information sharing across providers, payers, and state lines
- Enabling communication of health information to authorized users through state Health Information Exchanges (HIEs) and the National Health Information Network (NHIN).

Incentives will be available through both Medicaid and Medicare. Eligible healthcare professionals will be required to choose between Medicaid and Medicare. Those in border counties should choose the state from which they will receive the incentive payments. Hospitals may be able to receive incentive funds from both programs. The Bureau for Medical Services (BMS) will administer the Medicaid EHR Incentive Program for West Virginia.

If you are ready to register for the EHR Incentive Program with the National Level Repository (NLR) for your first participation year, please visit this website:


At this time you will not be able to select West Virginia from the list of states eligible at this time from the NLR registration portal. West Virginia Medicaid expects to have its registration process available for providers soon. Please send your email address to dhhreh@wv.gov if you would like to receive an email when the West Virginia PIP is ready.

Send Comments from this website:
Or mail comments to: dhhreh@wv.gov

Provider Appeals

All appeals must be submitted within 30 days of the adverse reaction (denied claim). Appeals may be submitted if you have a dispute regarding your participation as a Medicaid provider or a denied request for authorization. Most denied payments are due to billing errors and not considered “appeals”. Please contact Provider Relations for billing information or to explain reasons for denials. True appeals must be submitted directly to the Commissioner for the Bureau for Medical Services at:
350 Capitol Street, Room 251 Charleston, WV 25301.

Please follow directions outlined in Chapter 800.14 “General Administration” at www.dhhr.wv.gov/bms

Learning Management System (LMS)

Molina has initiated an online, self-paced e-learning system to assist West Virginia Medicaid providers. The training offers Medicaid providers online, web-based training. The Medicaid Training Center is accessible by all users 24 hours a day, 7 days a week.

Providers can access the Medicaid Training Center through a link on the WVMMIS website, www.wvmmis.com. After logging into the secured web portal, the provider selects the Medicaid Training Center link. After arriving at the Training Center page, the user completes the self registration process with the correct corresponding access code. This code is available on the WvMMIS website. The initial course that is posted is an introduction to West Virginia Medicaid. This is beneficial to providers and their billing staff who are new to Medicaid. There is a brief overview of the roles between Molina and West Virginia Medicaid, as well as a brief explanation of the billing process.

In order to gain access to the WvMMIS website, please call the Molina EDI Help Desk at at 888-483-0793, option 6.
Errors That Result In Denied Claims

This information is presented for you to review your internal procedures and identify areas where the number of denied claims could be reduced. Denied claims result in delay of payment. Please note HIPAA claim adjustment reason and remit remark codes as provided on the remittance advice.

Claim Errors  (Remittance Advice Remarks)

- The rendering provider is not eligible to perform the service billed (185) or claim/service lacks information which is needed for adjudication. (16/MA30)
  - Service code not covered to the provider type or specialty
    - Note: If a procedure code is not covered, the provider will need to submit documentation for review to Molina per the following:
      - The request must be submitted in writing
      - The request must be supported with documentation
        - documentation should include any claim examples or indicate why the code should be payable
        - If there is no supporting documentation, the request will not be considered.

- Missing/incomplete/invalid HCPCS Code (A1/M20)
  - Validate code keyed correctly
  - Validate code is current for Date of Service (DOS)

- Missing/incomplete/invalid/deactivated/withdrawn National Drug Code (NDC) (16/M119)
  - For resolution to these denials, please refer to www.dhhr.wv.gov/bms
    Select Drug Code/NDC Drug Information.
  - NDC, unit of measure and units should be submitted on Medicare primary claims (even though not required by Medicare) so the information will cross over to Medicaid, eliminating the need to submit Medicaid secondary claims on paper.

- Incomplete/invalid plan information for other insurance (Invalid Medicare Action Code) (16/N245)
  - Claims denied by Medicare and submitted electronically must include a Medicare Action Code (MAC)

- This service/equipment/drug is not covered under the patient's current benefit plan (204)
  - Non-covered WV Medicaid Service

- This case may be covered by another payer per coordination of benefits/secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. (22/MA04)
  - Payer information is not submitted on electronic claim
  - Explanation of Benefit (EOB) is not submitted with paper claim

- Charges are covered under a capitation agreement/managed care plan (24)
  - For members enrolled in Medicaid MCO - MCO is responsible for the service
  - For Members who have a PAAS provider, PAAS approval is required
    - View member’s Medicaid Card to verify MCO or PAAS information
    - Utilize AVRS to verify MCO or PAAS information

Errors That Result In Returned Claims

When claims are returned to providers, payment is delayed. Review of claim forms and billing instructions could decrease simple paper claim errors. Make sure to:

1. Enter the eleven (11) digit Medicaid Member ID number or the Insured’s ID number, not the Social Security number.
2. Enter the provider NPI and Tax ID in the appropriate fields.
3. Enter diagnosis codes in the numeric order to match the numeric order of the claim form. (See order on CMS1500).
4. Enter service dates in appropriate fields…particularly Field 6 on the UB04. Confirm that these dates are inclusive of all service lines.
5. Enter Place of Service (POS) in 24B of the CMS1500.
6. Confirm your claim forms are not printing too light. Confirm your printer alignment. Information must be in the assigned fields.
7. See Billing Instructions at www.wvmnis.com
Revised License Maintenance Policy

Health care providers, who under the state plan and/or state statute are required to be licensed in West Virginia (WV) or the state in which they practice, must maintain and ensure that a current license is on file at all times with the West Virginia Bureau for Medical Services (BMS) Provider Enrollment Unit, Molina. A provider’s participation in the WV Medicaid program may be terminated if Molina cannot verify the current status of a provider’s license.

Effective, October 1, 2009 the Provider License Update Reminder Process is as follows:

- Sixty (60) days prior to the license expiration date, an initial reminder letter will be sent to the provider’s correspondence address indicating their current license expiration date. If an updated license is not received on or before the expiration date, the provider will be placed on pay hold.

- If a provider fails to submit a copy of their updated license 30 days after the expiration date, Molina will check listings from the licensing boards. If a provider’s license renewal date can be verified through the board listings, the pay hold will be removed. If Molina cannot verify an effective license renewal date via the board listing, the provider will remain on pay hold.

- A letter will be sent 30 days after the provider’s license expiration date to providers who have failed to submit their updated license and Molina was not able to verify license renewal through the licensing boards. The provider will remain on pay hold until the updated license is sent to Molina.

- Sixty (60) days after the license expiration date, Molina will make a telephone call to those providers that have not submitted an updated license. Providers who have failed to send an updated license to Molina will remain on pay hold.

- Ninety (90) days after the license expiration date, Molina will determine which providers have not complied and submitted an updated license. Providers who have not submitted an updated license will receive notification of intent to terminate if the updated license is not received within 30 days.

- If after 121 days from the initial license expiration date Molina has not received the provider’s updated license, the provider’s claims will be voided from Accounts Payable and the provider will be terminated from West Virginia Medicaid. A letter will be sent to the provider notifying them of the termination. Instructions on how to resubmit claims for payment for services rendered by the provider prior to the expiration date will be included in the letter. All other claims will remain voided and not payable. A listing of voided claims will accompany the letter.

- Providers may mail or fax a copy of any license renewal information or other credential/certification updates prior to expiration of the current license. Mailing address: Molina Provider Enrollment, PO Box 625, Charleston, WV 25322. Fax: Provider Enrollment 304-348-3380.

- All providers who have mailed or faxed their updated license will continue their Medicaid enrollment without interruption.

Provider Exclusion from Participation in Federal Health Care Programs

The Office of Inspector General (OIG) has the authority to exclude from participation in Medicare, Medicaid, and other Federal health care programs individuals or entities who have engaged in abuse or fraud. If an individual or entity is excluded from participation, this exclusion applies to all states and all Federal health care programs. Any provider excluded by the OIG is not permitted to participate in the West Virginia Medicaid or other Federal health care programs. The OIG publishes names of excluded individuals and entities. Access this list and other information relating to the exclusion program from the OIG Web site at: http://www.oig.hhs.gov/fraud/exclusions/listofexcluded.html.

Providers are encouraged to check all current and future employees, subcontractors, and agency staff for possible exclusion from participation in Federal health programs. Failure to verify this information may result in recoupment of monies paid for services provided by an excluded individual or entity. It is the providers’ responsibility to ensure they do not bill or receive payment from WV Medicaid or any other federal health care program for services rendered or ordered by an individual on the exclusions list. Providers are advised to self-report any violation of the Federal Exclusion policy to the Office of Quality and Program Integrity (OQPI) by calling (304) 558-1700.
**Timely Filing Policy**

To meet timely filing requirements for WV Medicaid, claims must be received within one year from the date of service.

The year is counted from the date of receipt to the “from date” on a CMS 1500, Dental or UB04.

Claims that are over one year old must have been billed and received within the one year filing limit.

(See exceptions below for Medicare primary claims and backdated medical card.)

The original claim must have had the following valid information:

- Valid provider number
- Valid member number
- Valid date of service
- Valid type of bill

Claims that are over one year old must be submitted with a copy of the remittance advice showing where the claim was received prior to turning a year old. Claims with dates of service over two years old are NOT eligible for reimbursement.

This policy is applicable to reversal/replacement claims. If a reversal/replacement claim is submitted with a date of service that is over one year old, the replacement claim must be billed on paper with a copy of the original remittance advice to: Provider Relations, PO Box 2002, Charleston, WV 25327-2002. You are NOT allowed to add additional services to the replacement claim.

If additional services are billed on the replacement claim that were not billed on the original claim and the dates of service are over one year old, the claim will be denied for timely filing.

**Medicare Primary Claims/Secondary Claims**

Timely filing requirement for Medicare primary claims is one year from the EOMB date.

Did you know that secondary claims can be submitted electronically? For more information, please call our EDI help desk at 888-483-0793, option 6.

**TPL Primary Claims**

Timely filing requirement for TPL insurance primary claims is one year from the date of service.

**Backdated Medicaid Cards**

If a member receives a backdated medical card and the provider wishes to accept it and bill Medicaid for services that occurred over a year ago, the claims must be billed within one year of the issuance of the card. Claims must be billed on paper with a copy of the medical card or letter of eligibility and mailed to Provider Relations address at PO Box 2002, Charleston, WV 25327-2002.

**MCO’s and Timely Filing**

Molina does not reimburse for any services the provider does not bill timely to the MCO. If the MCO denial is due to the member not being covered under the MCO and the provider determines that the member was covered with WV Medicaid at the time services were rendered, Molina may be responsible. In this case, Molina will accept MCO Medicaid remits as proof of timely filing as long as the date of the denial is not over a year from the date of service.

Please Note: The MCO must be one of the MCO’s that are contracted with WV Medicaid and not an MCO that has a private insurance policy for the member.

**Timely Filing Reminders**

Following these reminders can reduce the number of denied claims:

- Claims with dates of service over the filing limit must be submitted on paper with proof of timely filing to: PO Box 2002, Charleston WV 25327-2002.
- Reversal/Replacement and claims with dates of service over the filing limit should also be sent to: PO Box 2002, Charleston WV 25327-2002.
- It is not necessary to submit all remittance advices related to a claim. Only one remittance advice that documents proof of filing is required. See Timely Filing Guidelines at www.wvmmis.com.

*Please note: 824 reports are no longer accepted as proof of timely filing.
Suggestions for Web Portal Improvements

We are looking for ways to improve the Web Portal. If you have any suggestions on how we can improve the portal to make it more 'user friendly', please contact our EDI helpdesk at edihelpdesk@molinahealthcare.com.

1. Accounts Payable Information
2. Eligibility Information
3. Claim Status Information
4. Provider Enrollment Department
5. Hysterectomy Sterilization Review
6. EDI Help Desk/Electronic Submission Inquiries
7. LTC Department

Molina Automated Voice Response System (AVRS) Prompt Tree
(1 888 483 0793)

Please make sure that you are utilizing the appropriate prompts when making your selection(s) on the AVRS system to ensure that you will be connected to the appropriate department for your inquiry. Once you have entered in your provider number, the following prompts will be announced:

1. Accounts Payable Information
2. Eligibility Information
3. Claim Status Information
4. Provider Enrollment Department
5. Hysterectomy Sterilization Review
6. EDI Help Desk/Electronic Submission Inquiries
7. LTC Department

Contact Information

Provider Relations
888 483 0793
304 348 3360
wvmms@molinahealthcare.com (email)

EDI Helpdesk
888 483 0793, prompt 6
304 348 3360

Provider Enrollment
888 483 0793, prompt 4
304 348 3365

Molina PR Pharmacy Help Desk
888 483 0801
304 348 3360

Member Services
888 483 0797
304 348 3365
Monday-Friday, 8:00 am until 5:00 pm

Provider Services Fax
304 348 3380
BMSmedclaimdoc@wvdhhr.org (email)

MCO Contacts
Carelink
888 348 2922

The Health Plan
888 613 8385

Unicare
800 782 0095

Claim Form Mailing Addresses
Please mail your claims to the appropriate Post Office Box as indicated below.

PO Box 3765 NCPDP UCF Pharmacy
PO Box 3766 UB-92
PO Box 3767 CMS-1500
PO Box 3768 ADA-2002
Charleston WV 25337

PO Box 2254
Hysterectomy, Sterilization and Pregnancy Termination Forms
Charleston WV 25328-2254

Molina Mailing Addresses
Provider Relations & Member Services.
PO Box 2002
Charleston WV 25327-2002
Fax # 304 348 3380

Provider Enrollment & EDI Help Desk.
PO Box 625
Charleston WV 25322-0625
Fax # 304 348 3380

BMSmedclaimdoc@wvdhhr.org (email)

Claims and Application Information

As a participating provider and to expedite timely claims processing, please make sure claims are sent to the correct mailing address as indicated below.

- Facilities, and Institutional Providers who bill on a UB04 Claims form – PO Box 3766, Charleston, WV 25337
- Medical Professionals billing on a CMS Claims form – PO Box 3767, Charleston, WV 25337
- Dental Professionals billing on ADA 2006 Claims forms – PO Box 3768, Charleston, WV 25337
- Pharmacy Claim forms NCPDP UCF – PO Box 3765, Charleston, WV 25337

Please send provider enrollment applications and provider enrollment changes to: PO Box 625, Charleston, WV 25337

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