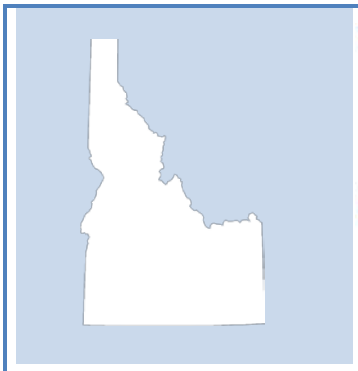

MedicAide

An Informational Newsletter for Idaho Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid **June 2014**

In This Issue

Information Releases

Medicaid Program Integrity Unit

The Medicaid Program Integrity Unit has identified providers who are not obtaining or adequately documenting Healthy Connections/Health Home referrals. Although the Healthy Connections referral number is not required on a claim and claims will process regardless of the referral status, it is the responsibility of the billing provider to ensure a referral has been received and is documented in the participant's record or online, prior to rendering services. Backdated or retroactive referrals are not valid. Please refer to *Referrals* in the Healthy Connections section of the General Provider and Participant Information Handbook for current information on referrals.

The core elements of a referral include:

- Name of primary care provider granting the referral
- Date referral was issued
- Duration of the referral (not to exceed one year)
- Number of visits – if applicable
- Specific scope/reason for referral
- Referring diagnosis or condition

All referrals must include the core elements and be documented in both the *referred from* and *referred to* patient's record, or entered online.

- Healthy Connections/Health Home referrals are required regardless of whether Medicaid is the primary or secondary insurer.
- A list of services not requiring a referral can be found under *Referrals* in the Healthy Connections section of the General Provider and Participant Information Handbook.
- Referral requirements are applicable for participants enrolled in the Healthy Connections or Idaho Medicaid Health Home Program.

The Department will recover overpayments and assess civil monetary penalties from providers who do not obtain and properly document Healthy Connections referrals prior to providing services.

Adult Developmental Disabilities – Supported Employment Exception Review

During the 2014 legislative session, the Idaho Legislature passed House Bill 476, which amended Idaho Code and directed the state to develop rules to allow adult developmental disability budget modifications when the modification is needed for the participant to obtain or maintain employment.

The Department is in the process of promulgating the rule to define the criteria that will be used when the Exception Review process described in *IDAPA 16.03.10.515.93* is expanded to include Supported Employment. Temporary Rule related to a Supported Employment exception review is currently scheduled to implement July 1, 2014.

In June and July, the Department will provide additional communication related to the exception review process for Supported Employment on the Adult DD Care Management website. This additional information will include a Supported Employment Exception Review form, a sample employment recommendation, and training opportunities for providers to learn how to support participants in making exception review requests.

Residential Habilitation – Intense Level of Support

Agencies, participants, and other stakeholders have requested that the Department clarify documentation requirements for *IDAPA 16.03.10.514.02.b.i – iv Residential Habilitation Intense Support*.

To accommodate this request, the Department has created two worksheets specific to the intense level of support.

Intense Supported Living Questionnaire: This questionnaire provides qualification information for Intense Supported Living services. Submission of the questionnaire is not required. However, a participant and their person-centered planning (PCP) team must submit documentation to the Independent Assessment Provider (IAP) that shows the participant meets at least one of the Intense Supported Living criteria identified on the questionnaire.

If documentation is not provided, the IAP will not be able to calculate a participant's budget using a response of Intense Supported Living.

Intense Supported Living Request for Blended Staffing Form: Information on this form allows the Department to determine the appropriateness of a blended service array providing less than one-to-one support. Again, submission of the *Request* form is not required. However, if a participant and their PCP team choose to make their request in some other format, the request must include information that answers all of the questions on the Department's form. In addition, the request must include the endorsement statement and signatures identified on the Department's *Intense Supported Living Request for Blended Staffing Form*.

The Intense Supported Living Questionnaire and the *Intense Supported Living Request for Blended Staffing Form* may be accessed under the **Resources** tab on the Adult DD Care Management website.

Idaho Recognized for Successful ICD-10 Test Pilot; Testing Continues

A successful ICD-10 test pilot was completed in March. See the article at http://icd10monitor.com/enews/item/1189-the-little-guys-did-it-perfectly.

The ICD-10 compliance date has been extended to October 1, 2015; however, Idaho Medicaid, along with Molina Medicaid Solutions, will continue with ICD-10 testing as planned.

Testing continues with our active trading partners who submit electronic claims transactions (837s). All details related to our test effort are available on our ICD-10 testing webpage at https://www.idmedicaid.com/ICD10%20Testing/Forms/AllItems.aspx.

Providers submitting claims individually on the Molina Medicaid website will not need to test with us. The expected impact to your billing processes for the change to ICD-10 has been determined to be low. However, if you have questions or need additional information please see our ICD-10 webpage at https://www.idmedicaid.com/ICD/10%20Transition.aspx, or contact us via e-mail at IdahoMedicaidICD-10@dhw.idaho.gov.

Billing Medicaid Participants – FAQs

Idaho Medicaid covers a comprehensive set of benefits. You can find more detailed information on covered services and verifying participant eligibility in:

- The *Idaho Health Plan Coverage* booklet located under **Resources** on the Medicaid provider website at http://www.healthandwelfare.idaho.gov/Providers/MedicaidProviders/tabid/214/Default.aspx
- The *Provider Handbook* located on www.idmedicaid.com.

Providers must accept Medicaid payment as payment in full for services rendered if they bill Medicaid for covered services. Providers can bill non-covered Medicaid services to the participant. Medicaid requires the provider to inform the participant, preferably in writing, before rendering service if the service is not covered or if a particular covered service will not be billed to Medicaid. (Refer to item 7.2 under section *7. Payment* in the Idaho Medicaid Provider Agreement.) If the participant agrees to pay for the service before it is provided, then the provider may bill the participant for the entire amount of the fee.

What is a covered service? A covered service is any service within the participant's Medicaid benefit package that does not exceed service limitations, and for which any applicable prior approval and/or referral requirements have been met.

What if payment is denied for a covered service? Denial of a covered service provided by a qualified provider will only occur in three circumstances, and in each of these cases billing the participant is not allowed:

1. A third party is liable for payment. In this circumstance, the provider must pursue the third party for payment.
2. A billing error occurred. In this situation, the provider must resubmit a corrected billing. Molina is available to help providers resolve billing problems.
3. The provider submitted the billing in excess of one year after the service was provided and did not reference an earlier timely filing date. Providers must submit an initial billing within one year of providing the service (see IR MA04-59).

What if the service to be provided is not covered by Medicaid? If the provider informs the participant that the specific service in question is not covered by Medicaid before providing the service, and both the provider and the participant agree (preferably in writing) that the participant will be liable for payment, then, and only then, can the provider bill the participant. An acceptable written agreement might read as follows and can be part of a larger generic patient liability document, as long as it is clear that this is the only part of the document that is pertinent for a Medicaid participant:

Prior to receiving the following services: _____, _____, _____, I have been informed by _____ that these services will not be covered by Medicaid and I agree to assume responsibility for the total associated costs.

_____ _____

Signed *Date*

(Continued on page 4)

What if the provider does not typically meet with the participant before providing the service (for example, anesthesiologist, laboratory, etc.) and does not have an opportunity to obtain the participant's consent to accept liability? An initial provider (PCP, surgeon, hospital, etc.) that had an opportunity to meet with the participant arranged for these specialty services. If the initial provider has informed the participant (preferably in writing) that all services associated with the procedure to be performed are not covered by Medicaid and will be the liability of the participant, then the associated specialty provider can bill the participant as well. The specialty provider needs to confirm, before billing, that this condition has been met.

What if a necessary referral from the Healthy Connections provider has not been received before the participant's care appointment? A service within the Medicaid scope of care, but lacking a necessary, valid referral, is considered a non-covered service. The provider and participant can agree to a private pay arrangement or the provider can refer the participant back to the Healthy Connections provider who can then determine if a referral is warranted.

What if a referral is received from a provider other than the Healthy Connections provider? A valid Healthy Connections referral can only be initiated by the participant's Healthy Connections provider. Before serving the participant, it is important to confirm that the referring provider is, in fact, the participant's Healthy Connections provider. A service within the Medicaid scope of care, but lacking a necessary, valid referral, is considered a non-covered service.

How does a provider determine if a participant is eligible for Medicaid and who the participant's Healthy Connections primary care provider is? This information can be accessed four different ways:

- Medicaid Automated Customer Service (MACS) 1 (866) 686-4272
- Trading Partner Account on www.idmedicaid.com
- HIPAA-compliant vendor software (tested with Molina)

To obtain information, submit either the participant's Medicaid ID number or two participant identifiers from the following list:

- Social Security Number (SSN)
- Last name, first name
- Date of birth

Is it acceptable to hold the Medicaid participant primarily responsible for all medical expenses and then offset any liability for services paid for by Medicaid, as is a common arrangement with persons covered by private insurance? No. Medicaid participants are different from individuals covered by insurance policies. Medicaid is an entitlement program, not an insurance program. A person insured under a private insurance program is primarily liable for covered charges, while the insurer indemnifies the person's liability as to those charges. In the Medicaid program, the State Medicaid Agency and the Medicaid provider enter into an agreement to provide services to persons entitled to Medicaid coverage. Only when the service provided is not covered under Medicaid and the above prior arrangement, specific to the non-covered service is in place, can the participant be held responsible for payment.

What if the provider is unsure if a service will be covered by Medicaid? The provider can contact Molina at 1 (866) 686-4272 to determine if a specific service, as defined by CPT code, is covered. Providers with any doubts as to whether Medicaid will cover a service should notify the patient in advance and make arrangements for the participant to accept liability on the assumption that the specific service is non-covered. If, and only if, the subsequent Medicaid billing is denied as a non-covered service, then the provider can bill the participant.

Idaho Medicaid Helps to Prevent Early Childhood Vision Loss

On May 1, 2014, the Department began covering procedure code 99174 (Instrument-based ocular screening [e.g., photoscreening, automated-refraction], bilateral) when completed by a physician or a mid-level practitioner (advance practice professional nurse or physician assistant).

Idaho Medicaid considers one ocular photoscreening to be medically necessary for screening all children three years of age, and for screening children ages four to five years of age who are unable to cooperate with routine acuity screening (e.g., intellectual disability, developmental delay, and severe behavioral disorders).

Many children permanently lose vision each year as a result of amblyopia, media opacities, and treatable ocular disease processes. Early diagnosis and treatment of these conditions has been shown to yield better visual outcomes.

Medicaid follows the U.S. Preventive Services Task Force (USPSTF), which recommends vision screening for all children at least once between the ages of three and five years, to detect the presence of amblyopia or its risk factors. The USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of vision screening for children less than three years of age.

Young, preverbal children are difficult to screen because they are unable to provide subjective responses to visual acuity testing and do not easily cooperate with testing of ocular alignment or stereoacuity (AAP, 2002). For similar reasons, it also is difficult to screen certain older children (ages four and five), such as those who are nonverbal or have developmental delays.

Studies show that photoscreening has the potential to improve vision screening rates in preverbal children and those with developmental delays who are the most difficult to screen. Many of the children that are most difficult to screen using conventional methods are also at highest risk of amblyopia (e.g., premature infants, children with developmental delays).

Oregon Woman Jailed for Causing the Submittal of False Claims to Idaho Medicaid

On April 25, 2014, a Milton-Freewater, Oregon woman was sentenced to fifteen (15) days in jail for causing the submission of false claims for services to Idaho Medicaid. Twenty-eight year old Melissa McNeil paid restitution in full prior to sentencing in the amount of $1,714.64, which was remitted to the Idaho Department of Health & Welfare Division of Medicaid, as well as the woman's former employer, Seubert's Quality Home Care, Inc. Pursuant to a plea agreement, the charge was reduced from a felony Provider Fraud charge.

Between July 31, 2009 and September 4, 2009, McNeil was a personal care and homemaker services provider for a Medicaid recipient in Lewiston, Idaho. McNeil submitted timesheets to her employer Seubert's Quality Home Care, Inc., falsely claiming time spent rendering Medicaid-covered services to the recipient.

Lewiston Woman Jailed for Submission of False Claims to Medicaid

On April 16, 2014, a Lewiston woman was sentenced to sixty (60) days in jail for causing the submission of false claims for services to Idaho Medicaid. Twenty-six year-old Nichole Lounsberry was ordered to pay $1,010.85 in combined restitution to the Idaho Department of Health & Welfare, Medicaid, and to the State of Idaho for costs incurred in the investigation of the case.

Pursuant to a plea agreement, Lounsberry pled guilty to one count of misdemeanor Petit Theft, reduced from felony charges of Provider Fraud and Forgery.

From July, 2011 to February, 2012, Nichole Lounsberry was a personal care and homemaker services provider for a Medicaid recipient in Lewiston, Idaho. Lounsberry submitted timesheets to her employer Addus HealthCare, Inc., falsely claiming time spent rendering Medicaid-covered services to the recipient. The recipient's family stated that Lounsberry had not worked the hours claimed. Additionally, timesheets showed Lounsberry to be in two places at once—working a second job at a local hotel during the times she claimed to spend caring for the Medicaid recipient. Lounsberry admitted to an investigator from the Attorney General's Medicaid Fraud Control Unit that she billed for and was paid by Addus HealthCare, Inc. for hours she did not actually work.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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DIVISION OF MEDICAID
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PHONE: (208) 334-5747
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May 16, 2014

Medicaid Information Release MA14-03

To: Personal Assistance Agency Providers and Aged and Disabled Waiver Providers, Adult Residential Care Service Providers (Certified Family Homes and Residential Care or Assisted Living Facilities), School-Based Services Providers

From: Lisa Hettinger, Administrator
Division of Medicaid

Subject: New Payment Rates Effective July 1, 2014

Effective July 1, 2014, the Department is making changes to the reimbursement rates for the service codes outlined below. In accordance with IDAPA 16.03.10.307, the Department calculated the new rates because of the changes represented in our annual Weighted Average Hourly Rate (WAHR) Survey.

Services provided before July 1, 2014, must be billed separately from the services provided on or after July 1, 2014. There may be an error in your payment if you do not bill separately for these dates of service.

Personal Care Services	
Code	**Rate**
G9001 Coordinated Care Fee (Agency)	$99.04 per assessment
G9002 RN Care Plan Development and Placement (Initial – 10 units, Redetermination – 5 units)	$10.19 per 15 minute unit
H2020 Therapeutic Behavior Services	$31.97 per visit
T1019 Personal Care	$3.94 per 15 minute unit
T1019 PCS Family Alternate Care Home	$3.36 per 15 minute unit

Private Duty Nursing for Children	
Code	**Rate**
T1001 Nursing Assessment/Evaluation	$50.95 per visit
T1002 Nursing Services RN	$10.19 per 15 minute unit
T1003 Nursing Services LPN	$7.31 per 15 minute unit

Aged and Disabled (A&D) Waiver Services	
Code	**Rate**
S5125 Attendant Care Services	$3.94 per 15 minute unit
S5130 Homemaker Services	$3.55 per 15 minute unit
S5135 Adult Companion Care	$3.43 per 15 minute unit
S5140 Adult Residential Care	**
T1001 Nursing Assessment/Evaluation (Initial – 2 units, Redetermination – 1 unit)	$50.95 per unit (visit)
T1002 Nursing Services RN	$10.19 per 15 minute unit
T1003 Nursing Services LPN	$7.31 per 15 minute unit

School-Based Services	
Code	**Rate**
G9001 PCS – QIDP Assessment and Plan	$99.04 per assessment
G9002 RN Assessment and Plan	$10.19 per 15 minute unit
T1001 Supervising RN visit	$50.95 per visit
T1002 Nursing Services RN Oversight of LPN	$10.19 per 15 minute unit
T1002 TD Nursing Services – RN	$10.19 per 15 minute unit
T1003 Nursing Services – LPN	$7.31 per 15 minute unit
T1019 Personal Care Services by a Paraprofessional	$3.94 per 15 minute unit

** Aged and Disabled Waiver adult residential care service providers (certified family homes and residential care or assisted living facilities) billing this code will receive a new prior authorization reflecting the new rate for each participant. If you do not receive an updated prior authorization for a participant living in your facility, please contact Molina at 1 (866) 686-4272.

If you have questions about this process, please contact your local Medicaid office. Thank you for participating in the Idaho Medicaid Program.

LH/rs

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May 16, 2014

MEDICAID INFORMATION RELEASE MA14-04

To: All Non-Institutional and School-Based Services Providers

From: Lisa Hettinger, Administrator

Subject: Provider Payments

Effective July 1, 2014, in compliance with Idaho code 56-265 (b), Medicaid reimbursement rate will be at 90% of the current Medicare rate for all non-primary care procedure codes defined by the Centers for Medicare and Medicaid Services. Where there is no Medicare rate on file, the payment rate to Medicaid providers will be based on current Medicaid pricing. Here is a link to the Medicaid Fee Schedule page of the Idaho Department of Health and Welfare's website where you will be able view the updated rates.

If you have additional questions about this change in provider payments, please contact Robert Kellerman, Senior Financial Specialist, Office of Reimbursement at (208) 364-1994.

Thank you for your continued participation in the Idaho Medicaid Program.

LH/rs

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May 16, 2014

Medicaid Information Release #MA14-05

To: Medicaid Dental, Anesthesia, Hospital, Ambulatory Surgical Center (ASC), and Case Management providers

From: Lisa Hettinger, Administrator

Subject: House Bill 395 Changes to the Medicaid Dental Program

Effective July 1, 2014, Medicaid participants age 21 and over who are eligible for Enhanced Plan benefits will have access to full dental benefits including routine dental exams, preventative services such as cleanings, and other dental services including permanent fillings and dentures.

The Idaho Smiles program administrator will individually notify the affected participants of this change. Dental providers will receive an updated Office Reference Manual reflecting these changes. Benefits for all other participants will remain the same.

If you have questions, please contact Idaho Smiles Customer Services at (800) 936-0978. Thank you for participating in the Idaho Medicaid Program.

LH/rs

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May 16, 2014

MEDICAID INFORMATION RELEASE MA14-06

To: Home Health Providers

From: Lisa Hettinger, Administrator

Subject: Home Health Medicaid Caps

The table below summarizes Medicaid cap limits for all home health agency cost settlements effective for dates of service from **July 1, 2014, through June 30, 2015**. Please see IDAPA 16.03.09, Sections 720 and 725 for more information.

Service Type	Revenue Code	Medicaid Cap Limits
Skilled Nursing	551	$172.34
Physical Therapy	421	$163.03
Occupational Therapy	431	$178.80
Speech Therapy	441	$217.98
Home Health Aide	571	$ 69.04

If you have questions about this information, please contact the principal financial specialist in the Office of Reimbursement at the Division of Medicaid at (208) 364-1817.

Thank you for participating in the Idaho Medicaid Program.

LH/rs

Provider Training Opportunities in 2014

You are invited to attend the following webinars offered by Molina Medicaid Solutions Regional Provider Relations Consultants.

June: Claims Adjustments
This course will assist you in adjusting claims on the Trading Partner Account for quick resolution.

Training is delivered at the times shown in the table below. Each session is open to any region but space is limited to 25 participants per session, so please choose the session that works best with your schedule. To register for training, or to learn how to register, visit www.idmedicaid.com and click on the **Training** link in the left-hand menu.

	10 a.m. - 11 a.m. MT	10 a.m. - 11 a.m. MT	10 a.m. - 11 a.m. MT	10 a.m. - 11 a.m. MT	2 p.m. - 3 p.m. MT	2 p.m. - 3 p.m. MT	2 p.m. - 3 p.m. MT
June Claims Adjustments	6/18/2014	6/19/2014	6/11/2014	6/17/2014	6/19/2014	6/17/2014	6/12/2014
July Enrollment	7/16/2014	7/17/2014	7/9/2014	7/15/2014	7/17/2014	7/15/2014	7/10/2014
August Reports	8/20/2014	8/21/2014	8/13/2014	8/19/2014	8/21/2014	8/19/2014	8/14/2014
September Referrals	9/17/2014	9/18/2014	9/10/2014	9/16/2014	9/18/2014	9/16/2014	9/11/2014
October COB	10/15/2014	10/16/2014	10/8/2014	10/21/2014	10/16/2014	10/21/2014	10/9/2014
November Eligibility	11/19/2014	11/20/2014	11/12/2014	11/18/2014	11/20/2014	11/18/2014	11/13/2014
December Claims Adjustments	12/17/2014	12/18/2014	12/10/2014	12/16/2014	12/18/2014	12/16/2014	12/11/2014

If you would prefer one-on-one training in your office with your Regional Provider Relations Consultant, please feel free to contact them directly. Provider Relations Consultant contact information can be found on page 16 of this newsletter.

Medical Care Unit Contact and Prior Authorization Information

Prior Authorizations, Forms, and References
To learn about prior authorization (PA) requirements, Qualis review, or print request forms, go to the medical service area webpage at www.medunit.dhw.idaho.gov. Prior authorization request forms containing the "fax to" number can be found at www.idmedicaid.com. Click on **Forms** under the References section and you will see the PA request forms under the DHW Forms heading. If you prefer to mail in your form, the mailing address is:

Medicaid Medical Care Unit
P.O. Box 83720
Boise, ID 83720-0009

Note: The Medical Care Unit (MCU) does not give authorizations for services over the telephone.

To Check Prior Authorizations Status
Log on to your Trading Partner Account on www.idmedicaid.com. Choose **Form Entry**, then choose **Authorization Status**. If you are unable to identify the reason for a denied service, a Molina Medicaid Solutions representative can provide the medical reviewer's reason captured in the participant's non-clinical notes. If you are unable to view the authorization status, please review the Trading Partner Account Authorization Status Guide located under **User Guides** on www.idmedicaid.com.

To speak to a Molina Medicaid Solutions representative, call 1 (866) 686-4272, option 3.

MCU Medical Review Decisions
If you have any questions about medical review decisions, please refer to the following contact numbers.

	Fax Number	Phone Number
Administratively Necessary Days	1 (877) 314-8779	1 (208) 364-1830
Ambulance*	1 (877) 314-8781	1 (800) 362-7648
Breast & Cervical Cancer	1 (877) 314-8779	1 (208) 364-1839
Durable Medical Equipment	1 (877) 314-8782	1 (866) 205-7403
Hospice	1 (877) 314-8779	1 (208) 364-1904
Pharmacy	1 (800) 327-5541	1 (866) 827-9967
Preventive Health Assistance	1 (877) 845-3956	1 (208) 364-1843
Service Coordination	1 (877) 314-8779	1 (208) 364-1904
Surgery-Procedure-Lab	1 (877) 314-8779	1 (208) 287-1148
Therapy: OT, PT, SLP	1 (877) 314-8779	1 (208) 364-1904
Vision	1 (877) 314-8779	1 (208) 364-1904

* Idaho Medicaid contracts with American Medical Response (AMR) for all non-emergency medical transportation services. Please go to www.idahonemt.net or call 1 (877) 503-1261 for more information.

DHW Resource and Contact Information

DHW Web site	www.healthandwelfare.idaho.gov
Idaho CareLine	2-1-1 1 (800) 926-2588
Medicaid Program Integrity Unit	P.O. Box 83720 Boise, ID 83720-0036 prvfraud@dhw.idaho.gov Fax: 1 (208) 334-2026
Qualis Health	1 (800) 783-9207 Fax: 1 (800) 826-3836 http://www.qualishealth.org/healthcare-professionals/idaho-medicaid
Healthy Connections Regional Health Resource Coordinators	
Region I **Coeur d'Alene**	1 (208) 666-6766 1 (800) 299-6766
Region II **Lewiston**	1 (208) 799-5088 1 (800) 799-5088
Region III **Caldwell**	1 (208) 455-7244 1 (208) 642-7006 1 (800) 494-4133
Region IV **Boise**	1 (208) 334-0717 1 (208) 334-0718 1 (800) 354-2574
Region V **Twin Falls**	1 (208) 736-4793 1 (800) 897-4929
Region VI **Pocatello**	1 (208) 235-2927 1 (800) 284-7857
Region VII **Idaho Falls**	1 (208) 528-5786 1 (800) 919-9945
In Spanish **(en Español)**	1 (800) 378-3385

Insurance Verification

HMS PO Box 2894 Boise, ID 83701	1 (800) 873-5875 1 (208) 375-1132 Fax: 1 (208) 375-1134

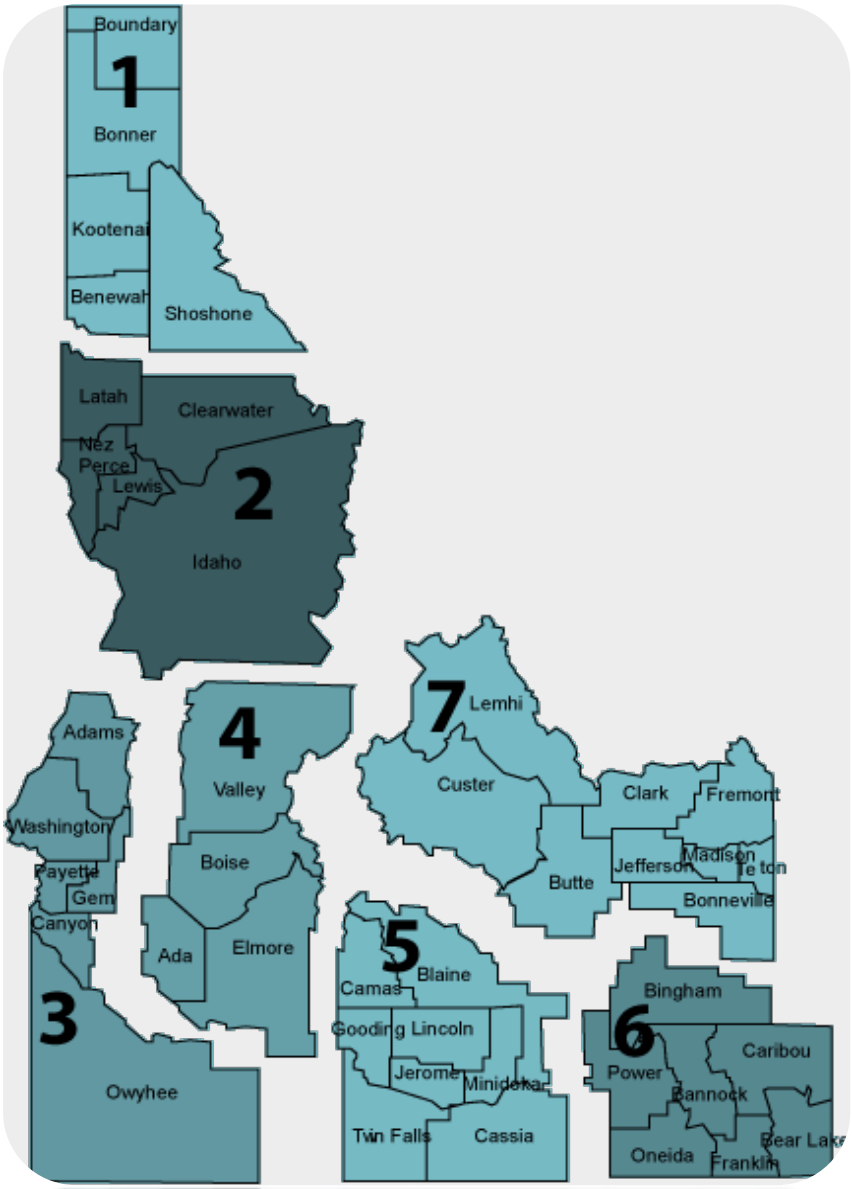
Molina Provider and Participant Services Contact Information

Provider Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4272 1 (208) 373-1424
Provider Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4272 1 (208) 373-1424
E-mail	idproviderservices@molinahealthcare.com idproviderenrollment@molinahealthcare.com
Mail	P.O. Box 70082 Boise, ID 83707
Participant Services	
MACS (Medicaid Automated Customer Service)	1 (866) 686-4752 1 (208) 373-1432
Participant Service Representatives Monday through Friday, 7 a.m. to 7 p.m. MT	1 (866) 686-4752 1 (208) 373-1424
E-mail	idparticipantservices@molinahealthcare.com
Mail – Participant Correspondence	P.O. Box 70081 Boise, ID 83707
Medicaid Claims	
Utilization Management/Case Management	P.O. Box 70084 Boise, ID 83707
CMS 1500 Professional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional	P.O. Box 70084 Boise, ID 83707
UB-04 Institutional Crossover/CMS 1500/Third-Party Recovery (TPR)	P.O. Box 70084 Boise, ID 83707
Financial/ADA 2006 Dental	P.O. Box 70087 Boise, ID 83707

Molina Provider Services Fax Numbers

Provider Enrollment	1 (877) 517-2041
Provider and Participant Services	1 (877) 661-0974

Provider Relations Consultant (PRC) Information



Region 1 and the state of Washington
120 Ironwood Drive Suite 102
Coeur d'Alene, ID 83814
1 (208) 559-4793
Region.1@MolinaHealthCare.com

Region 2 and the state of Montana
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1 (208) 991-7138
Region.2@MolinaHealthCare.com

Region 3 and the state of Oregon
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Caldwell, ID 83605
1 (208) 860-4682
Region.3@MolinaHealthCare.com

Region 4 and all other states
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1720 Westgate Drive, Suite A
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1 (208) 373-1343
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