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**Michigan Medicaid Health Plan Credentialing Reference Guide**

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|  | Application Submission Process | | | | Expectation of Claims Processing/Reprocessing | | | Process Updates |
| Medicaid Health Plan Questions | **Where can a health center locate the plan’s provider credentialing form(s) and process(es), including any credentialing instructions specific to health centers (FQHCs, RHCs, THCs), to ensure credentialing applications are complete when submitted?** | **How long after submission of a credentialing application should a health center anticipate receiving acknowledgement of submission and verification the application was complete from the plan?** | **If a health center does not receive acknowledgement within that timeframe, who can the health center contact to verify the plan received the credentialing application and that it was considered complete?** | **If a health center has not received a final credentialing and contracting outcome for a provider within 150 days of submitting a credentialing application, how and to whom can a health center escalate the issue/delay within the plan?** | **While a provider is undergoing credentialing by the plan, what should a health center do with claims for services rendered to plan members?** | **When a provider’s credentialing process is finished, will the plan require a health center to request retroactive claim adjudication (for services rendered while provider credentialing was occurring)? If yes, how and to whom should a health center submit the request? If no, how will claims adjudication be initiated if not by request?** | **If a health center experiences a problem with adjudication of claims for services rendered while provider credentialing was occurring, who can a health center contact to assist in troubleshooting and resolving the issue?** | **Where can providers expect to find updates or changes to any required forms, processes, or required documentation and are there any associated timeframes that changes can be expected?** |
| Aetna Better Health of Michigan | <https://www.aetnabetterhealth.com/michigan/providers/network> | Within 30 days or less – Once a provider credentialing application is complete and under review, a confirmation correspondence is sent from Aetna Credentialing to the provider. | Provider Relations: **1-855-676-5772** or [e-mail us](mailto:AetnaBetterHealth-MI-ProviderServices@aetna.com). | **Provider Relations: 1-855-676-5772 or**[**e-mail us**](mailto:AetnaBetterHealth-MI-ProviderServices@aetna.com) **–** Provider Relations staff are the point of contact to address any issue, delay or to escalate within the plan. Providers can also email directly to PR for questions on credentialing status at:[**aetnabetterhealth-MI-ProviderServices@aetna.com**](mailto:aetnabetterhealth-MI-ProviderServices@aetna.com) | Continue to submit as normal.  FQHC/RHCs should expect claims to adjudicate as normal in that provisions are in place to allow claims to process and pay under the MDHHS Provider Manual guidance. Should FQHC/RHC experience any issues they should contact Aetna’s Claims Inquiry Claims Research (CICR) team for assistance at 1-855-676-5772. | No. Aetna will automatically pull claims projects retro back to any approved start date. | Aetna Better Health of MI Claims Inquire Claims Research (CICR) at: **1-855-676-5772** | <https://www.aetnabetterhealth.com/michigan/providers/network> - See the Aetna Better Health website under Provider Section the Provider Manual, Chapter 5 for detailed information on credentialing/recredentialing activities/timelines [abhmi\_provider\_manual\_medicaid.pdf (aetnabetterhealth.com)](https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.aetnabetterhealth.com%2Fcontent%2Fdam%2Faetna%2Fmedicaid%2Fmichigan%2Fprovider%2Fpdf%2Fabhmi_provider_manual_medicaid.pdf&data=04%7C01%7Ctstone%40mahp.org%7Ccc541abc5ec348a7482c08da18bf5556%7Cf53d369428c440659f4ef4f07de29ddc%7C0%7C0%7C637849507454964830%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0&sdata=DnIBLiKwkjSPaHUOcSsAK%2BgNShRGxiSBksc0B9izpqY%3D&reserved=0) |
| Blue Cross Complete of Michigan | Blue Cross Complete of MI-applications and forms can be found here: <https://www.bcbsm.com/providers/join-the-blues-network/join-provider-network.html>  Blue Cross Complete information can be found here:  <https://www.mibluecrosscomplete.com/index/>  Questions regarding BCC enrollment can be addressed to the BCC Provider Data Mailbox at: [BCCProviderData@mibluecrosscomplete.com](mailto:BCCProviderData@mibluecrosscomplete.com) and are generally responded to within 2 business days. – BCC has a special link for the FQHC providers under Enrollment Forms. | When completed applications are submitted to the BCC Provider Data Mailbox at: [BCCProviderData@mibluecrosscomplete.com](mailto:BCCProviderData@mibluecrosscomplete.com) an automated response is sent back for confirming receipt. If the provider’s information is incomplete, a BCC Data Analyst will outreach to the provider’s contact alerting them to what is needed. The provider has 30 days to provide the needed documentation or the provider’s record will be closed. If the application is complete - a welcome letter notifying the provider they are enrolled/PAR is sent to the provider’s contact usually within 60 - 90 days. | Inquiries regarding a provider’s BCC enrollment can be submitted to the BCC Provider Data Mailbox at: [BCCProviderData@mibluecrosscomplete.com](mailto:BCCProviderData@mibluecrosscomplete.com)  The mailbox administrator will route inquiries to the appropriate BCC analyst(s) and are generally responded to within 2 business days. | Any and all Inquiries regarding a provider’s BCC enrollment/credentialing can be submitted to the BCC Provider Data Mailbox at: [BCCProviderData@mibluecrosscomplete.com](mailto:BCCProviderData@mibluecrosscomplete.com)  The mailbox administrator will route inquiries to the appropriate data analysts BCC – The application informs providers how long they can expect it to take depending on their situation. If they have to be credentialed by BCN, we indicate that can take about 30 days. Then once that comes back we need about 30 days to complete the process for a total of 60 days on average. | They should bill claims normally while they are undergoing the credentialing process. Providers can see BCC members and will be reimbursed at MDHHS Rates as long as they are active CHAMPS providers. (See details in [BCC Enrollment process for FQHCs, RHCs, and THCs](file:///C://Users/KelseaFrazier/Downloads/bcc-fqhc-enrollment-process%20(2).pdf) for details) | Provider is not required to request retroactive claim adjudication at the completion of credentialing. However, if provider identifies any issues with claims processing, they may contact their assigned account executive for assistance in addressing. | The provider can reach out to their assigned Account Executive.  <https://www.mibluecrosscomplete.com/providers/resources> | Blue Cross Complete information can be found here:  <https://www.mibluecrosscomplete.com/index/>  <https://www.mibluecrosscomplete.com/providers/resources> |
| HAP Empowered | The credentialing process and forms can be found at <https://www.hap.org/providers/become-a-provider>. If providers have questions or need help, they can email [providernetwork@hap.org](mailto:providernetwork@hap.org) during any step in the process. For physicians, Credentialing will also download information from their CAQH file (universal credentialing application). | The enrollment process takes approximately 60 days. Credentialing turn-around average is 30 days. – If the practitioner requests the status of his/her application, HAP provides practitioner with the approximate data when the application will be presented to the Credentialing Committee and any outstanding primary source verification letters either by telephone, email, or written correspondence. | They can email providernetwork@hap.org. | The HCC can email the Credentialing Manager, Janet Krajnovic, [jkrajno@hap.org](mailto:jkrajno@hap.org) or VP of Provider Network Management, Richard Trembowicz, rtrembo1@hap.org. | A provider is non-par until the credentialing process is completed. If a provider bills prior to the effective date, claims will deny. HAP allows FQHC providers to request a retroactive effective date for network participation. The provider will be non-par until the provider is credentialed and contracted. Once the credentialing and contracting processes are completed, the provider will be loaded as par. Upon provider request the claims will be reprocessed as par with no impact to the providers. This is true for all provider types. | Due to the future effective date based on the current credentialing process, reprocessing will not change the outcome of the previously submitted claim. – Upon the provider’s request Provider Network Management will retroactive the effective date back to the date of receipt of the application. | All claims processing issues should be directed to Provider Inquiry at 866-766-4661. | In the HAP Empowered Provider Newsroom or the HAP Empowered Provider Manual. Both are located at hap.org\empoweredproviders. Providers are notified of updates, changes, etc. at least 15 days in advance of the effective date. |
| McLaren Health Plan | On the McLaren Health Plan website at Mclarenhealthplan.org – click are you a Provider / Provider Information/Credentialing | Within 7 Calendar Days. – A letter will be mailed or emailed to the Provider stating MHP has received all required information and that the Provider has been sent to Credentialing and after Credentialing is complete a determination letter will be mailed. | McLaren Health Plan will always send an acknowledgement letter; however, if you do not receive one, please reach out to your Provider Relations Representative. If you do not know your Provider Relations Representative, please contact our Provider line at 888-327-0671 option 2. | Please contact our Credentialing department via email at mhpcredentialing@mclaren.org if you do not hear back from us within 60 days of receiving your acknowledgement letter. | Submit all claims for service rendered as normal, expecting that they will deny, and work with your provider Relations Representative for the necessary reprocessing upon receiving committee approval for network participation. – After credentialing is complete and provider is active and loaded into McLaren system - Provider office would contact their Representative by contacting Cust Service at (888) 327-0671 or via portal requesting claims be reprocessed or check status. | Contact your McLaren Health Plan Provider Relations Representative. If you do not know your Provider Relations Representative, please contact our Provider line at 888-327-0671 option 2. – After credentialing is complete and the provider is active and loaded into McLaren system - Provider office would contact their Representative by contacting Cust Service at (888) 327-0671 or via portal requesting claims be reprocessed and a retro effective date be put into place. | Contact your McLaren Health Plan Provider Relations Representative. If you do not know your Provider Relations Representative, please contact our Provider line at 888-327-0671 option 2. | Providers may navigate to the McLaren Health Plan website at Mclarenhealthplan.org to learn of any updates by review of our Provider Newsletter, Provider Update Communication or Provider Manual. |
| Meridian Health Plan of Michigan | Health centers can enroll providers through the [Provider Network Participation & Enrollment Process webpage](https://www.mimeridian.com/providers/become-a-provider.html). A listing of the provider representatives & contact information is available on Meridian’s website at [Provider Home | MeridianHealth of Michigan (mhplan.com)](https://corp.mhplan.com/en/provider/michigan/meridianhealthplan/). | Once information has been submitted to the webpage, providers will receive email notification indicating that information was received. Meridian is working to include credentialing reference numbers in the future. | The health center can contact their assigned provider representative or Meridian’s provider call center (at 888-773-2647) - see column 2 for website with provider reps. Please include provider name and NPI in outreach. | The health center can contact their assigned provider representative. Please include provider name and NPI in outreach emails. | The health center may submit claims throughout the credentialing process to review payment. Meridian will review and process if claims meet all other billing criteria. | Because Meridian pays claims from non-par providers, claims should not require retroactive adjudication. If a health center needs assistance, the health center can contact their assigned provider representative.  This is the same for all provider types. | The health center can contact their assigned provider representative. | Updates may be shared via Meridian’s Provider Newsletter, within updates to the Provider Manual, notices within the Provider Portal/Website, or during JOC meetings with assigned provider representatives. – JOC meetings are held between Meridian and the provider/provider group. |
| Molina Healthcare of Michigan | Established health centers have instructions to submit new providers directly to Molina’s Contract Configuration Department at [MHMContractConfigDept@MolinaHealthCare.Com](mailto:MHMContractConfigDept@MolinaHealthCare.Com)  New providers/groups can access information in the Provider Manual at: <https://www.molinahealthcare.com/providers/mi/medicaid/manual/provmanual.aspx> or by submit a contract request form at: https://www.molinahealthcare.com/providers/mi/medicaid/forms/crf.aspx | For new groups/ providers with the web form, Providers may expect a response within 5-7 business days.  For new providers in currently established groups using the roster submission, providers can expect a response within 5 business days. – Responses to groups/providers are sent via email to the submitter(s). | Health centers can reach out to the MHM Contract Configuration Department at [MHMContractConfigDept@MolinaHealthCare.Com](mailto:MHMContractConfigDept@MolinaHealthCare.Com) | Health centers can reach out to the MHM Contract Configuration Department at [MHMContractConfigDept@MolinaHealthCare.Com](mailto:MHMContractConfigDept@MolinaHealthCare.Com) – These follow-ups are categorized as Status Checks and have a 2-3 business day turn around time for a response back to the health center to provide the status. | In order for providers to bill claims while undergoing credentialing, Molina has a unique process of creating a provisional record for providers with a new COMPLETE contract or for new providers within an already established group while being credentialed.  The provisional record allows claims to go through as if the provider was participating---however, the provider is still considered non-participating until fully credentialed for directory and member assignment (if PCP) purposes. – As long as all required information for a provider is received on a roster, no additional steps are needed from health centers. | With the provisional process, the need to request retroactive claims adjudication is generally not needed. However, Molina does make specific exceptions working with providers to retroactively add the provisional record to cover past claims. These exceptions require internal approval and requests are generally handled through Provider Network, at which point impacted claims are reprocessed by the plan. | The assigned Provider Network Representative | Providers are encouraged to utilize the Molina website for updated forms, processes, or required documentation. Plan will also send email, fax blasts, and/or written correspondence of updates, changes, etc directly to provider groups.  Note:  Molina utilizes the CAQH for validation in many instances so, providers are encouraged to update their information in CAQH also. |
| Priority Health Choice | On our provider website: [Credentialing criteria by organization type | Priority Health](https://www.priorityhealth.com/provider/manual/standards/credentialing/organizations) | 2-4 business days the provider will receive an inquiry number that they will utilize throughout the process. The application will be reviewed within 30 days for accuracy – Information will be made available on the portal. | The provider representative can reach out to our customer service phone number [800.942.4765](tel:800-942-4765) | We have a dedication email that the provider can reach out to [Exceedsprocessingtime@priorityhealth.com](mailto:Exceedsprocessingtime@priorityhealth.com) | The provider is informed not to see members until they receive the notice that they have been enrolled in our health plan – Priority Health will retro dates for FQHC provider groups back to the date the request was submitted, upon request. | They would need to appeal any claim denied before they were enrolled and able to provide services to our members. <https://www.priorityhealth.com/provider/manual/news/priority-health/10-15-2020-new-process-for-post-claim-appeals> - Priority Health will retro dates for FQHC provider groups back to the date the request was submitted. | The provider representative can reach out to our customer service phone number [800.942.4765](tel:800-942-4765) | The Priority Health website: <https://www.priorityhealth.com/provider> -  <https://www.priorityhealth.com/provider/manual/standards/credentialing/application>  <https://www.priorityhealth.com/provider/manual/news> |
| UnitedHealthcare Community Plan | Health Center can view credentialing process at [Join Our Network | UHCprovider.com](https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html). They can also reach out to their Network Contractor or [networkhelp@uhc.com](mailto:networkhelp@uhc.com) for a facility credentialing application. | Health Center should expect all information was received and is complete unless outreached to by the credentialing team. Credentialing may be completed within 60 days. – Health center would be communicated to by email to the credentialing contact listed on the application.  For practitioners, when credentialing is submitted via OnboardPro, status can be viewed there, approval notice of credentialing should be communicated via email to the submitter of OnboardPro. | Health Center should reach out to [natlcred\_components@uhc.com](mailto:natlcred_components@uhc.com) or contact their network contractor. | Health Center should reach out to [natlcred\_components@uhc.com](mailto:natlcred_components@uhc.com) or contact their network contractor. | Unless otherwise allowed by state regulations, the provider must be approved through both the credentialing and contracting processes – and receive confirmation from us that each step is complete – before provider can see patients as an approved network provider  If there is a need prior to provider being approved as a network provider, provider should obtain authorization to see members.  Health Centers are identified out of network until credentialed. Claims payments are made regardless under this out of network status. Therefore, Health Center should submit claims as services are rendered.  While a health center is waiting to be credentialed , they should be able to see Medicaid members and be reimbursed according to the state agency rate for FQHCs, whether par or non-par.  While practitioners are waiting to be credentialed, they would only be billing if providing services outside of the FQHC services; therefore, would need to obtain prior authorization as an out-of-network provider until credentialing and added to the FQHC agreement. | If the provider is not credentialed, they are not contracted, and claims will not be reconsidered unless authorization was obtained.  For Health Centers, claims payments are made regardless under an out of network status. Therefore, Health Center should submit claims as services are rendered. | Health Center should utilize UHC provider portal or contact customer service for troubleshooting and resolving claim issues. | UHC will post updates/changes at least 30 days in advance through the Network Bulletin, or at [www.uhcprovider.com](http://www.uhcprovider.com)  All providers are encouraged to subscribe to receive UHC’s Network Bulletin, [Subscription Page (uhc.com)](https://cloud.provideremail.uhc.com/subscribe). |
| Upper Peninsula Health Plan | Provider Manual at uphp.com or email [credentialing@uphp.com](mailto:credentialing@uphp.com) or [uphpproviderrelations@uphp.com](mailto:uphpproviderrelations@uphp.com) | 2 Weeks – This would be communicated via email. Once we have inputted the provider’s data into our system and determined if the application is complete or if we are missing something, we would then send an email. | [uphpproviderrelations@uphp.com](mailto:uphpproviderrelations@uphp.com) or [credentialing@uphp.com](mailto:credentialing@uphp.com) | Contact Taylor Fraley, Credentialing Manager at [tfraley@uphp.com](mailto:tfraley@uphp.com) or 906-227-5695 | UPHP will pay all FQHC claims regardless of network status.  Network status is not considered in the adjudication of FQHC claims. | Send request to [tfraley@uphp.com](mailto:tfraley@uphp.com) | Claims Services at [claimservices@uphp.com](mailto:claimservices@uphp.com) | Provider Manual at uphp.com or email [credentialing@uphp.com](mailto:credentialing@uphp.com) or [uphpproviderrelations@uphp.com](mailto:uphpproviderrelations@uphp.com) |