Mississippi Medicaid:

Telligen Provider Review Training – DME/Durable Medical Supplies

September 2025

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Agenda

- Agenda
- Contact Information
- Review Timing Overview
- Verifying Eligibility
- Entering Physician Information
- InterQual
- RFI, Change Request and Discharge Task
- Appeals & Denials
- Website Tour
- Q&A

Housekeeping

Questions

- Please enter all questions into the chat
- Any unanswered questions will be answered and posted to the website

Survey

- All registrants will be sent a Survey via email following today's training. Telligen welcomes your feedback and suggestions on future training opportunities.

Feedback

- For specific complaints or to provide feedback on the review process, please send your concerns through our Provider Help Desk via Email: msmedicaidum@telligen.com or Toll-Free Phone: 855-625-7709

Contact Us

Education Manager – Primary Point of Contact

Charity A Jones chjones@telligen.com

Book 1 on 1: Book with Charity

Website: https://msmedicaid.telligen.com/

Mississippi Call Center & Provider Help Desk

- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Portal Registration Questions

- Email: qtregistration@telligen.com
- Toll-Free Phone: (833) 610-1057

Program Manager

Claudia Collins

Assistant Program Manager

Cassandra Bullock

Understanding Key Review Terms

Review Types, Review Timings, & Extension of Services

Review Timings

- **Prospective**—Review submitted before services begin, covering future dates
- **Concurrent**—Initial review for services already in progress, covering a date span under one authorization. Concurrent reviews are ongoing admission.
- **Retrospective:** Retroactive authorizations are applicable when there has been a change in coverage, and the patient is determined to be retroactively eligible. The start and discharge/end dates must occur before the request date.

The timing of a review in Qualitrac is determined by when the services are/were provided

Submitting a Review

Telligen Provider Portal – Required Sections

The following panels will be required for your request:

- **Authorization Request Type**
- **Dates of Service**
- **Eligibility Verification**
- **Providers & Provider Organization Visibility**
- **Diagnosis &Procedures**
- **Documentation**
- **InterQual**

Verifying Eligibility

Verifying Eligibility

- **Why Eligibility Verification Matters**
  - Confirms active Medicaid coverage for the date of service
  - Avoids denials due to eligibility issues
  - Provides details on benefit plans, managed care assignments, and limitations

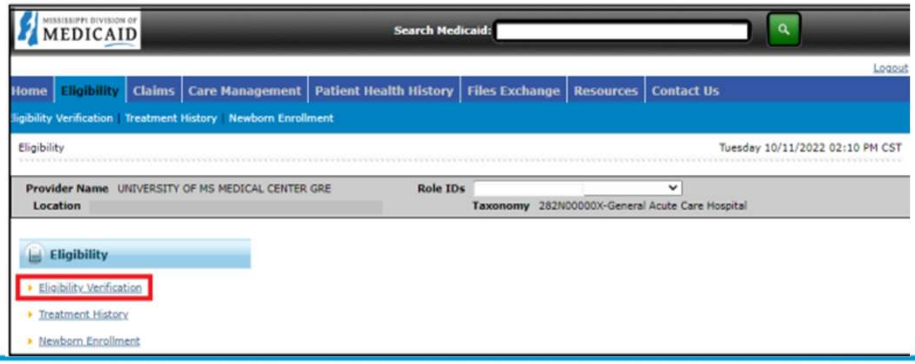
Telligen reviews only beneficiaries enrolled in the TXIX Benefit Plan, except for three specific review types.

- Swingbed services
- ICF-IID
- KBP (formerly DCLH)

Key Takeaways

- Verify eligibility **before** submitting Prior Authorization Request
- Verify eligibility **before** providing services





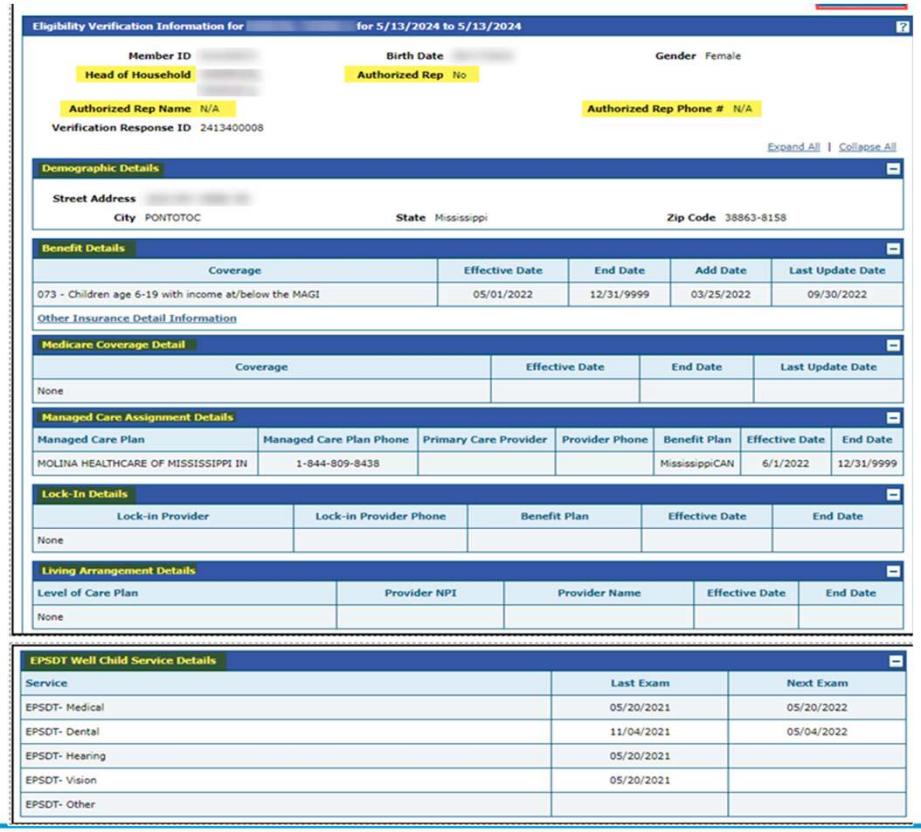
Verifying Eligibility

1. Enter the Member ID, or if you don't have it, enter two of the following: SSN• DOB or Member's Full Name
2. Enter the Beain Date and the End Date





Verifying Eligibility · Beneficiary Record Summary



Eligibility Verification Information for [redacted] for 5/13/2024 to 5/13/2024

Member ID [redacted] Birth Date [redacted] Gender Female
Head of Household [redacted] Authorized Rep No
Authorized Rep Name N/A Authorized Rep Phone # N/A
Verification Response ID 2413400008

Expand All | Collapse All

Demographic Details

Street Address [redacted]
City PONTOTOC State Mississippi Zip Code 38863-8158

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
073 - Children age 6-19 with income at/below the MAGI	05/01/2022	12/31/9999	03/25/2022	09/30/2022

Other Insurance Detail Information

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	6/1/2022	12/31/9999

Lock-In Details

Lock-in Provider	Lock-in Provider Phone	Benefit Plan	Effective Date	End Date
None				

Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

EPSDT Well Child Service Details

Service	Last Exam	Next Exam
EPSDT- Medical	05/20/2021	05/20/2022
EPSDT- Dental	11/04/2021	05/04/2022
EPSDT- Hearing	05/20/2021	
EPSDT- Vision	05/20/2021	
EPSDT- Other		

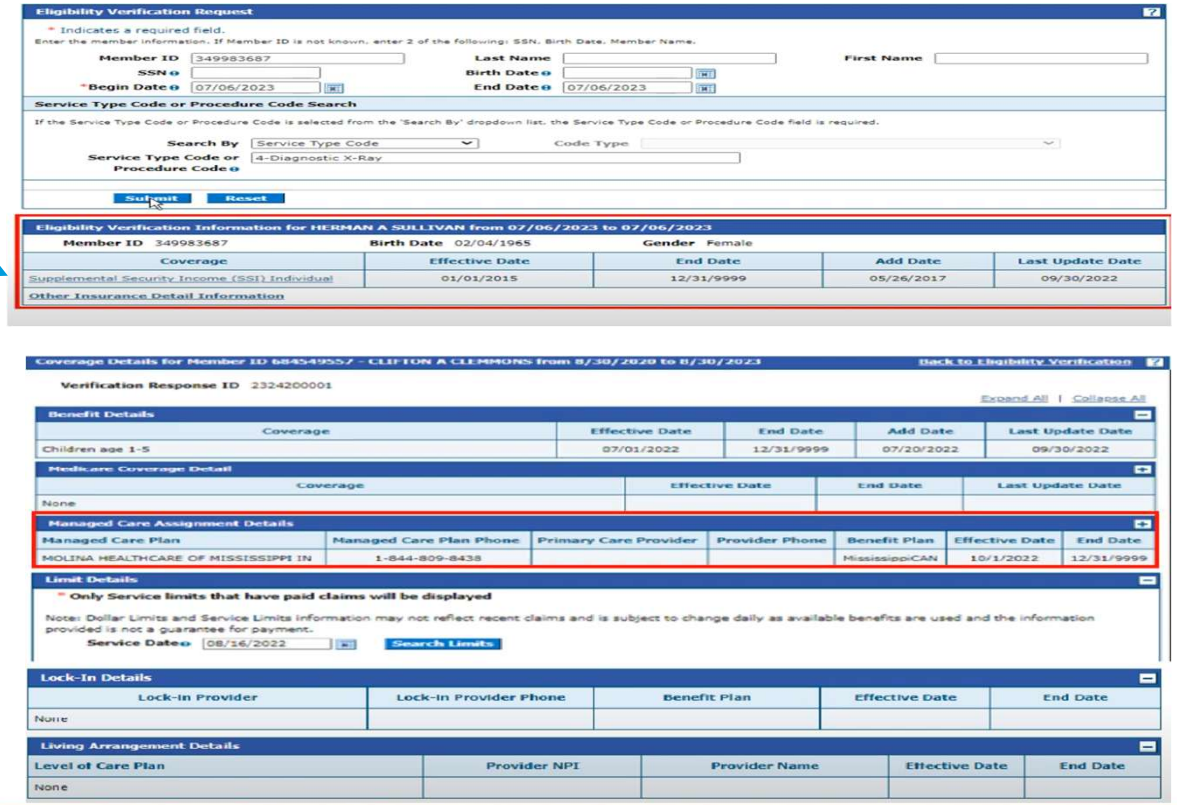
The system returns the eligibility verification for the member including the following: applicable

- Head of Household
- Authorized Rep Name
- Authorized Rep Phone #
- Demographic Details,
- Benefit Details
- Managed Care Details
- Lock-In Details
- Living Arrangement Details, and EPSTD details.

Remember, coverage is not a guarantee as a member can lose eligibility for a variety of reasons

Verifying Eligibility · Beneficiary Record Summary

To see more of the benefit plan, click the Medicaid Policy link.



Eligibility Verification Request

* Indicates a required field.

Enter the member information. If Member ID is not known, enter 2 of the following: SSN, Birth Date, Member Name.

Member ID 349983687 | Last Name | First Name

SSN | Birth Date

*Begin Date 07/06/2023 | End Date 07/06/2023

Service Type Code or Procedure Code Search

If the Service Type Code or Procedure Code is selected from the 'Search By' dropdown list, the Service Type Code or Procedure Code field is required.

Search By: Service Type Code | Code Type

Service Type Code or Procedure Code: 4-Diagnostic X-Ray

Submit | Reset

Eligibility Verification Information for HERMAN A SULLIVAN from 07/06/2023 to 07/06/2023

Member ID 349983687 | Birth Date 02/04/1965 | Gender Female

Coverage	Effective Date	End Date	Add Date	Last Update Date
Supplemental Security Income (SSI) Individual	01/01/2015	12/31/9999	05/26/2017	09/30/2022

Other Insurance Detail Information

Coverage Details for Member ID 684549557 - CLIFTON A CLEMMONS from 8/30/2020 to 8/30/2023 — Back to Eligibility Verification

Verification Response ID 2324200001

Expand All | Collapse All

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
Children age 1-5	07/01/2022	12/31/9999	07/20/2022	09/30/2022

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	10/1/2022	12/31/9999

Limit Details

** Only Service limits that have paid claims will be displayed

Note: Dollar Limits and Service Limits information may not reflect recent claims and is subject to change daily as available benefits are used and the information provided is not a guarantee for payment.

Service Date 08/16/2022 | Search Limits

Lock-In Details

Lock-In Provider	Lock-In Provider Phone	Benefit Plan	Effective Date	End Date
None				

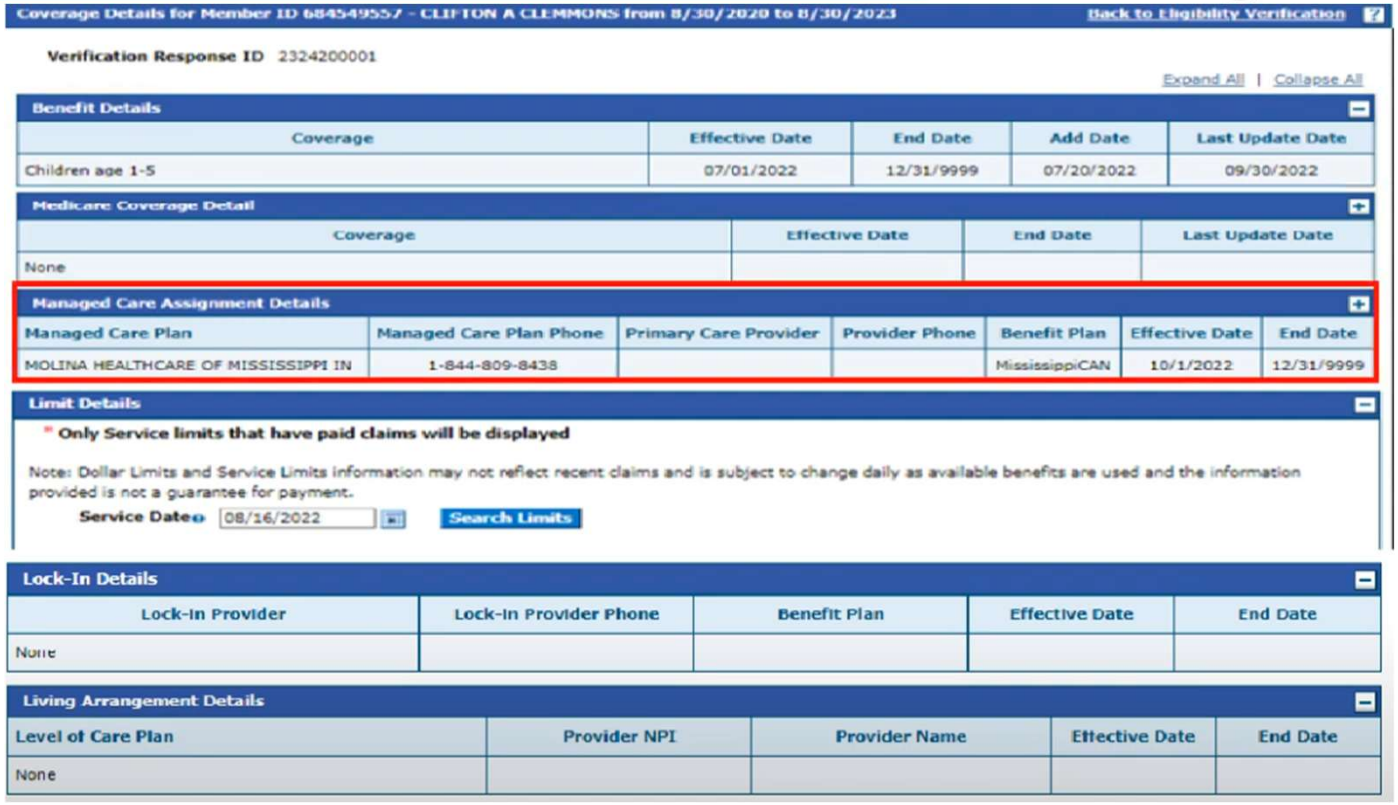
Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

Verifying Eligibility · Beneficiary Record Summary

The Benefit Screen

- Benefit Plan
- Medicare Coverage Detail
- Manage Care Details
- Lock In Details & more



Coverage Details for Member ID 684549557 – CLIFTON A CLEMMONS from 8/30/2020 to 8/30/2023 — Back to Eligibility Verification

Verification Response ID 2324200001

Expand All | Collapse All

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
Children age 1-5	07/01/2022	12/31/9999	07/20/2022	09/30/2022

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	10/1/2022	12/31/9999

Limit Details

** Only Service limits that have paid claims will be displayed

Note: Dollar Limits and Service Limits information may not reflect recent claims and is subject to change daily as available benefits are used and the information provided is not a guarantee for payment.

Service Date 08/16/2022 Search Limits

Lock-In Details

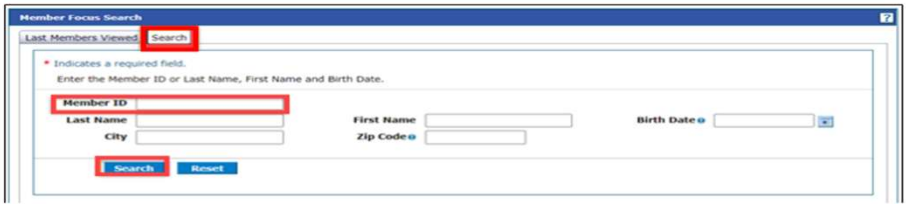
Lock-In Provider	Lock-In Provider Phone	Benefit Plan	Effective Date	End Date
None				

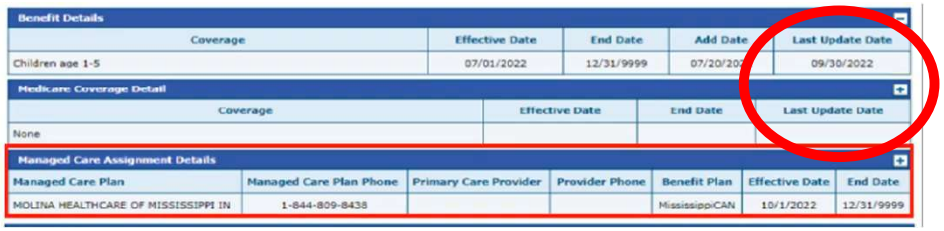
Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

Verifying Retro Eligibility







1. To view Retro Eligibility, log into the portal, and select the Member Focused Viewing Link found at the bottom, left side of the home page.

2. Select the Search Tab, enter the Member ID, and select Search.

3. This shows you the member demographics, the original effective date, and the end date of coverage.

Per Mississippi Medicaid Admin Code Title 23, Part 200, Rule 1.8, claims denied for untimely filing may only be reviewed if the member has retroactive eligibility and prior authorization (if required) was obtained within 90 days of the eligibility add date.

Timely filing depends on whether the date of service is before or after the add date:

Retro Vs. Not Retro Eligible

Date of Service (DOS): 2/4/2025

Benefit Add Date in MESA: 4/2/2025

📌 **Explanation:**

The Date of Service occurred **before** the add date, the patient is **retro eligible**.

The provider now has **90 calendar days from the Add Date** to submit a prior authorization request.

Date of Service (DOS): 6/2/2025

Benefit Add Date in MESA: 3/25/2024

📌 **Explanation:**

The Date of Service occurred after the add date, the patient is **not retro eligible.**

Entering Physician / Facility Information

Providers Panel: Physician and Provider Information

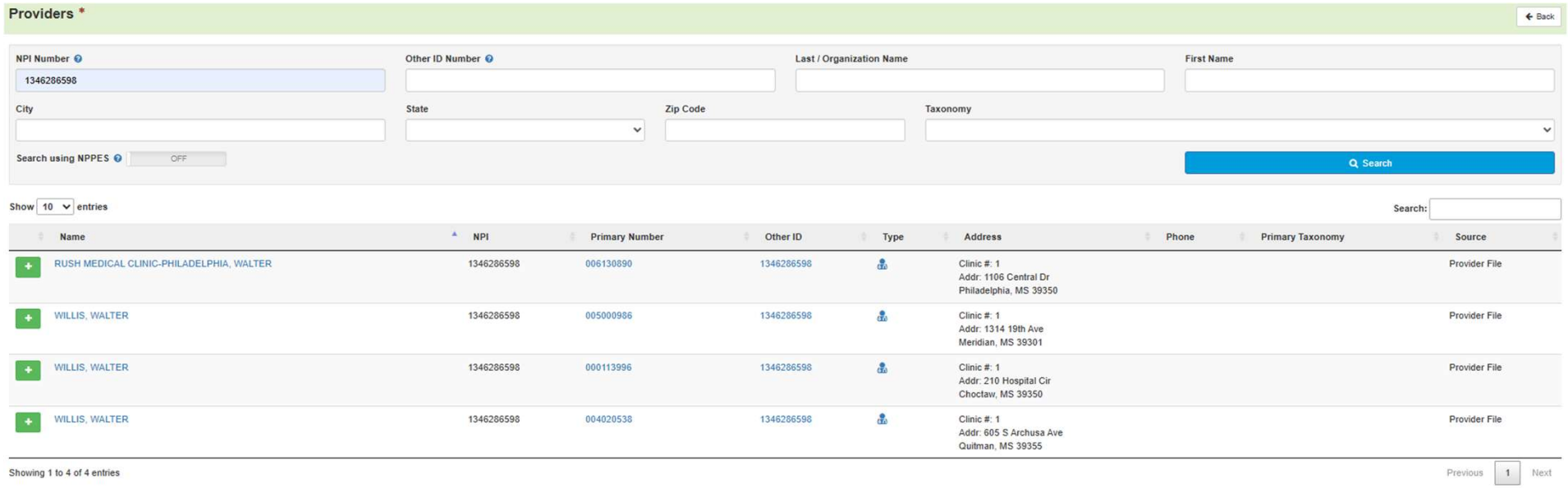
- **Providers:** This section requires information related to who is ordering and providing the care:
  - *Ordering Provider*- The person or Organization ordering the care
  - *Treating Provider* – The **DME Provider**



click the Add button on each box to fill in the necessary provider information

Entering Physician and Facility Information by NPI

- **Clicking** + Add will open a search box. You can search by entering an **NPI number**, Medicaid ID, or by filling in any of the information boxes provided if the NPI is not known.
- Once you have entered the necessary information, click search to locate the physician or facility you are looking for.

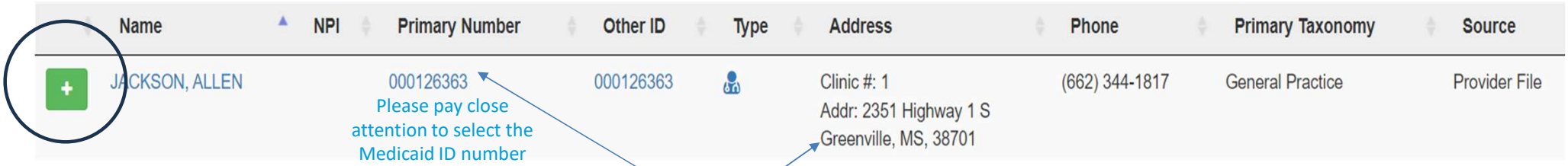


Entering Physician and Facility Information

- Clicking search will return **all** results that meet your entered criteria.
- Click the blue hyperlink in the provider's name to view additional details.
- Check the provider details before selecting, validating the correct provider and the taxonomy ID align to the services being requested

Use the green plus box next to the name to select the provider/facility that you need for the review.

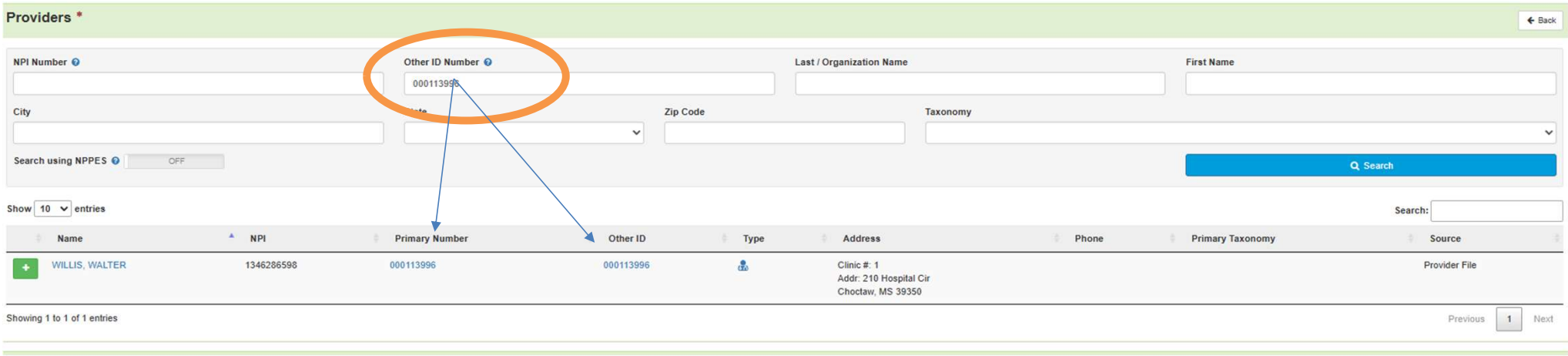




Please pay close attention to the name and location selected.
Example: DME Services LLC vs DME Services Inc. This is an important point because some providers have multiple locations under the same NPI and possibly similar name.

Entering Physician and Facility Information by Medicaid Provider ID

- **Clicking** + Add will open a search box. You can search by entering an NPI number, **Medicaid ID**, or by filling in any of the information boxes provided if the NPI is not known.
- Once you have entered the necessary information, click search to locate the physician or facility you are looking for.



Documentation

Understanding the Clinical Narrative in F2F Documentation

The clinical narrative is a **critical component** of any Face-to-Face (F2F) document. It provides a clear, detailed account of the patient's condition, limitations, and the **clinical justification** for the requested service or equipment. This narrative helps establish **medical necessity**, particularly for Durable Medical Equipment (DME), Home Health Services, and other Medicaid-covered services requiring prior authorization.

What Should the Clinical Narrative Include?

- Date of the face-to-face encounter
- Relevant diagnosis and medical history
- Current clinical condition, including physical and/or functional limitations (e.g., mobility, ADLs, pain, cognitive status)
- Provider's reasoning for recommending the specific item or service
- Evidence of decision-making, based on the exam, observations, or patient report
- Explanation of how the requested service or equipment will benefit the patient's health or daily functioning

Understanding the Clinical Narrative in F2F (continued)

Avoid generic language such as "*Patient needs wheelchair.*"

Option 1
A wheelchair is medically necessary as the patient's diagnosis of _____ causes significant functional limitations, preventing safe ambulation and requiring a wheelchair to complete activities of daily living.

Option 2
Due to the patient's condition of _____ and related mobility impairments, a wheelchair is required to ensure safe mobility and allow participation in essential activities of daily living within the home.

Option 3
Because of the patient's diagnosis of _____ and resulting inability to ambulate independently, a wheelchair is medically necessary to support safe transfers, mobility, and completion of daily living tasks.

Option 4
The patient's diagnosis of _____ results in functional deficits that make ambulation unsafe; therefore, a wheelchair is required to maintain independence and safety with activities of daily living.

Sample Clinical Narrative

The patient was evaluated in clinic today for mobility needs. The patient has a documented diagnosis of _____ with functional limitations including _____, which result in an inability to ambulate independently or safely with less supportive devices such as a walker or crutches. Due to these limitations, the patient requires the use of a _____ (manual/power) wheelchair for safe mobility within the home and community. The wheelchair will provide independence with activities of daily living, reduce caregiver burden, and allow the patient to safely access essential areas of the home including the bathroom, bedroom, and kitchen. Without the use of a wheelchair, the patient is at increased risk for _____ (e.g., falls, skin breakdown, immobility complications) and decreased participation in therapy and daily care. A _____ wheelchair with appropriate seating and positioning features is medically necessary to address these needs.

Patient was evaluated in clinic today for ongoing mobility needs. The patient has a documented diagnosis of cerebral palsy with significant lower extremity weakness and spasticity, resulting in inability to ambulate independently or safely with assistive devices such as a walker or crutches.
Due to these limitations, the patient requires the use of a wheelchair for safe mobility within the home and community. The wheelchair will provide independence with activities of daily living, reduce caregiver burden, and allow the patient to safely access necessary areas of the home including bathroom, bedroom, and kitchen. Without a wheelchair, the patient is at risk for falls, skin breakdown from prolonged bed rest, and decreased participation in therapy and daily care. A manual wheelchair with appropriate seating and positioning features is medically necessary to address these functional needs.

Sample Clinical Narrative (shorter versions)

A wheelchair is medically necessary due to the patient's diagnosis of _____ and resulting functional limitations, which prevent safe ambulation with less supportive devices and require a_____(manual or power) wheelchair to complete activities of daily living within the home.

Patient with **paraplegia** was evaluated today for mobility. Due to inability to ambulate or use less supportive devices safely, a **manual wheelchair** is medically necessary for safe mobility and to complete activities of daily living within the home.

Required Documentation for Manual Wheelchairs

- **Telligen Generic Certificate of Medical Necessity** (CMN) (signed by the Ordering Provider)
  A completed CMN, that includes the physician's order, diagnosis, item description and duration (dates of service)
- **Face-to-Face**(within 6 months of the request)(Signed by the Ordering Provider)
  - Must be the original clinical document from the visit
  - Includes the statement of need for equipment
  - include mobility limitation
  - Plan of Care

- **Manual Pricing Documentation (if applicable)**
  - Manufacturer's Suggested Retail Price (MSRP) Quote & Summary

Reminder, All documentation should include 2 patient identifiers

Required Documentation for Power Wheelchairs

- **Physician Order**
- **Face-to-Face** (within 6 months of the request) that includes:(Signed by the Ordering Provider)
  - Must be the original clinical document from the visit
  - Includes the statement of need for equipment
  - include mobility limitation
  - Plan of Care
- **Complex Certificate of Medical Necessity Form** (CMN)(signed by the Ordering Provider)
- **Seating Evaluation &Home Evaluation**(signed by independent RESNA certified PT/OT)
- **Certified ATP Professional Certificate**
- **Manufacturer's Suggested Retail Price**(MSRP) **Quote and Summary**, if applicable

Reminder, All Documentation should include 2 patient identifiers

Required Documentation for Incontinence Supplies (overage)

If a beneficiary requires more than six (6) incontinence garments per day, prior authorization is necessary. In such cases, a physician must submit documentation justifying the medical necessity for the increased quantity. Providers must include:

- **Telligen Certificate of Medical Necessity** (CMN) (signed by the Ordering Provider)

  A completed CMN, that includes the physician's order, diagnosis, item description and duration

- **Face-to-Face** (within 6 months of the request) that includes:(Signed by the Ordering Provider)
  - Must be the original clinical document from the visit
  - Includes the statement of need for equipment
  - include mobility limitation
  - Plan of Care

- **Manufacturer's Suggested Retail Price**(MSRP) **Quote and Summary**, if applicable

Reminder, All Documentation should include 2 patient identifiers

Required Documentation for Oxygen

Per Title 23, Part 209, Rule 1.35 of the Admin Code: Recertification is required annually for continued oxygen therapy.

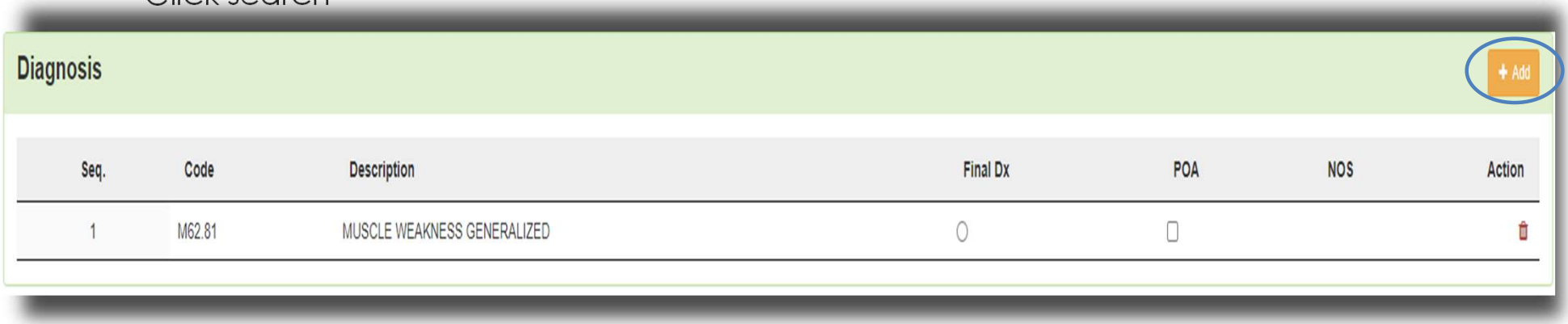
- **Physician Order** (should include):
  - Diagnosis necessitating oxygen therapy
  - Oxygen flow rate
  - Frequency and duration of use
  - Estimated period of need
  - Type of oxygen delivery system
  - A qualifying blood gas study (oximetry or ABG) must meet Group I or Group II criteria (e.g., $PO_2 \leq 55$ mmHg or O_2 saturation $\leq 88\%$) and be conducted under appropriate clinical conditions—either during an inpatient stay, outpatient visit, or with documentation that testing on room air would be life-threatening.

Reminder, All Documentation should include 2 patient identifiers

Procedure Codes and Modifiers

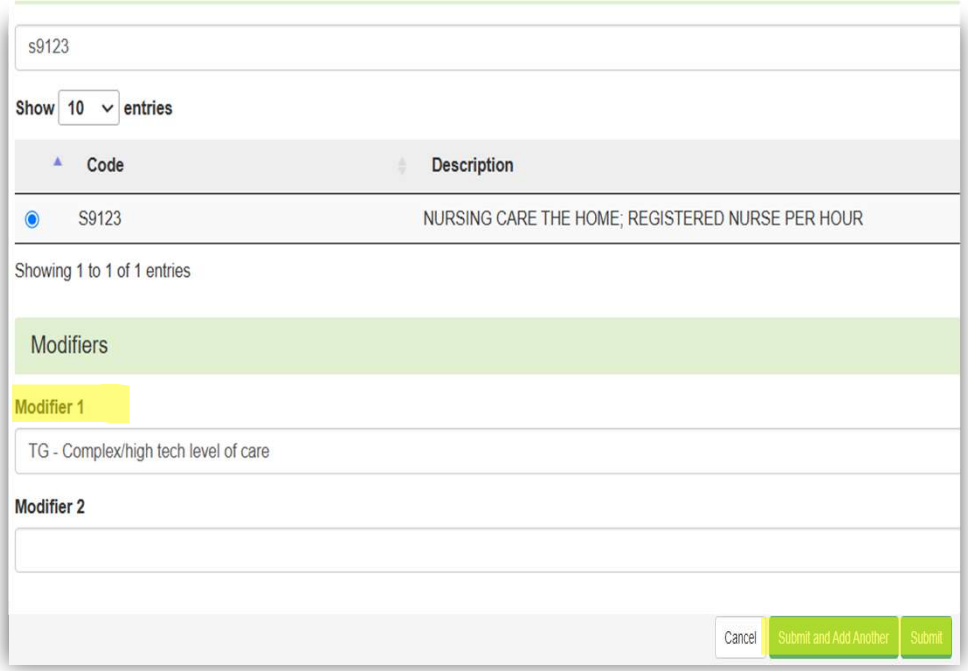
Procedure(s) Panel

- The **Procedures Panel** is where the procedure code information related to this review is added.
- Click the + Add button to add a new procedure to the panel.
  - Select Radio button to indicate a code or term search
  - Enter information in the search box
  - Click search



Modifiers

Once Query has populated your procedure code, use the radio button to select the correct Procedure(s) then the modifier section will be available to complete the details as needed



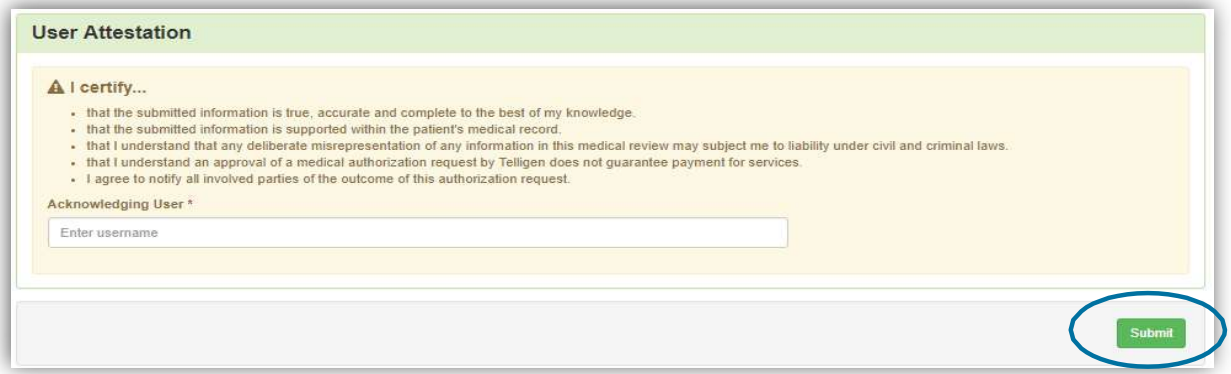
After selecting the procedure(s) you want added to the review:

Submit will add the procedure to the review.
Submit and Add Another will allow you to submit the procedure to the review and re-open the window where you can search for another procedure
Enter as many procedures as needed.

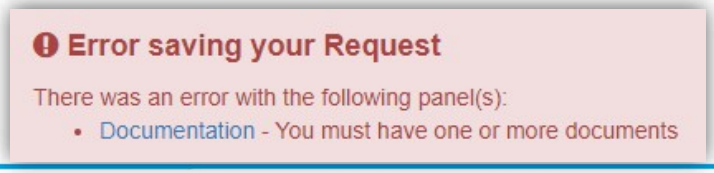
Note: Modifiers are a required field in Qualitrac for certain HCPC codes. Your prior authorizations should align with what you plan to submit on your claim. Please ensure that all appropriate modifiers are included when submitting your request.

Attestation

- The last piece of submission is to enter your **Username** in the attestation section

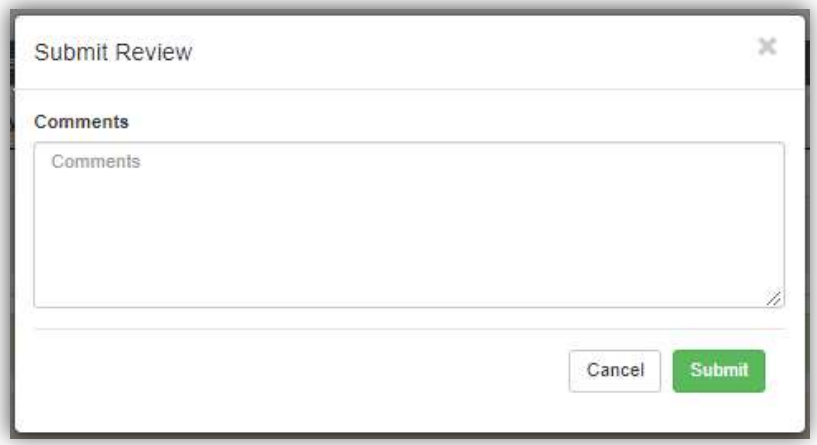


- Click the Submit button to send the review to Telligen
- If any information is missing, an error will indicate what is missing



Comments

- Users have the option to add comments to the review before it is sent to Telligen.
- A comments modal will open, and the user can enter additional information related to the review.
- **This is not required to complete the review**.



Comment Examples

Providing Context on Documentation

If a face-to-face visit note or proof of delivery is attached but might not be obvious in the file list. In the comments section, please include:

Example: *F2F note addressing mobility limitations is included under upload 'Clinical Note 7/1/25.*

Correcting Prior Requests

If you need to add a new code within an already approved date span, you must submit a new case that includes all relevant codes—both newly added and previously approved. In the comments section, please include:

Example: *This is a rebuilt case to add codes. Please cancel Case #XXXXXX.*

Requesting a Repair to Previously Approved Equipment

When the request is for repair or replacement of existing DME that was already approved.

Example: *Repair request for wheelchair originally approved under case# #123456; right wheel and footrest broken and no longer safe for use.*

Request for Information

A Note about Timeframes

Provider Timelines

- Initial requests for DME should be prior authorized.
- Retrospective requests will be reviewed for beneficiaries with retro-eligibility.
- Continued stay reviews must be submitted every 6 months prior to the end of the current certification period.

Provider Timeframes

- Providers have 10 business days to respond to a request for information (RFI).
- Providers should enter reviews for urgent or emergent admissions on the next business day after the admission.

The Telligen portal is available 24/7/365, except for scheduled maintenance days.

Request for Information

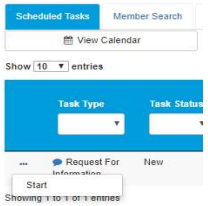
When a reviewer needs additional clinical documentation to make a determination, the submitter will be notified that additional Information is needed.

Notification Methods:

For portal users, you will receive an email notification of the request for more information
A task will populate in the Qualitrac system

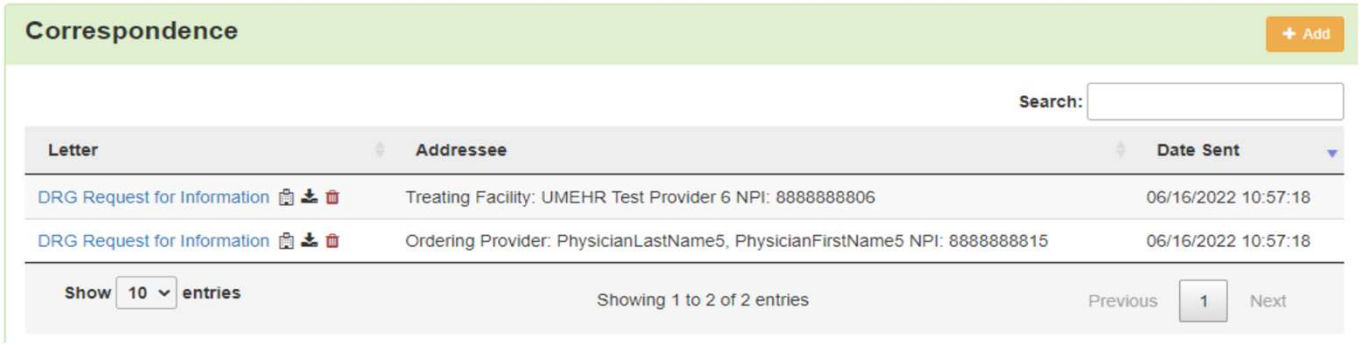
User steps:

Log into Qualitrac
Proceed to scheduled tasks
Click on the ellipsis to the left of the page, to start the task.



Request for Information

Scroll down the **summary page** of the review
Proceed to the correspondence section.
Click on the blue name of the letter to open it and see what information is being requested.



- ****Do NOT start a new review** to submit additional clinical information that was requested. This will delay the response. Please follow the steps outlined when a Request for Information task is available in the task queue.
- Once you have **added all** the additional information, the system will return you to the Scheduled tasks queue and the task will no longer be visible for the user.

Submitting Change Request

What is a Change Request?

A **Change Request Form** is used to request **simple modifications** to a **previously approved** prior authorization (PA).

It is **not** intended for:

- Reconsiderations or appeals of denied claim (including tech denials)
- Submitting new election periods
- Extending beyond current approved dates of service
- Updates to claims that have already been paid

Key Reminders

- A denied PA requires a reconsideration, not a change request.
- A paid PA cannot be modified—void the claim first.
- Submit the Change Request within 90 days of the PA approval date listed in your decision letter.
- Change Request should be faxed 800-524-5710 or email: MSMedicaidUM@Telligen.com

  Make sure to include any relevant documentation supporting your request
- Ensure the form is signed, dated, and submitted within the 90-day window.

When to use a Change Request

Scenario	Is Change Request Appropriate?	Required Action	Notes
Update minor data entry errors	Yes	Submit Change Request Form	Cannot extend beyond current lock-in
Correct diagnosis code	Yes	Submit Change Request Form	Provide correct diagnosis with justification
Change NPI or place of service	Yes	Submit Change Request Form	MANUAL UPDATE REQUIRED: Ensure accuracy to avoid denial
Denied authorization	No	Submit Reconsideration Request	Use the Appeals process
More than 90 days since approval	No	Contact Telligen	MANUAL UPDATE REQUIRED: Changes not accepted after 90 days
Extend Dates of Service	No	Submit a Concurrent Review	Submit before current auth expires

Change Request Notification

If a change request cannot be processed, a note will be added under Notes & Comments explaining the reason:



Notes & Comments

Show 10 entries

Notes / Comments	Notes / Comments Type	Date
changed request dates to 2/18/25-3/13/25 per change request form; cannot change start date to 2/14/25 because member is not retro eligible.	General Note	05/14/2025 07:39 am

Requesting an Extension of Services

Extension of Services

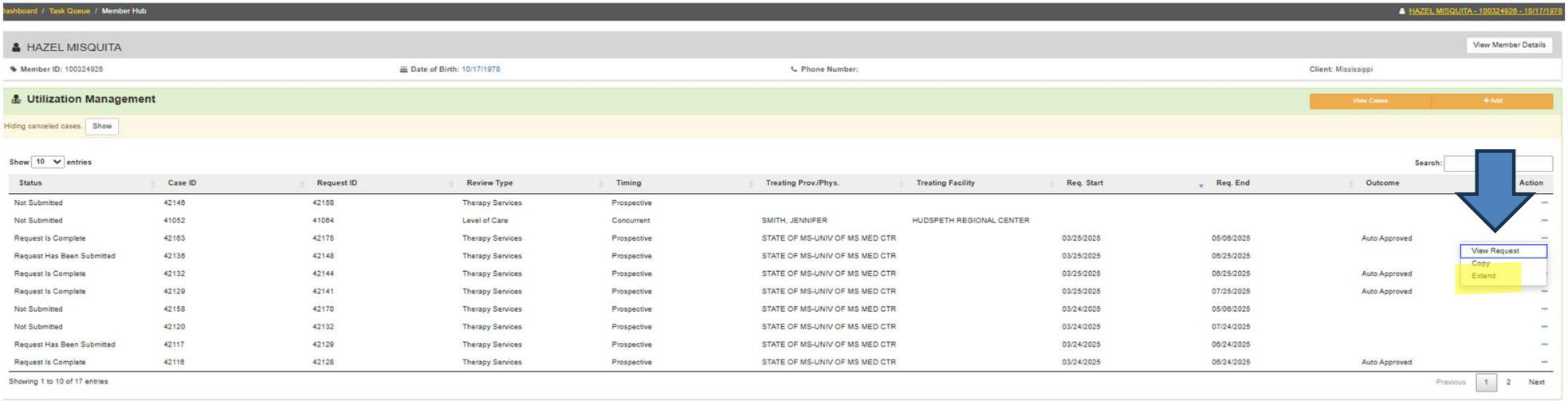
Providers may request to extend a beneficiary's stay beyond the initially approved authorization period. There are two types of extension requests: a Continued Stay and a Traditional Extension. All extension requests **must be submitted prior** to the current authorization end date.

Extension of Service:

- Ensures **continuity of care and quality of care**
- Provides **medical justification** based on **clinical criteria**
- Must be submitted **before** the current auth end date
- Maintains compliance with **Mississippi Medicaid** regulations and avoid **claim denials** due to lack of prior approval

Request for Extension Example

From the Member Hub, under UM Panel, locate the case you would like to request an extension for DOS



Requesting an Extension

Step 1: Access Qualitrac
Log into your Qualitrac provider account.

Step 2: Select Patient Case
Locate and select the **existing** patient therapy case requiring an extension.

Step 3: Initiate Extension Request
Click on the "Request Extension" button within the case options.

Step 4: Complete Required Information Provide:

- Updated therapy plan and revised therapy goals.
- Clinical justification clearly explaining the medical necessity for continued therapy.
- Specify the additional timeframe or additional number of visits requested.

Step 5: Upload Supporting Documentation
Attach necessary documentation in PDF or Word format.

Maximum File Size: 300 MB per document
Clearly indicate medical necessity and therapy progress.

Step 6: Complete InterQual process

Step 7: Submit Request

- Review all entered information.
- Click "Submit" to finalize the extension request.
- Save the confirmation number provided for your records.

Best Practices:

•Submit extension requests **prior** to expiration of current authorization.
•Ensure uploaded documents are unaltered originals clearly demonstrating medical necessity.

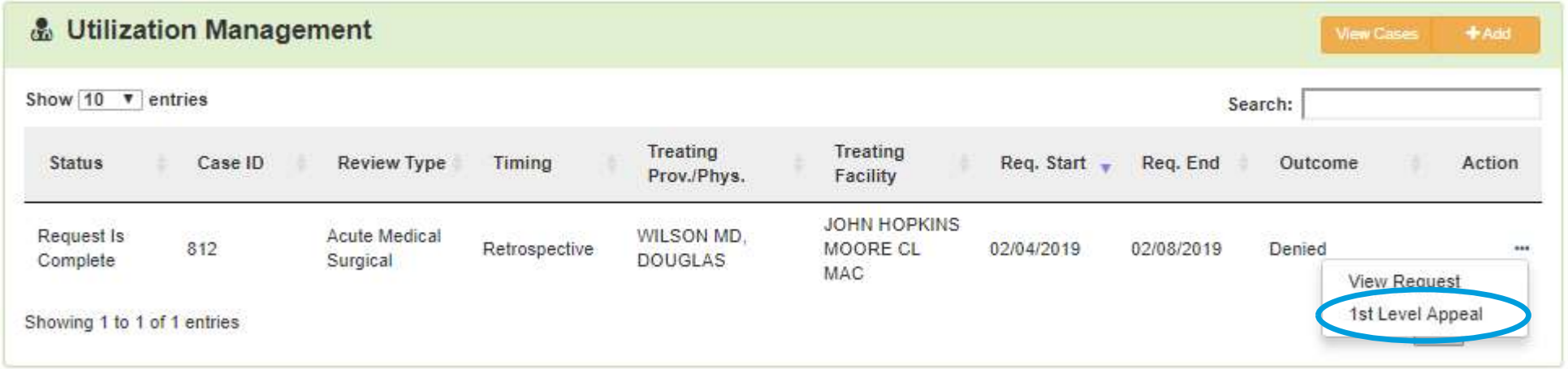
Appeal Rights and Submission Process

Appeal Rights & How to submit Appeal Levels

Appeal Level	Submission Method	Key Details Required	Submission
1st Level	Qualitrac Portal	Case # or Member ID + Upload additional documentation	Use Qualitrac
2nd Level	Peer-to-Peer (P2P)	Call or email with: Case #, physician info, contact #, and availability	1-855-625-7709 msmedicaidum@telligen.com
3rd Level	Written Administrative Appeal	Submit written request by mail (include case # and documentation)	Division of Medicaid Attn: Office of Appeals 550 High Street, Suite 1000 Jackson, MS 39201

Submitting a Reconsideration (1st Level Appeal)

- To submit a reconsideration for a denied review:
  - Go to the **UM panel** in the member hub
  - Click on the blue ellipsis within the denied case to open the action menu
  - Once there, select **1st Level Appeal** from the menu.



Contact Us

- **Education Manager – Primary Point of Contact**

Charity A Jones chjones@telligen.com

Book 1 on 1: Book with Charity

Website: https://msmedicaid.telligen.com/

Mississippi Call Center & Provider Help Desk

- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Portal Registration Questions

- Email: qtregistration@telligen.com
- Toll-Free Phone: (833) 610-1057

Program Manager

Claudia Collins

Assistant Program Manager

Cassandra Bullock



Questions

