MCE/PACE Organization Profile Form Instructions

To enroll as an Indiana Health Coverage Programs (IHCP) managed care entity (MCE) or Program of All-Inclusive Care for the Elderly (PACE) organization, the entity must complete this form and submit it to the Gainwell Care Programs manager.

A Trading Partner Agreement and Trading Partner Profile must also be completed in order to set up the Electronic Data Interchange (EDI) for the *Health Insurance Portability and Accountability Act* (HIPAA) electronic transactions. These forms are available online at the *Trading Partner Registration Procedure* page.

IHCP Companion Guides (production version 5010) are available online on the *IHCP Companion Guides* page.

Date Received:	

MCE/PACE Organization Enrollment Form

Section I – MCE/PACE Contract Information

Mark all programs in which your organization will participate:

☐ Healthy Indiana Plan ☐ Hoosier Healthwise ☐ Hoosier Care Connect ☐ PACE ☐ Pathways

1. MCE/PACE Contract Effective Date:	2. MCE/PACE Contract End Date:
3. MCE/PACE Name:	4. DBA Name: (This is the name that appears on all Core references to the entity.)
5. MCE/PACE Regions:	
6. MCE/PACE Contact Name: (This is the person in your organization who will receive all official program notifications.)	

7. MCE/PACE Address:	8. City:	9. State:	10. ZIP + 4:
11. MCE/PACE Member Services Telephone Number:	12. MCE/PACE Provider Services Telephone Number:		
13. MCE/PACE Email Address: (This is the person in your organization who will receive systems and other communications.)			

Section II – Update Authorization

Please provide the names, addresses, phone numbers and email addresses of all person(s) in your organization who are authorized to change or update any information contained in this enrollment request.

MCE/PACE Contact Information:

1a. Authorized Representative 1 Name and Title, including area(s) authorized for:	1b. Authorized Representative Telephone Number and Email Address:		
1c. Authorized Representative Address:	1d. City:	1e. State:	1f. ZIP + 4:
2a. Authorized Representative 2 Name and Title, including area(s) authorized for:	2b. Authorized Representative Telephone Number and Email Address:		
2c. Authorized Representative 2 Address:	2d. City:	2e. State:	2f. ZIP + 4:
3a. Authorized Representative 3 Name and Title, including area(s) authorized for:	3b. Authorized Representative Telephone Number and Email Address:		
3c. Authorized Representative 3 Address:	3d. City:	3e. State:	3f. ZIP + 4:
4a. Authorized Representative 4 Name and Title, including area(s) authorized for:	4b. Authorized Representative Telephone Number and Email Address:		
4c. Authorized Representative 4 Address:	4d. City:	4e. State:	4f. ZIP + 4:

Submission Information

1. MCE/PACE Representative/Title: (Please Print)		2. MCE/PACE Representative/Title: (Please Sign)	
3. Date:	4. Telephone Number:	5. Email Address:	
6. MCE/PACE Address:		7. City:	8. State:	9. ZIP + 4:

Electronic Funds Transfer

General Information for Capitation			
THE FOLLOWING APPLIES TO PER MEMBER PER MONTH CAPITATION FUNDS Complete all fields on this form. Obtain the American Banking Association (ABA) transit routing number from your bank.			
1. MCE/PACE Organization Name:			
2. MCE/PACE Organization Identification Number:			
3. MCE/PACE Tax ID Type:	4. MCE/PACE Tax ID Number:	5. Tax ID Effective Date:	6. Tax ID End Date:
7. Name on Account:	8. Bank Name:		
9. ABA Transit Routing Number:	10. Bank Account Number:		
11. Bank Address:			
12. City:	13. State:	14. ZIP + 4:	
15. Bank Telephone Number:	16. Type of Account ☐ Savings ☐ Checking		
17. Type of Authorization: ☐ Start ☐ Cancel ☐ Change			

On behalf of the MCE/PACE organization named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of payments claimed from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept, as payment in full, the amount paid by IHCP for capitation and/or claims submitted with the exception of authorized cost sharing by members. I understand payments are from state and federal funds, any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. This is to ensure that the information submitted to obtain payment is true, accurate, and complete.

I authorize the electronic transfer of Indiana Health Coverage Programs payments made to the above identification number. I understand that I am responsible for the validity of the above information.

This section must be completed by an authorized officer.

18. MCE/PACE Representative and Title:	19. Telephone Number:
20. Signature:	21. Date:

It will take approximately four weeks for this information to be processed by IHCP and validated by your bank. Please send this form to the Gainwell Care Programs manager, via email, or postal mail to 950 N. Meridian Street, Suite 1150, Indianapolis, IN 46204.