IHCP Annual Workshop October 2020
MDwise Provider Enrollment

HHW-HIPP0519(10/17)

Providing health coverage to Indiana families since 1994

Agenda

- Who is MDwise?
- MDwise Provider Requirements
- Credentialing vs. Enrollment
- Enrollment Forms
- Provider Updates
- Provider Disenrollment
- Processing Requests
- Contact Information
- Questions and Answers

MDwise History

MDwise is:

- A local, not-for-profit company serving Hoosier Healthwise and Healthy Indiana Plan members

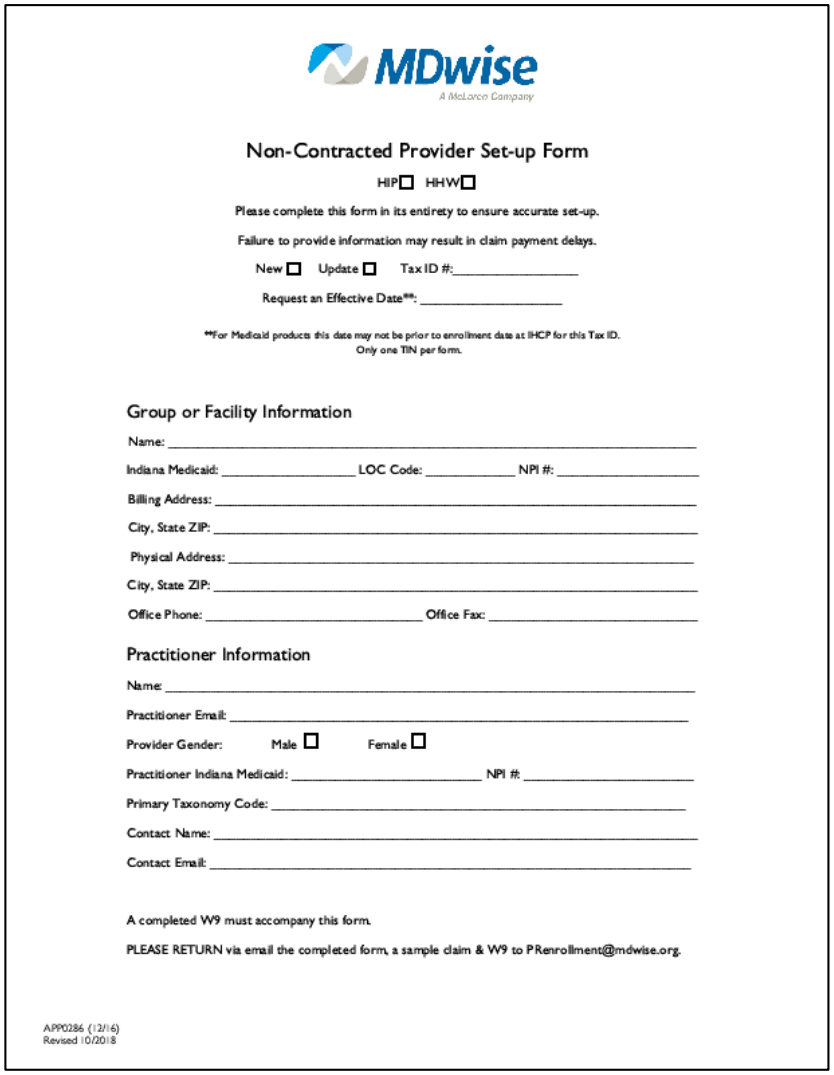
- Exclusively serving Indiana families since 1994
  - Over 300,000 members
  - 3,000 primary medical providers

MDwise Provider Requirements

- To participate as a MDwise provider
  - Must be enrolled as an IHCP provider with the State
  - PMPs must practice in one of the following fields:
    - General Practice
    - Family Practice
    - OB/GYN
    - General Pediatrics
    - Internal Medicine
    - Advanced Nurse Practitioner (APN)
    - Physician Assistant
    - Endocrinologists (if primarily engaged in Internal Medicine)
  - PMPs must be fully credentialed according to MDwise standards
  - Be a contracted provider or set up as non-contracted

MDwise Provider Requirements

- Non-Contracted Provider Form



MDwise
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Non-Contracted Provider Set-up Form

HIP☐ HHW☐

Please complete this form in its entirety to ensure accurate set-up.

Failure to provide information may result in claim payment delays.

New☐ Update☐ Tax ID #:_____

Request an Effective Date**: _____

**For Medicaid products this date may not be prior to enrollment date at IHCP for this Tax ID.
Only one TIN per form.

Group or Facility Information

Name: _____

Indiana Medicaid: _____ LOC Code: _____ NPI #: _____

Billing Address: _____

City, State ZIP: _____

Physical Address: _____

City, State ZIP: _____

Office Phone: _____ Office Fax: _____

Practitioner Information

Name: _____

Practitioner Email: _____

Provider Gender: Male☐ Female☐

Practitioner Indiana Medicaid: _____ NPI #: _____

Primary Taxonomy Code: _____

Contact Name: _____

Contact Email: _____

A completed W9 must accompany this form.

PLEASE RETURN via email the completed form, a sample claim & W9 to PRenrollment@mdwise.org.

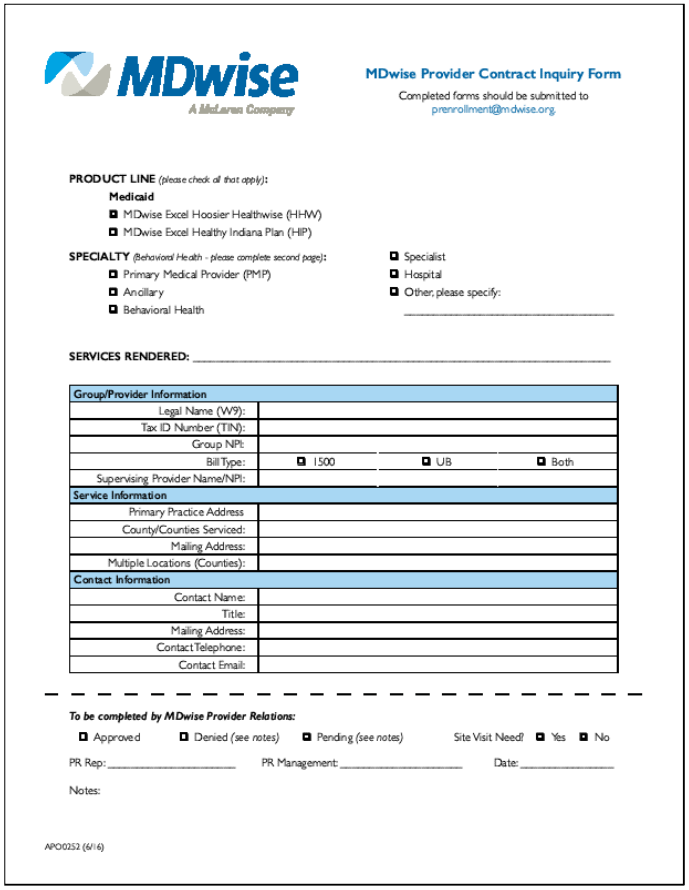
APP0286 (12/16)
Revised 10/2018

MDwise Provider Requirements

- Non-Contracted Provider
  - Self-referral providers do not need to be contracted
    - Self-referral services include:
      - Chiropractic
      - Vision care services
      - Psychiatry
      - Podiatry
    - Self-referral providers must complete and return the non-contracted provider to receive payment for services
      - Must include a completed W-9 Form
      - Send completed form and W-9 with first claim to prenrollment@mdwise.org

MDwise Provider Requirements

- To contract with MDwise:
  - Complete a Contract Inquiry Form
  - Submit to prenrollment@mdwise.org



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MDwise Provider Contract Inquiry Form

Completed forms should be submitted to
prenrollment@mdwise.org

PRODUCT LINE *(please check all that apply)*:

Medicaid

- ☐ MDwise Excel Hoosier Healthwise (HHW)
- ☐ MDwise Excel Healthy Indiana Plan (HIP)

SPECIALTY *(Behavioral Health - please complete second page)*:

- ☐ Primary Medical Provider (PMP)
- ☐ Ancillary
- ☐ Behavioral Health
- ☐ Specialist
- ☐ Hospital
- ☐ Other, please specify: _____

SERVICES RENDERED: _____

Group/Provider Information			
Legal Name (W9):			
Tax ID Number (TIN):			
Group NPI:			
Bill Type:	☐ 1500	☐ UB	☐ Both
Supervising Provider Name/NPI:			
Service Information			
Primary Practice Address			
County/Counties Serviced:			
Mailing Address:			
Multiple Locations (Counties):			
Contact Information			
Contact Name:			
Title:			
Mailing Address:			
Contact Telephone:			
Contact Email:			

To be completed by MDwise Provider Relations:

☐ Approved ☐ Denied *(see notes)* ☐ Pending *(see notes)* Site Visit Need? ☐ Yes ☐ No

PR Rep: _____ PR Management: _____ Date: _____

Notes:

APO0252 (6/16)

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Credentialing vs. Enrollment

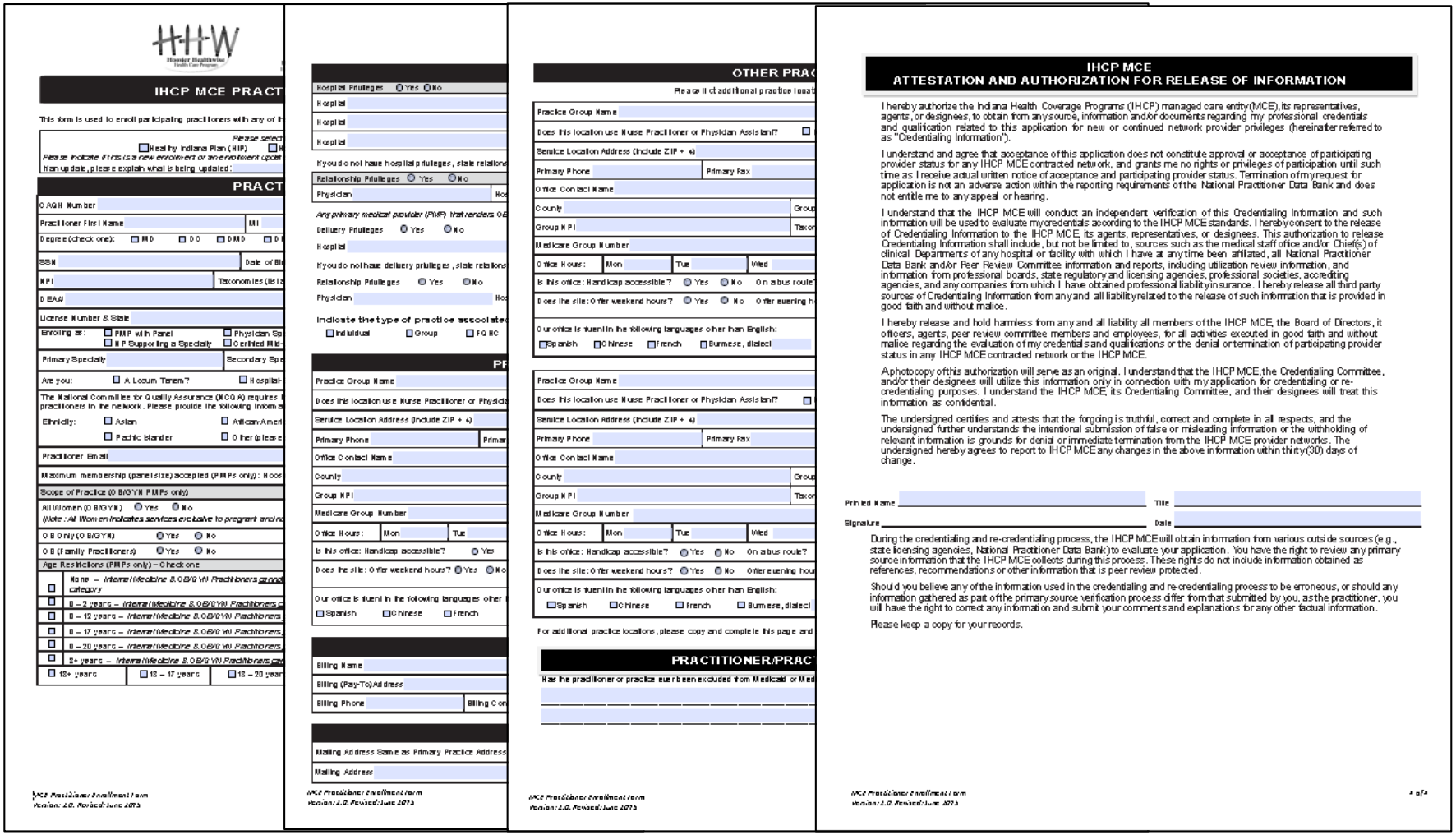
- Credentialing
  - MDwise review of provider qualifications
  - Completed after a MDwise Provider Contract has been fully executed
  - Must be done before a provider can be enrolled in any MDwise product
    - Once a provider is credentialed in one product, the credentialing covers all MDwise products
  - Credentialing Process
    - Between 60-90 days when all required information is submitted
    - prenrollment@mdwise.org

Credentialing vs. Enrollment

- Enrollment
  - Register as a provider of the MDwise products
  - Requires an IHCP Provider or Ancillary Enrollment form
    - Form must be completely filled out to process request
    - Forms available at www.MDwise.org
  - MDwise follows the OMPP-developed policies and procedures for handling enrollments of providers in the MDwise provider network
  - Enrollment Process
    - Between 30-60 days when complete form submitted
    - Incomplete forms will be returned to the provider
  - prenrollment@mdwise.org or 317-822-7300 ext. 5800

Enrollment Forms

- Provider Enrollment & Update Form



IHCP MCE PRACT

This form is used to enroll participating practitioners with any of t

Please select

Healthy Indiana Plan (HIP)

Please indicate if this is a new enrollment or an enrollment updat

If an update, please explain what is being updated:

PRACT

CAQH Number

Practitioner First Name

MI

Degree (check one): MD DO DMD

SSN

Date of Bir

NPI

Taxonomies (list

DEA#

License Number & State

Enrolling as: PMP with Panel Physician Sp

NP Supporting a Specialty Certified Mid-

Primary Specialty

Secondary Spe

Are you: A Locum Tenem? Hospital-

The National Committee for Quality Assurance (NCQA) requires

practitioners in the network. Please provide the following informa

Ethnicity: Asian African-Amer

Pacific Islander Other (please

Practitioner Email

Maximum membership (panel size) accepted (PMPs only): Hos

Scope of Practice (OB/GYN PMPs only)

All Women (OB/GYN) Yes No

(Note: All Women indicates services exclusive to pregnant and/o

OB Only (OB/GYN) Yes No

OB (Family Practitioners) Yes No

Age Restrictions (PMPs only) – Check one

None – Internal Medicine & OB/GYN Practitioners accept category

0 – 2 years – Internal Medicine & OB/GYN Practitioners

0 – 12 years – Internal Medicine & OB/GYN Practitioners

0 – 17 years – Internal Medicine & OB/GYN Practitioners

0 – 20 years – Internal Medicine & OB/GYN Practitioners

8+ years – Internal Medicine & OB/GYN Practitioners can

13+ years 13 – 17 years 13 – 20 year

IHCP Practitioner Enrollment Form

Version: 2.0, Revised: June 2013

Hospital Privileges Yes No

Hospital

Hospital

Hospital

If you do not have hospital privileges, state relations

Relationship Privileges Yes No

Physician

Any primary medical provider (PMP) that renders OB

Delivery Privileges Yes No

Hospital

If you do not have delivery privileges, state relations

Relationship Privileges Yes No

Physician

Indicate the type of practice associate

Individual Group FQHC

PR

Practice Group Name

Does this location use Nurse Practitioner or Physicia

Service Location Address (include ZIP + 4)

Primary Phone

Primar

Office Contact Name

County

Group NPI

Medicare Group Number

Office Hours: Mon Tue

Is this office: Handicap accessible? Yes

Does the site: Offer weekend hours? Yes No

Our office is fluent in the following languages other

Spanish Chinese French

Billing Name

Billing (Pay-To) Address

Billing Phone

Billing Con

Mailing Address Same as Primary Practice Address

Mailing Address

IHCP Practitioner Enrollment Form

Version: 2.0, Revised: June 2013

OTHER PRAC

Please fill out additional practice locat

Practice Group Name

Does this location use Nurse Practitioner or Physician Assistant?

Service Location Address (include ZIP + 4)

Primary Phone

Primary Fax

Office Contact Name

County

Group

Group NPI

Taxon

Medicare Group Number

Office Hours: Mon Tue Wed

Is this office: Handicap accessible? Yes No On a bus route?

Does the site: Offer weekend hours? Yes No Offer evening h

Our office is fluent in the following languages other than English:

Spanish Chinese French Burmese, dialect

Practice Group Name

Does this location use Nurse Practitioner or Physician Assistant?

Service Location Address (include ZIP + 4)

Primary Phone

Primary Fax

Office Contact Name

County

Group

Group NPI

Taxon

Medicare Group Number

Office Hours: Mon Tue Wed

Is this office: Handicap accessible? Yes No On a bus route?

Does the site: Offer weekend hours? Yes No Offer evening hou

Our office is fluent in the following languages other than English:

Spanish Chinese French Burmese, dialect

For additional practice locations, please copy and complete this page and

PRACTITIONER/PRAC

Has the practitioner or practice ever been excluded from Medicaid or Med

IHCP Practitioner Enrollment Form

Version: 2.0, Revised: June 2013

IHCP MCE

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Indiana Health Coverage Programs (IHCP) managed care entity(MCE), its representatives, agents, or designees, to obtain from any source, information and/or documents regarding my professional credentials and qualification related to this application for new or continued network provider privileges (hereinafter referred to as "Credentialing Information").

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any IHCP MCE contracted network, and grants me no rights or privileges of participation until such time as I receive actual written notice of acceptance and participating provider status. Termination of my request for application is not an adverse action within the reporting requirements of the National Practitioner Data Bank and does not entitle me to any appeal or hearing.

I understand that the IHCP MCE will conduct an independent verification of this Credentialing Information and such information will be used to evaluate my credentials according to the IHCP MCE standards. I hereby consent to the release of Credentialing Information to the IHCP MCE, its agents, representatives, or designees. This authorization to release Credentialing Information shall include, but not be limited to, sources such as the medical staff office and/or Chief(s) of clinical Departments of any hospital or facility with which I have at any time been affiliated, all National Practitioner Data Bank and/or Peer Review Committee information and reports, including utilization review information, and information from professional boards, state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which I have obtained professional liability insurance. I hereby release all third party sources of Credentialing Information from any and all liability related to the release of such information that is provided in good faith and without malice.

I hereby release and hold harmless from any and all liability all members of the IHCP MCE, the Board of Directors, it officers, agents, peer review committee members and employees, for all activities executed in good faith and without malice regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any IHCP MCE contracted network or the IHCP MCE.

A photocopy of this authorization will serve as an original. I understand that the IHCP MCE, the Credentialing Committee, and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. I understand the IHCP MCE, its Credentialing Committee, and their designees will treat this information as confidential.

The undersigned certifies and attests that the forgoing is truthful, correct and complete in all respects, and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information is grounds for denial or immediate termination from the IHCP MCE provider networks. The undersigned hereby agrees to report to IHCP MCE any changes in the above information within thirty(30) days of change.

Printed Name Title

Signature Date

During the credentialing and re-credentialing process, the IHCP MCE will obtain information from various outside sources (e.g., state licensing agencies, National Practitioner Data Bank) to evaluate your application. You have the right to review any primary source information that the IHCP MCE collects during this process. These rights do not include information obtained as references, recommendations or other information that is peer review protected.

Should you believe any of the information used in the credentialing and re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by you, as the practitioner, you will have the right to correct any information and submit your comments and explanations for any other factual information.

Please keep a copy for your records.

IHCP Practitioner Enrollment Form

Version: 2.0, Revised: June 2013

MDwise

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Enrollment Forms

- MDwise requires all fields on the form to be completed
  - Incomplete forms will be returned
  - If the form is returned, the 30-60 day process period will start over once the complete form is returned to MDwise

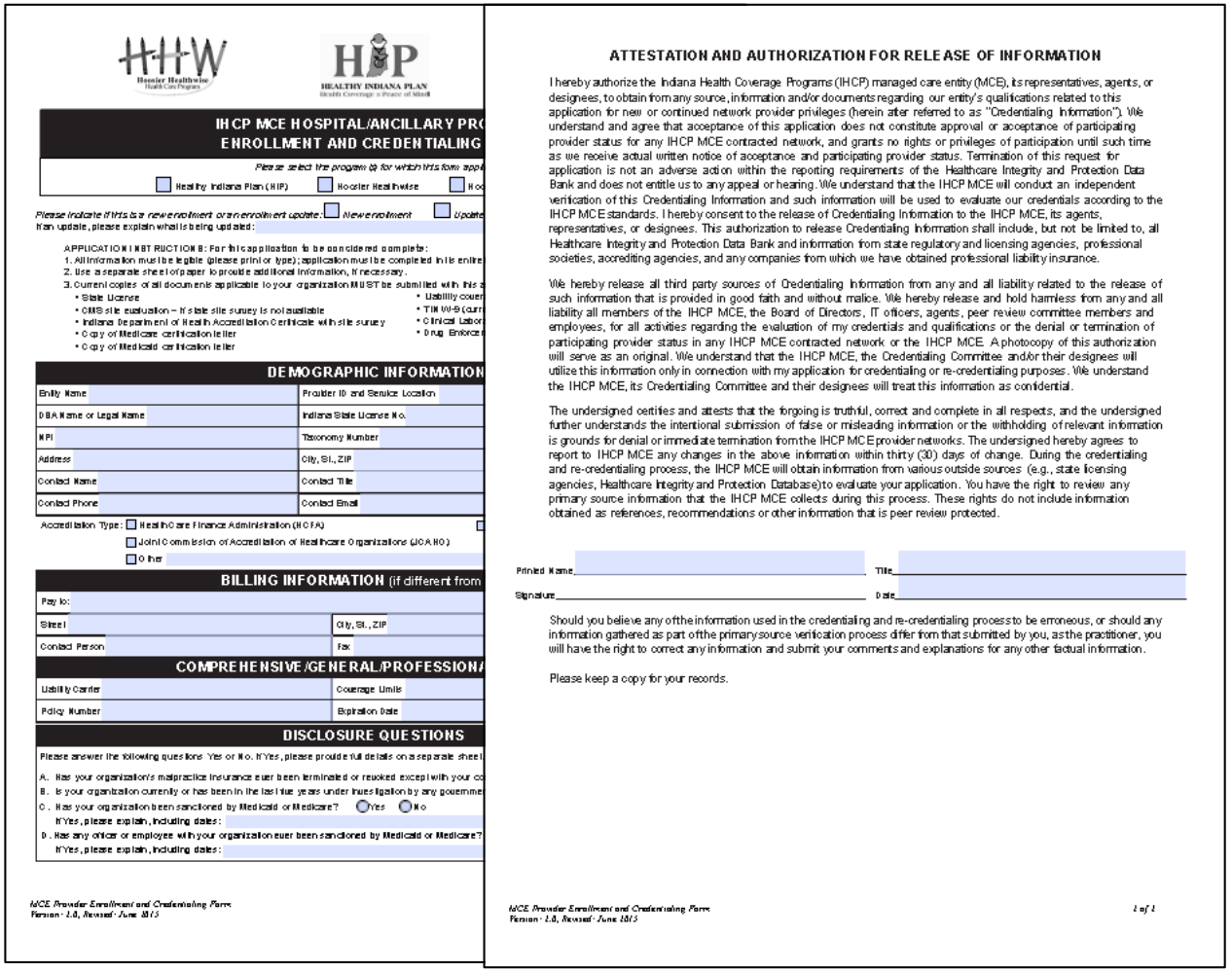
•If you are enrolling a PMP, the following fields must be complete to avoid enrollment issues:

  - Panel size
  - Age Restrictions
  - Delivery/Relationship Privileges
  - Confirmation of membership assignment to a location

•Nurse Practitioners/Physician Assistants require a Collaborative Agreement with their enrollments

Enrollment Forms

Ancillary Enrollment Form



IHCP MCE HOSPITAL/ANCILLARY PRO
ENROLLMENT AND CREDENTIALING

Please select the program(s) for which this form appl

☐ Healthy Indiana Plan (HIP) ☐ Hoosier Healthwise ☐ Ho

Please indicate if this is a new enrollment or an enrollment update: ☐ New enrollment ☐ Update
If an update, please explain what is being updated:

APPLICATION INSTRUCTIONS: For this application to be considered complete:
1. All information must be legible (please print or type); application must be completed in its entire
2. Use a separate sheet of paper to provide additional information, if necessary.
3. Current copies of all documents applicable to your organization MUST be submitted with this a
- State Licensure
- CMS site evaluation – If state site survey is not available
- Indiana Department of Health Accreditation Certificate with site survey
- Copy of Medicare certification letter
- Copy of Medicaid certification letter
- Liability cover
- TIN W-9 (curr
- Clinical Labor
- Drug Enforce

DEMOGRAPHIC INFORMATION

Entity Name	Provider ID and Service Location
DBA Name or Legal Name	Indiana State License No.
NPI	Taxonomy Number
Address	City, St., ZIP
Contact Name	Contact Title
Contact Phone	Contact Email

Accreditation Type: ☐ Health Care Finance Administration (HCFA) ☐
☐ Joint Commission of Accreditation of Healthcare Organizations (JCAHO)
☐ Other

BILLING INFORMATION (if different from

Pay to:	
Street	City, St., ZIP
Contact Person	Fax

COMPREHENSIVE/GENERAL/PROFESSIONA

Liability Carrier	Coverage Limits
Policy Number	Expiration Date

DISCLOSURE QUESTIONS

Please answer the following questions Yes or No. If Yes, please provide full details on a separate sheet
A. Has your organization's malpractice insurance ever been terminated or revoked except with your co
B. Is your organization currently or has been in the last five years under investigation by any governme
C. Has your organization been sanctioned by Medicaid or Medicare? ◯ Yes ◯ No
If Yes, please explain, including dates:
D. Has any officer or employee with your organization ever been sanctioned by Medicaid or Medicare?
If Yes, please explain, including dates:

MCE Provider Enrollment and Credentialing Form
Version: 2.0, Revised: June 2015

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Indiana Health Coverage Programs (IHCP) managed care entity (MCE), its representatives, agents, or designees, to obtain from any source, information and/or documents regarding our entity's qualifications related to this application for new or continued network provider privileges (herein after referred to as "Credentialing Information"). We understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any IHCP MCE contracted network, and grants no rights or privileges of participation until such time as we receive actual written notice of acceptance and participating provider status. Termination of this request for application is not an adverse action within the reporting requirements of the Healthcare Integrity and Protection Data Bank and does not entitle us to any appeal or hearing. We understand that the IHCP MCE will conduct an independent verification of this Credentialing Information and such information will be used to evaluate our credentials according to the IHCP MCE standards. I hereby consent to the release of Credentialing Information to the IHCP MCE, its agents, representatives, or designees. This authorization to release Credentialing Information shall include, but not be limited to, all Healthcare Integrity and Protection Data Bank and information from state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which we have obtained professional liability insurance.

We hereby release all third party sources of Credentialing Information from any and all liability related to the release of such information that is provided in good faith and without malice. We hereby release and hold harmless from any and all liability all members of the IHCP MCE, the Board of Directors, IT officers, agents, peer review committee members and employees, for all activities regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any IHCP MCE contracted network or the IHCP MCE. A photocopy of this authorization will serve as an original. We understand that the IHCP MCE, the Credentialing Committee and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. We understand the IHCP MCE, its Credentialing Committee and their designees will treat this information as confidential.

The undersigned certifies and attests that the forgoing is truthful, correct and complete in all respects, and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information is grounds for denial or immediate termination from the IHCP MCE provider networks. The undersigned hereby agrees to report to IHCP MCE any changes in the above information within thirty (30) days of change. During the credentialing and re-credentialing process, the IHCP MCE will obtain information from various outside sources (e.g., state licensing agencies, Healthcare Integrity and Protection Database) to evaluate your application. You have the right to review any primary source information that the IHCP MCE collects during this process. These rights do not include information obtained as references, recommendations or other information that is peer review protected.

Printed Name_____ Title_____

Signature_____ Date_____

Should you believe any of the information used in the credentialing and re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by you, as the practitioner, you will have the right to correct any information and submit your comments and explanations for any other factual information.

Please keep a copy for your records.

MCE Provider Enrollment and Credentialing Form
Version: 2.0, Revised: June 2015
1 of 1

MDwise
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Enrollment Forms

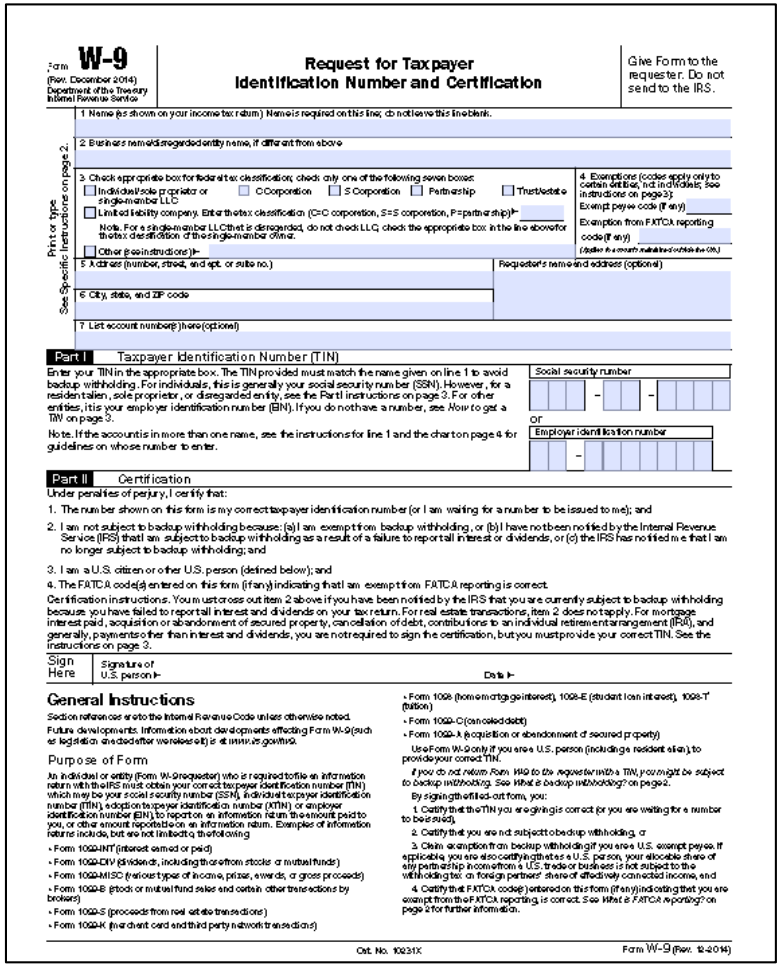
- Ancillary Enrollments must include:
  - W-9
  - Certificate of Insurance (COI)

•Please note: If an Ancillary provider requires credentialing, additional documents may be requested

•prenrollment@mdwise.org

Enrollment Forms

W-9 Form



Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

Print or type
See Specific Instructions on page 2.

3 Check appropriate box for federal tax classification; check only one of the following seven boxes:
☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate
☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶
Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.
☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
___ - ___ - ____

or

Employer identification number
__ - _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | Signature of U.S. person ▶ | Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Cat. No. 10231X

Form W-9 (Rev. 12-2014)

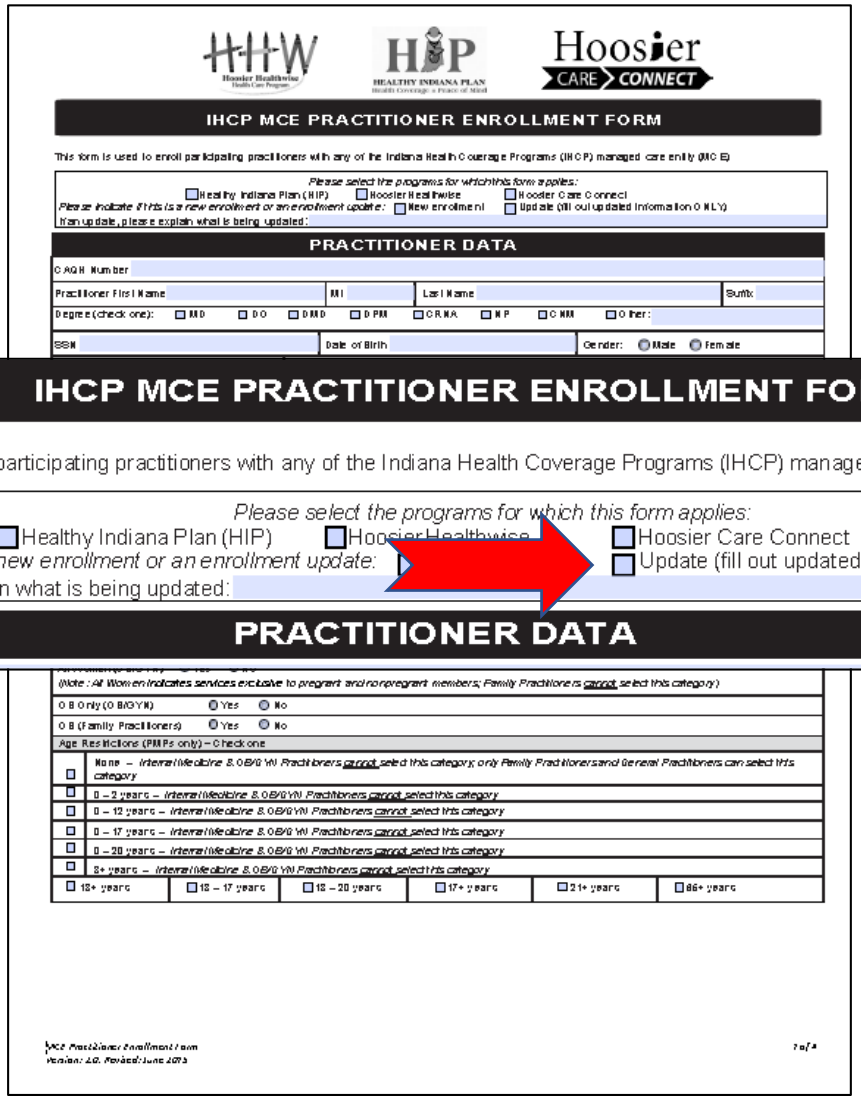
MDwise
A McLaren Company

Provider Updates

- What is considered a provider update?
  - Enrollment in a new program (Hoosier Healthwise or HIP)
  - Provider Name Change
  - Age Restrictions
  - Location Add
  - Tax ID Change
    - Requires Letter of Liability and new W-9

*Please remember to update this information with the state prior to sending updates to MDwise

Provider Updates



IHCP MCE PRACTITIONER ENROLLMENT FORM

This form is used to enroll participating practitioners with any of the Indiana Health Coverage Programs (IHCP) managed care entity (MCE)

Please select the programs for which this form applies:

☐ Healthy Indiana Plan (HIP) ☐ HoosierHealthwise ☐ Hoosier Care Connect

Please indicate if this is a new enrollment or an enrollment update: ☐ New enrollment ☐ Update (fill out updated information ONLY)

If an update, please explain what is being updated:

PRACTITIONER DATA

IHCP MCE PRACTITIONER ENROLLMENT FORM

This form is used to enroll participating practitioners with any of the Indiana Health Coverage Programs (IHCP) managed care entity (MCE)

Please select the programs for which this form applies:

☐ Healthy Indiana Plan (HIP) ☐ HoosierHealthwise ☐ Hoosier Care Connect

Please indicate if this is a new enrollment or an enrollment update: ☐ Update (fill out updated information ONLY)

If an update, please explain what is being updated:

PRACTITIONER DATA

Provider Updates

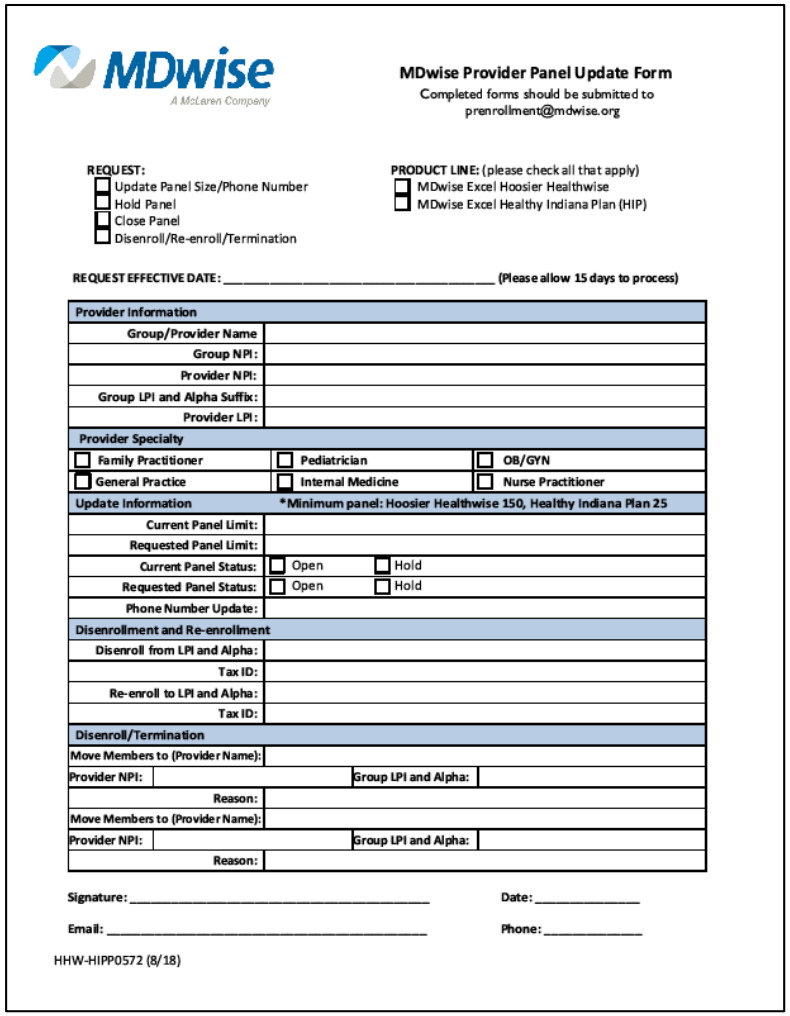
- PMP Panel Update Form
  - Change Panel Limit
    - Increase or decrease panel limit
  - Place panel on hold
    - A hold on the panel allows members with a history with the PMP or with a family member already on the panel to be added
  - Remove a panel hold
  - Submit to prenrollment@mdwise.org

*Be sure to include an effective date for the update

Provider Disenrollment

- A Disenrollment Form can be used for rendering providers, facilities, or service locations
- To disenroll a provider:
  - Complete the provider disenrollment form in its entirety
  - For PMPs:
    - Please designate where the PMPs panel should be moved
      - Include the PMPs NPI and the Group LPI and alpha code on the disenrollment form and in the email body
      - Ex: Please move members to John Smith NPI:10XXXXX999, Group LPI:100XXXX720 A
- Submit to prenrollment@mdwise.org

PMP Panel Update Form



MDwise
A McLaren Company

MDwise Provider Panel Update Form

Completed forms should be submitted to
prenrollment@mdwise.org

REQUEST:
- ☐ Update Panel Size/Phone Number
- ☐ Hold Panel
- ☐ Close Panel
- ☐ Disenroll/Re-enroll/Termination

PRODUCT LINE: (please check all that apply)
- ☐ MDwise Excel Hoosier Healthwise
- ☐ MDwise Excel Healthy Indiana Plan (HIP)

REQUEST EFFECTIVE DATE: _____ **(Please allow 15 days to process)**

Provider Information			
Group/Provider Name			
Group NPI:			
Provider NPI:			
Group LPI and Alpha Suffix:			
Provider LPI:			
Provider Specialty			
☐ **Family Practitioner**	☐ **Pediatrician**	☐ **OB/GYN**	
☐ **General Practice**	☐ **Internal Medicine**	☐ **Nurse Practitioner**	
Update Information	***Minimum panel: Hoosier Healthwise 150, Healthy Indiana Plan 25**		
Current Panel Limit:			
Requested Panel Limit:			
Current Panel Status:	☐ Open	☐ Hold	
Requested Panel Status:	☐ Open	☐ Hold	
Phone Number Update:			
Disenrollment and Re-enrollment			
Disenroll from LPI and Alpha:			
Tax ID:			
Re-enroll to LPI and Alpha:			
Tax ID:			
Disenroll/Termination			
Move Members to (Provider Name):			
Provider NPI:		**Group LPI and Alpha:**	
Reason:			
Move Members to (Provider Name):			
Provider NPI:		**Group LPI and Alpha:**	
Reason:			

Signature: _____ **Date:** _____

Email: _____ **Phone:** _____

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Processing Requests

- The Provider Relations (PR) Enrollment team uses a ticket system called Vivantio to provide real-time updates as a provider request is processed
- Ticket Process:
  - Provider submits request to prenrollment@mdwise.org
  - Vivantio receives and logs the request, issuing a ticket number in a response email to the provider
  - The PR Enrollment team works the ticket from the documents attached to the email
  - The PR Enrollment team sends email when request is complete
    - Includes provider information and effective dates
- If the provider request is missing required information, the provider will be directed to correct information and resubmit

Processing Requests

- Tips for a successful Provider request:
  - Make sure all documentation is complete
  - Include your contact information
  - Call the Provider Relations line with inquiry requests
    - 317-822-7300 ext. 5800
    - Do not email prenrollment@mdwise.org, as this will create a new request and new ticket number
  - Allow proper timelines before inquiring about a ticket
    - Credentialing: 60-90 days
    - Enrollment/Update/Disenrollment: 30-60 days

Contact Information

Provider Relations Line

•317-822-7300 ext. 5800

Provider Relations Enrollment

•prenrollment@mdwise.org

MDwise Quick Contact Guide

•http://www.mdwise.org/for-providers/contact-information/

MDwise Customer Service

•1-800-356-1204 or 317-630-2831

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Questions