



INSTRUCTIONS FOR ENROLLMENT AND CREDENTIALING WITH HOOSIER HEALTHWISE (HHW), HEALTHY INDIANA PLAN (HIP) AND CARE SELECT MANAGED CARE ENTITIES

To reduce the need for practitioners to complete multiple enrollment and credentialing forms for participation in multiple IHCP Managed Care MCO/CMOs, the following forms have been developed. **Please complete all applicable forms and return to the MCO/CMO with which you seek participation.**

PRACTITIONERS (HHW, HIP AND CARE SELECT):

All practitioners must complete the **IHCP MCO/CMO Provider Enrollment Form**. If you participate in the Council for Affordable Quality Healthcare (CAQH), the Provider Enrollment Form is the only form you will be required to submit for the enrollment/credentialing process. Please add the appropriate IHCP MCO/CMO as an authorized plan, giving permission to print a provider CAQH application.

CAQH is a credentialing data warehouse that allows you to keep all of your credentialing information in a central location. This information can be accessed by a variety of credentialing entities and can save you time when seeking participation with multiple health plans.

If you do not participate in CAQH, you must also complete and submit a credentialing application. OMPP will require utilization of the CAQH application as the universal credentialing application. You may obtain the application through a link at the OMPP Web site at www.indianamedicaid.com or directly from the CAQH Web site at <https://upd.caqh.org>.

PROVIDERS (HHW, HIP AND CARE SELECT):

Facilities such as hospitals, home health agencies, etc, are not eligible to participate in CAQH. As such, you must fill out the **Hoosier Healthwise Managed Care Organization Hospital/Ancillary Credentialing/Enrollment Form** and return to the appropriate MCO/CMO with the required documentation

If you have any questions about the enrollment or credentialing process, please contact the appropriate MCO/CMO at:

ADVANTAGE Health Solutions

Phone: 1-866-504-6708

Web: www.advantageplan.com

Anthem

Phone: 1-800-455-6805

Web: www.anthem.com

Managed Health Services

Phone: 1-877-647-4848

Web: www.managedhealthservices.com

MDwise

Phone: 1-800-356-1204

Web: www.mdwise.org



HOOSIER HEALTHWISE, HEALTHY INDIANA PLAN AND CARE SELECT PROVIDER ENROLLMENT FORM

This form is for use in enrolling as a participating provider with one of the IHCP MCO/CMOs.

Please select the program(s) for which this form applies:

- Healthy Indiana Plan (HIP)
 Hoosier Healthwise (HHW)
 Care Select

- New Enrollment**
 Update (Fill in only updated info)

PRACTITIONER DATA

CAQH Number			
Provider First Name	MI	Last Name	Suffix
Degree (check one): <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DMD <input type="checkbox"/> DPM <input type="checkbox"/> CRNA <input type="checkbox"/> NP <input type="checkbox"/> CNM <input type="checkbox"/> Other: _____			
SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
NPI	Taxonomies (list all)		
DEA #	CSR #		
License Number & State	UPIN	LPI (Medicaid) Number	
Enrolling as: <input type="checkbox"/> PMP with Panel <input type="checkbox"/> Physician Specialist <input type="checkbox"/> NP-supporting a PMP <input type="checkbox"/> Other _____ <input type="checkbox"/> NP-supporting a Specialty <input type="checkbox"/> Certified Mid-Wife <input type="checkbox"/> Prenatal Care Coordinator			
Primary Specialty	Secondary Specialty	NP - specialty supported	
Are you: <input type="checkbox"/> A Locum Tenem <input type="checkbox"/> Hospital-based Physician <input type="checkbox"/> Hospitalist			
The National Committee for Quality Assurance (NCQA) requires that health plans assess the cultural, ethnic, racial and linguistic needs of members to the practitioners in the network. Please provide the following information:			
Ethnicity: <input type="checkbox"/> Asian <input type="checkbox"/> African-American/Black <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other (please specify) _____			
Practitioner E-mail _____		Fax	Phone
Maximum membership accepted (PMPs only) - panel size			

Scope of Practice (OB/GYN PMPs only)	
All Women (OB/GYN) includes pregnant and non-pregnant members, <i>Family Practitioners cannot render to All Women</i>	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
OB Only <input type="checkbox"/> YES <input type="checkbox"/> NO	

Age Restrictions (PMPs only) check one					
<input type="checkbox"/>	None Internal Med & OB/GYN Practitioners <u>cannot</u> select this category (Only Family Practitioners and General Practitioners can select this category)				
<input type="checkbox"/>	0 – 2 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 12 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 17 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	0 – 20 years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	3+ years Internal Med & OB/GYN Practitioners <u>cannot</u> select this category				
<input type="checkbox"/>	<input type="checkbox"/> 13+ years	<input type="checkbox"/> 13 – 17 years	<input type="checkbox"/> 13 – 20 years	<input type="checkbox"/> 17+ years	<input type="checkbox"/> 21+ years <input type="checkbox"/> 65+ years

PRACTITIONER DATA – cont'd

Hospital Privileges YES NO

Name	Address
Name	Address
Name	Address

If you do not have Hospital Privileges, state relationship privileges below:

Relationship Privileges YES NO

Physician	Hospital	Address
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Any Primary Medical Provider (PMP) who renders OB services must have delivery privileges and/or relationship privileges to deliver

Delivery Privileges YES NO

Name	Address
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If you do not have Delivery Privileges, state relationship privileges below

Delivery Privileges YES NO

Physician	Name	Address
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ARE YOU ENROLLING AS:

- Individual
 Group
 FQHC
 RHC
 Clinic (Type: _____)
 Urgent Care
 Health Department

PRIMARY PRACTICE INFORMATION

Practice Group Name

Does this location utilize Nurse Practitioner or Physician Assistant? NP PA

Service Location Address (include ZIP + 4)

Primary Phone	Primary Fax	If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO
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Office Contact Name	Office Contact E-mail
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County	Group IHCP Number (including Alpha suffix)
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Group NPI	Taxonomies
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Medicare Group Number

Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
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Is this office: Handicap accessible YES NO On a bus route YES NO

Does the site offer: Weekend hours YES NO Evening hours YES NO CSHCN (Children w/Special Needs) YES NO

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

- Spanish
 Chinese
 French
 Burmese, dialect _____
 Russian
 Other (please specify) _____

PAY TO INFORMATION

Billing Name	TIN
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Billing (Pay To) Address

Billing Phone	Billing Contact Name	Billing Contact E-mail
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MAILING ADDRESS

Mailing Address same as Primary Practice Address

Mailing Address

OTHER PRACTICE LOCATIONS

Please list up to two additional Practice Locations in which you will see IHCP members

Practice Group							
Does this location utilize Nurse Practitioner or Physician Assistant? <input type="checkbox"/> NP <input type="checkbox"/> PA							
Service Location Address (include ZIP + 4)							
Primary Phone		Primary Fax			If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO		
Office Contact Name				Office Contact E-mail			
County			Group IHCP Number (including Alpha suffix)				
Group NPI			Taxonomies				
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible <input type="checkbox"/> YES <input type="checkbox"/> NO On a bus route <input type="checkbox"/> YES <input type="checkbox"/> NO							
Does the site offer: Weekend hours <input type="checkbox"/> YES <input type="checkbox"/> NO Evening hours <input type="checkbox"/> YES <input type="checkbox"/> NO CSHCN (Children w/Special Needs) <input type="checkbox"/> YES <input type="checkbox"/> NO							
Our office is fluent in the following languages other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Burmese, dialect _____ <input type="checkbox"/> Russian <input type="checkbox"/> Other (please specify) _____							

Practice Group							
Does this location utilize Nurse Practitioner or Physician Assistant? <input type="checkbox"/> NP <input type="checkbox"/> PA							
Service Location Address (include ZIP + 4)							
Primary Phone		Primary Fax			If PMP, assign membership to this location <input type="checkbox"/> YES <input type="checkbox"/> NO		
Office Contact Name				Office Contact E-mail			
County			Group IHCP Number (including Alpha suffix)				
Group NPI			Taxonomies				
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible <input type="checkbox"/> YES <input type="checkbox"/> NO On a bus route <input type="checkbox"/> YES <input type="checkbox"/> NO							
Does the site offer: Weekend hours <input type="checkbox"/> YES <input type="checkbox"/> NO Evening hours <input type="checkbox"/> YES <input type="checkbox"/> NO CSHCN (Children w/Special Needs) <input type="checkbox"/> YES <input type="checkbox"/> NO							
Our office is fluent in the following languages other than English: <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> French <input type="checkbox"/> Burmese, dialect _____ <input type="checkbox"/> Russian <input type="checkbox"/> Other (please specify) _____							

For additional addresses, please copy and complete this page and submit with application.

Indiana Health Coverage Program Managed Care Organization and or Care Management Organization (IHCP MCO/CMO)

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Indiana Health Coverage Program Managed Care Organization and/or Care Management Organization (IHCP MCO/CMO), 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 MCO/CMO 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 MCO/CMO will conduct an independent verification of this Credentialing Information and such information will be used to evaluate my credentials according to the IHCP MCO/CMO standards. I hereby consent to the release of Credentialing Information to the IHCP MCO/CMO, 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 MCO/CMO, 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 MCO/CMO contracted network or the IHCP MCO/CMO.

A photocopy of this authorization will serve as an original. I understand that the IHCP MCO/CMO, 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 MCO/CMO, 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 MCO/CMO provider networks. The undersigned hereby agrees to report to IHCP MCO/CMO 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 MCO/CMO 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 MCO/CMO 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.