IHCP MCE HOSPITAL/ANCILLARY PROVIDER ENROLLMENT AND CREDENTIALING FORM

This form is used to enroll participating facilities such as hospitals, home health agencies, and other nonpractitioner providers with any of the Indiana Health Coverage Programs (IHCP) managed care entities (MCEs).

Note: Home- and Community-Based Services (HCBS) waiver providers enrolling with an MCE for the Indiana PathWays for Aging program must use the IHCP MCE Enrollment Form for HCBS Providers instead of this form.

Please select the programs for which this form applies:

☐ Healthy Indiana Plan (HIP) ☐ Hoosier Care Connect ☐ Hoosier Healthwise ☐ Indiana PathWays for Aging

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:

APPLCATION INSTRUCTIONS: For this application to be considered complete:

1. All information must be legible (please print or type); application must be completed in its entirety, signed, and dated.
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 application:
   - State license
   - CMS site evaluation – If state site survey is not available
   - Indiana Department of Health Accreditation Certificate with site survey
   - Copy of Medicaid certification letter
   - Liability coverage face sheet
   - Federal *W-9* form (current)
   - Clinical Laboratory Improvement Amendments **(**CLIA)
   - Drug Enforcement Agency (DEA) #

DEMOGRAPHIC INFORMATION

Entity Name:	DBA Name or Legal Name:	
IHCP Provider ID:	Indiana State License No.:	Taxpayer ID Number (TIN):
National Provider Identifier (NPI):	Taxonomy Number:	Medicare Number:
Address:	City, St., ZIP:	County:
Contact Name:	Contact Title:	
Contact Phone:	Contact Email:	

Accreditation Type: ☐ Health Care Finance Administration (HCFA) ☐ National Commission of Quality Assurance (NCQA) ☐ Joint Commission of Accreditation of Healthcare Organizations (JCAHO) ☐ Indiana Department of Health (IDOH) ☐ Other:

ACCESSIBILITY INFORMATION

Does this site offer accessible accommodations for the following?

Building: ☐ Yes ☐ No Parking: ☐ Yes ☐ No Restroom: ☐ Yes ☐ No Other:

Does this site offer other services for people with disabilities?

Text Telephony (TTY): ☐ Yes ☐ No American Sign Language: ☐ Yes ☐ No Mental/Physical Impairment Services: ☐ Yes ☐ No

Other:

Is this site accessible by public transportation?

Bus: ☐ Yes ☐ No Subway: ☐ Yes ☐ No Regional Train: ☐ Yes ☐ No Other:

BILLING INFORMATION (if different from above)

Pay To		
Street:	City, St., ZIP:	Phone:
Contact Person:	Fax:	

COMPREHENSIVE/GENERAL/PROFESSIONAL LIABILITY

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 consent or request? ◯ Yes ◯ No

B. Is your organization currently or has been in the last five years under investigation by any government entity or peer review? ◯ Yes ◯ No

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? ◯ Yes ◯ No
If Yes, please explain, including dates:

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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.