IHCP MCE PRACTITIONER ENROLLMENT FORM

This form is used to enroll participating practitioners 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:

PRACTITIONER DATA

Council for Affordable Quality Healthcare (CAQH) Number:			
Practitioner First Name:	MI:	Last Name:	Suffix:
Degree (check one): ☐ MD ☐ DO ☐ DMD ☐ DPM ☐ CRNA ☐ NP ☐ CNM ☐ Other:			
Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female	
National Provider Identifier (NPI):	Taxonomies (list all):		
DEA #:	CSR #:		
License Number & State:	UPIN:	IHCP Provider ID:	
Enrolling as: ☐ PMP with Panel ☐ Physician Specialist ☐ NP Supporting a PMP ☐ Behavioral Health ☐ NP Supporting a Specialty ☐ Certified Midwife ☐ Prenatal Care Coordinator ☐ Other:			
Primary Specialty:	Secondary Specialty:	NP – Specialty-Supported? ☐ Yes ☐ No	
Are you: ☐ A Locum Tenem? ☐ Hospital-Based Physician? ☐ Hospitalist?			
The National Committee for Quality Assurance (NCQA) requires that health plans assess the cultural, ethnic, racial, and linguistic needs of members of the practitioners in the network. Please provide the following information: Ethnicity: ☐ Asian ☐ African American/Black ☐ Caucasian/White ☐ Hispanic/Latino ☐ Native American ☐ Pacific Islander ☐ Other (please specify):			
Practitioner Email:	Fax:	Phone:	
Maximum membership (panel size) accepted (PMPs only): Hoosier Healthwise HIP Hoosier Care Connect PathWays			

Scope of Practice (OB/GYN PMPs only)

All Women (OB/GYN)? ☐ Yes ☐ No

(Note: All Women indicates services exclusive to pregnant and nonpregnant members; Family Practitioners cannot select this category.)

OB Only (OB/GYN)? ☐ Yes ☐ No

OB (Family Practitioners)? ☐ Yes ☐ No

Age Restrictions (PMPs only) – Check one

☐	**None –** *Internal Medicine & OB/GYN Practitioners cannot select this category; only Family Practitioners and General Practitioners can select this category*
☐	**0 – 2 years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*
☐	**0 – 12 years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*
☐	**0 – 17 years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*
☐	**0 – 20 years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*
☐	**3+ years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*

☐ **13+ years**	☐ **13 – 17 years**	☐ **13 – 20 years**	☐ **17+ years**	☐ **21+ years**	☐ **65+ years**

PRACTITIONER DATA – cont'd

Hospital Privileges? ☐ Yes ☐ No	
Hospital:	Address:
Hospital:	Address:
Hospital:	Address:

If you do not have hospital privileges, state relationship privileges:

Relationship Privileges? ☐ Yes ☐ No		
Physician:	Hospital:	Address:

Any primary medical provider (PMP) that renders OB services must have delivery privileges and/or relationship privileges to deliver.

Delivery Privileges? ☐ Yes ☐ No

Hospital: _____ Address: _____

If you do not have delivery privileges, state relationship privileges:

Relationship Privileges? ☐ Yes ☐ No

Physician: _____ Hospital: _____ Address: _____

Indicate the type of practice associated with this enrollment:

☐ Individual ☐ Group ☐ FQHC ☐ RHC ☐ Other Clinic (Type): ☐ Urgent Care ☐ Health Department

PRIMARY PRACTICE INFORMATION

Practice Group Name:							
Does this location use Nurse Practitioner or Physician Assistant? ☐ NP ☐ PA ☐ N/A							
Service Location Address (include ZIP + 4):							
Primary Phone:		Primary Fax:		If PMP, assign membership to this location? ☐ Yes ☐ No			
Office Contact Name:				Office Contact Email:			
County:			Group IHCP Provider ID:				
Group NPI:			Taxonomies:				
Medicare Group Number:							
Office Hours:	Mon:	Tue:	Wed:	Thu:	Fri:	Sat:	Sun:

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:

Does the site: Offer weekend hours? ☐ Yes ☐ No Offer evening hours? ☐ Yes ☐ No Serve CSHCN (Children w/Special Needs)? ☐ Yes ☐ No

Our office is fluent in the following languages other than English:
☐ Spanish ☐ Mandarin ☐ French ☐ Burmese, dialect: ☐ Russian ☐ Other (please specify):

PAY-TO INFORMATION

Billing Name:		Taxpayer ID Number (TIN):
Billing (Pay-To) Address:		
Billing Phone:	Billing Contact Name:	Billing Contact Email:

MAILING ADDRESS

Mailing Address Same as Primary Practice Address? ☐ Yes ☐ No
Mailing Address:

OTHER PRACTICE LOCATIONS

Please list additional practice locations in which you will see IHCP members

Practice Group Name:

Does this location use Nurse Practitioner or Physician Assistant? ☐ NP ☐ PA ☐ N/A

Service Location Address (include ZIP + 4):

Primary Phone:	Primary Fax:	If PMP, assign membership to this location? ☐ Yes ☐ No

Office Contact Name:	Office Contact Email:

County:	Group IHCP Provider ID:
Group NPI:	Taxonomies:

Medicare Group Number:

Office Hours:	Mon:	Tue:	Wed:	Thu:	Fri:	Sat:	Sun:

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:

Does the site: Offer weekend hours? ☐ Yes ☐ No Offer evening hours? ☐ Yes ☐ No Serve CSHCN (Children w/Special Needs)? ☐ Yes ☐ No

Our office is fluent in the following languages other than English:
☐ Spanish ☐ Mandarin ☐ French ☐ Burmese, dialect: ☐ Russian ☐ Other (please specify):

Practice Group Name:

Does this location use Nurse Practitioner or Physician Assistant? ☐ NP ☐ PA ☐ N/A

Service Location Address (include ZIP + 4):

Primary Phone:	Primary Fax:	If PMP, assign membership to this location? ☐ Yes ☐ No

Office Contact Name:	Office Contact Email:

County:	Group IHCP Provider ID:
Group NPI:	Taxonomies:

Medicare Group Number:

Office Hours:	Mon:	Tue:	Wed:	Thu:	Fri:	Sat:	Sun:

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:

Does the site: Offer weekend hours? ☐ Yes ☐ No Offer evening hours? ☐ Yes ☐ No Serve CSHCN (Children w/Special Needs)? ☐ Yes ☐ No

Our office is fluent in the following languages other than English:
☐ Spanish ☐ Mandarin ☐ French ☐ Burmese, dialect: ☐ Russian ☐ Other (please specify):

For additional practice locations, please copy and complete this page and submit with this form.

PRACTITIONER/PRACTICE DISCLOSURES

Has the practitioner or practice ever been excluded from Medicaid or Medicare? If so, provide explanation, including dates:

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.