MDwise

Behavioral Health Provider Enrollment/Update Form

Provider/Contract Information Change - please check all that are applicable	
☐ Are you a new provider? If yes, date of your provider site visit: _____	☐ Provider Status Change ☐ Community Mental Health Center ☐ Contracted provider adding new employee
Please check the program you are enrolling in: ☐ HIP ☐ HHW ☐ MDwise Marketplace	
Rendering provider and Degree/Licensure:	Provider Gender: Provider Ethnicity: Provider Date of Birth:
Supervising Provider Name and Degree/Licensure:	
Group DBA or Legal Name (if applicable) (For groups, please include a group roster so we can validate all providers in the Group):	
CAQH Number:	
Rendering NPI:	NPI Group:
Rendering Social Security Number	LPI Number:
Rendering Provider Taxonomy:	License Number:
Credentialing Contact (if different than contact name):	
Credentialing Contact Email (if different than contact email):	
Person Submitting Form:	
Physical Address Change/Add:	
☐ Change	☐ Additional Office
Current Practice Address:	New Practice Address:
Billing Address:	
Current Practice Phone:	New Practice Phone:
Current Billing/Mailing Phone:	New Billing/Mailing Phone:
Current Billing/Mailing Address:	New Billing/Mailing Address:
Communication Add/Change:	
☐ Fax	☐ Email
Current fax number:	New fax number:
Current email:	New email:
Tax Identification Number Change:	
Current Group Tax ID:	New Group Tax ID
Please contact MDwise Provider Relations as a change in your Tax ID Number may require a new contract.	
Please send form to:	
Contact Name:	Phone number:
Contact Email:	
Mail to: MDwise, Inc. Attn: Provider Relations 1200 Madison Ave. Suite 400 Indianapolis, IN 46225	Email to: prenrollment@mdwise.org

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Please fill out additional information for each location adding to provider Tax ID.

Facility/Group Services		
☐ Substance Abuse Inpatient ☐ Psychiatric Inpatient ☐ Detox Inpatient	☐ Detox Outpatient ☐ PHP ☐ IOP	☐ Group ☐ Outpatient ☐ OTP

Specialty	
☐ Autism Specialist ☐ Addictions ☐ Suboxone	☐ Child/Adolescent ☐ Geriatric

Location Services: (check all that apply to this location and provider)			
☐ Inpatient ☐ Detox ☐ Substance Abuse ☐ Psychiatric	☐ Child/Adult ☐ Adult ☐ Geriatric	☐ Outpatient ☐ PHP ☐ IOP (psych) (substance abuse) ☐ Group	☐ ABA ☐ Detox ☐ Suboxone

Additional Locations	
Provider/Group Name:	
Location 2	

Facility/Group Services		
☐ Substance Abuse Inpatient ☐ Psychiatric Inpatient ☐ Detox Inpatient	☐ Detox Outpatient ☐ PHP ☐ IOP	☐ Group ☐ Outpatient

Specialty	
☐ Autism Specialist ☐ Addictions ☐ Suboxone	☐ Child/Adolescent ☐ Geriatric

Location Services (check all that apply)			
☐ Inpatient ☐ Detox ☐ Substance Abuse ☐ Psychiatric	☐ Child/Adult ☐ Adult ☐ Geriatric	☐ Outpatient ☐ PHP ☐ IOP (psych) (substance abuse) ☐ Group	☐ ABA ☐ Detox ☐ Suboxone

LPI Number:	Practice Number:
Practice Address:	Fax Number:
	Email:
Individual Provider Specialty:	

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Location 3

Facility/Group Services

- ☐ Substance Abuse Inpatient
- ☐ Psychiatric Inpatient
- ☐ Detox Inpatient
- ☐ Detox Outpatient
- ☐ PHP
- ☐ IOP
- ☐ Group
- ☐ Outpatient

Specialty

- ☐ Autism Specialist
- ☐ Addictions
- ☐ Suboxone
- ☐ Child/Adolescent
- ☐ Geriatric

Location Services (check all that apply)

- ☐ Inpatient
- ☐ Detox
- ☐ Substance Abuse
- ☐ Psychiatric
- ☐ Child/Adult
- ☐ Adult
- ☐ Geriatric
- ☐ Outpatient
- ☐ PHP
- ☐ IOP (psych) (substance abuse)
- ☐ Group
- ☐ ABA
- ☐ Detox
- ☐ Suboxone

LPI Number:

Practice Number:

Practice Address:

Fax Number:

Email:

Individual Provider Specialty:

Location 4

Facility/Group Services

- ☐ Substance Abuse Inpatient
- ☐ Psychiatric Inpatient
- ☐ Detox Inpatient
- ☐ Detox Outpatient
- ☐ PHP
- ☐ IOP
- ☐ Group
- ☐ Outpatient

Specialty

- ☐ Autism Specialist
- ☐ Addictions
- ☐ Suboxone
- ☐ Child/Adolescent
- ☐ Geriatric

Location Services (check all that apply)

- ☐ Inpatient
- ☐ Detox
- ☐ Substance Abuse
- ☐ Psychiatric
- ☐ Child/Adult
- ☐ Adult
- ☐ Geriatric
- ☐ Outpatient
- ☐ PHP
- ☐ IOP (psych) (substance abuse)
- ☐ Group
- ☐ ABA
- ☐ Detox
- ☐ Suboxone

LPI Number:

Practice Number:

Practice Address:

Fax Number:

Email:

Individual Provider Specialty:

Send form to:

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Supervising Provider Form

Mid-level providers (MSW, MA, MS, LSW, LCSW, LMHC-A, LMHC, LMFT, MMFT, LCAC, BCBA, BCBA-D, BCaBA, RBT, Ph.D, Psy.D) must have a supervising provider (HSPP or MD/DO) in order to submit claims for Managed Medicaid Programs. NP, CNS and APRN must have supervising physician only if they are not an IHCP provider. Please include collaborating agreement when submitting enrollment.

Please complete this form if you are a Mid-level Provider regarding your supervising provider. Individual Provider:

Last Name _____ First Name _____

License/Degree

☐ MSW	☐ LMHC-A	☐ BCBA	☐ LAC
☐ MA	☐ LMHC	☐ BCBA-D	☐ CADAC II
☐ MS	☐ LMFT	☐ BCaBA	☐ CADAC IV
☐ LCSW	☐ MMFT	☐ RBT	☐ ICACII
☐ LSW	☐ LCAC	☐ Ph.D	

Individual Provider Specialty _____

Supervising Provider Information: ☐ MD/DO ☐ HSPP
Last Name _____ First Name _____

License Number: _____ Taxonomy Code _____

Address _____

City _____ State _____ Zip _____

Phone number _____ Fax number _____

Email Address _____

IHCP# (Medicaid#) _____ NPI# _____

Please provide the following information for <u>each location</u> the HSPP/MD/DO supervises. You may copy additional sheets as needed.

Group Name _____

Location/Address _____

Group NPI# _____ Company Tax ID# _____

Group IHCP# (Medicaid# + Location code) _____