

MDwise Care Select Program First Amendment to the Addendum of the Indiana Health Coverage Programs/Medicaid Provider Agreement

This is the First Amendment to the *Care Select* Addendum to the Indiana Health Coverage Programs/Medicaid (IHCP/Medicaid) Provider Agreement ("the Agreement"). All other matters previously agreed to and set forth in the original Agreement, and not affected by this First Amendment, shall remain in full force and effect.

Effective January 1, 2011, the following changes are made to the Agreement:

1. Paragraph 10 is amended as follows:
Non-Emergency Admissions. Non-emergency inpatient admissions require approval from the PMP. The PMP shall not refuse to approve any appropriate, medically necessary inpatient admissions.

2. Paragraph 32 is amended as follows:
The PMP may refer a member under his/her care to another IHCP participating provider for any medically necessary service. Referrals may be given in writing or by telephone. Referrals must be documented in the medical record by the PMP. The PMP must specify which services are covered by the referral and may cover one or multiple visits to complete a plan of care. An optional sample referral form is included in the *Care Select* Manual.

3. Paragraph 33 is removed in its entirety.

4. Paragraph 50 is amended as follows:
PMPs enrolled in the *Care Select* Program will receive a six dollar (\$6.00) monthly administration fee for each member on the panel roster. Administration fees will not be paid for any month during which the PMP's license lapsed or was terminated for all or part of that month. Further, failure to comply with all *Care Select* Program guideline-based care may result in forfeiture of this fee, as appropriate and as approved by OMPP.

The undersigned, being the provider, or having the specific authority to bind the provider to the terms of this agreement, and having read this agreement and understanding it in its entirety, hereby agrees, both individually and on behalf of the provider as a business entity, to abide by and comply with all the stipulations, conditions, and terms set forth herein

Signature

Date

PMP's Full Name or PMP Group Name (Typed or Printed)

PMP's IHCP Provider ID (if PMP Group, please attach a list)

PMP's or PMP Group Practice Name (If Different)

County