



All fields must be complete for processing
Please print legibly – except signatures

Fax this form to MDwise at 1-877-822-7188
or 317-822-7519 in the Indianapolis area

Full Panel Add Request

Date of Request _____

Contact Name _____ Contact Telephone _____

Member Information

Care Select ID Number _____

Member Name _____

Social Security Number _____

Member Address _____

Member (or parent/guardian signature) _____

Date Signed _____

Provider Information

As a PMP, I agree to add the above *Care Select* member to my panel that is full.

Physician Name (print) _____

Physician Signature _____

Provider ID Number _____

Provider Location _____

Provider Group # _____

MAXIMUS Use Only

Date Received _____ Date Approved _____

Date Denied _____ Return Code/Reason _____