



# MDwise Panel Add Request

Fax Form to MDwise 317.829.5530 or 877-822-7190; or fax to your delivery system Provider Relations

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

Date of Request \_\_\_\_\_

Contact Name \_\_\_\_\_ Contact Telephone \_\_\_\_\_

## Member Information

Hoosier Healthwise ID Number \_\_\_\_\_

Member Name \_\_\_\_\_

Social Security Number \_\_\_\_\_

Member Address \_\_\_\_\_

\_\_\_\_\_

Member (or parent/guardian signature) \_\_\_\_\_

Date Signed \_\_\_\_\_

## Provider Information

**NOTICE to MEMBER: This provider may belong to more than one Hoosier Healthwise Managed Care Entity (MCE). Please discuss your MCE choice options with this provider before signing this form. You may also call Hoosier Healthwise at 1-800-889-9949 to discuss options available for choosing your MCE.**

**Why do you wish to add this member to your panel? Please check only one – Reason is required.**

- This is an established patient or family member of an established patient whom I have treated in the past 24 months from today's date.
- This is a patient whom I would like to add to my panel.

**As a PMP, I agree to add the above Hoosier Healthwise/HIP member to my panel.**

Physician Name (print) \_\_\_\_\_

Physician Signature \_\_\_\_\_

Physician Provider ID Number \_\_\_\_\_

Physician Group Number \_\_\_\_\_ Location Code \_\_\_\_\_

### Maximus Use Only

Date Received: \_\_\_\_\_

Date Approved: \_\_\_\_\_

Date Denied: \_\_\_\_\_

Return Code/Reason: \_\_\_\_\_