Full Panel Add Request

Fax Form to MDwise 317.829.5530

**** 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

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

Physician Name (print) ____

Physician Signature ____

Physician Provider ID Number ____

Group Number ____

Location Code ____

Maximus Use Only

Date Received ____

Date Approved____

Date Denied ____

Return Code/Reason____