



Managed Care Primary Medical Provider Disenrollment With Re-enrollment Form

<input type="checkbox"/> Advantage		<input type="checkbox"/> Anthem		<input type="checkbox"/> MDwise		<input type="checkbox"/> Managed Health Services (MHS)	
Date Submitted:		Mail to: EDS Provider Enrollment Managed Care P.O. Box 7263 Indianapolis, IN 46207-7263		For questions, call (877) 707-5750		Please select applicable Program <input type="checkbox"/> Risk Based Managed Care(RBMC) <input type="checkbox"/> Care Select	
Instructions							
Complete this form to request a PMP service location disenrollment with re-enrollment from the above programs. The PMP's disenrollment notification letter with a valid signature must accompany the PMP Disenrollment request form. Please include ZIP+4 on all addresses on this form. NOTE: PMP disenrollments are processed on the 24 th of the month; the effective end-date will be the last date of the current month the disenrollment is approved.							
Information							
1. MCE contact name:			2. MCE Contact Phone number:		3. MCE Contact E-mail:		
4. Provider Name:			5. IHCP Provider Number:		6. Provider NPI Number:		
7. Is the PMP disenrolling from a PMP individual or group service location(s)? (Care Select users: If more than two service locations, utilize additional forms) Individual <input type="checkbox"/> Group <input type="checkbox"/>							
8. Individual existing service location address:					8a. Alpha Service location Code:		
9. Group Number:			10. Group NPI Number:				
11. Group existing service location address:					11a. Alpha Service location Code:		
12. PMP service location disenrollment desired effective end date:							
13. Is the PMP re-enrolling with a different MCE Yes <input type="checkbox"/> No <input type="checkbox"/>			13a. If yes, MCE name:			14. Re-Enrollment Effective Date:	
15. Is the PMP re-enrollment for an individual or group service location address? Individual <input type="checkbox"/> Group <input type="checkbox"/>				16. Is the PMP re-enrolling at a new or existing service location address? New <input type="checkbox"/> Existing <input type="checkbox"/>			
17. Individual new or existing service location address:					17a. Alpha Service location Code:		
18. Group Name:			19. Group Number:		20. Group NPI Number:		
21. Group new or existing service location address:					21a. Alpha Service location Code:		
22. Please indicate the PMP's Specialty Type: (Other is utilized for Care Select only) <input type="checkbox"/> Family Practitioner <input type="checkbox"/> Pediatrician <input type="checkbox"/> OB/GYN <input type="checkbox"/> General Practice <input type="checkbox"/> Internist <input type="checkbox"/> Other _____							
23. Hospital admitting privileges? Yes <input type="checkbox"/> No <input type="checkbox"/>			23a. Relationship privileges? Yes <input type="checkbox"/> No <input type="checkbox"/>			24. Delivery privileges? Yes <input type="checkbox"/> No <input type="checkbox"/>	
25. Age restrictions:		<input type="checkbox"/> None	<input type="checkbox"/> 0-2 yrs	<input type="checkbox"/> 0-12 yrs	<input type="checkbox"/> 0-17 yrs	<input type="checkbox"/> 0-20 yrs	<input type="checkbox"/> 13-17 yrs
		<input type="checkbox"/> 13-20 yrs	<input type="checkbox"/> 3+ yrs	<input type="checkbox"/> 13+ yrs	<input type="checkbox"/> 17+ yrs	<input type="checkbox"/> 21+ yrs	<input type="checkbox"/> 65+ yrs ^{CS only}
26. Please indicate PMP scope of practice: Obstetrics: Yes <input type="checkbox"/> No <input type="checkbox"/> All women (OB/GYN only): Yes <input type="checkbox"/> No <input type="checkbox"/> Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Male/Female <input type="checkbox"/>							
27. Desired panel size:							
28. Comments:							
To be completed by EDS Staff							
Date received:			Date completed:			Completed by:	