



Managed Care Primary Medical Provider 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 every field on this form. Incomplete forms will be returned and may delay the PMP's enrollment. Note: A provider must be enrolled in the Indiana Health Coverage Programs (IHCP) to enroll as a PMP.								
Information								
1. MCE Contact Name:			2. MCE Contact Telephone Number:		3. MCE Contact E-mail:			
4. Is the PMP disenrolling from one Managed Care Entity (MCE) to enroll into another MCE? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>								
5. Provider name:								
6. IHCP Provider Number:			7. Provider NPI Number:			8. Indiana Provider License Number (If Known):		
9. Please check the appropriate box to indicate whether the provider is enrolling as an individual or group PMP. Individual Enrollment <input type="checkbox"/> (Go to Question 12) Group Enrollment <input type="checkbox"/> (Go to Question 10)								
10. Group Number:			11. Group NPI Number:		12. MCE Network Name:		13. MCE Network ID:	
14. RBMC PMPs may have two service locations. Care Select PMPs may have multiple service locations; Additional forms will be required for more than two service locations.								
14a. First service location address, including county name, ZIP code +4, and daytime phone number						14b. Alpha Service Location Code:		
14c. Second service location address, including county name, ZIP code +4 and daytime phone number (if applicable)						14d. Alpha Service Location Code:		
15. 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 _____								
16. Hospital admitting privileges? Yes <input type="checkbox"/> No <input type="checkbox"/>			16a. Relationship privileges? Yes <input type="checkbox"/> No <input type="checkbox"/>			17. Delivery privileges? Yes <input type="checkbox"/> No <input type="checkbox"/>		
18. Age restrictions (Please check one per service location)								
18a. 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}	
18b. 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}	
19. 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"/>								
20. Desired panel size:						21. Desired effective date of enrollment:		
22. Comments:								
To be completed by EDS Staff								
Date received:			Date completed:			Completed by:		