



MDwise Behavioral Health Provider Contract Inquiry Form

Completed forms should be submitted to prenrollment@mdwise.org.

PRODUCT LINE (please check all that apply):

Medicaid

- MDwise Excel Hoosier Healthwise (HHW)
- MDwise Excel Healthy Indiana Plan (HIP)

SPECIALTY:

- Midlevel Therapist Office
- OTP
- Psychiatrist/Psychologist
- Residential SUD
- Other, please specify*: _____

SERVICES RENDERED: _____

Group/Provider Information	
Legal Name (W9):	
Tax ID Number (TIN):	
Group NPI:	
Bill Type:	<input type="checkbox"/> I 500 <input type="checkbox"/> UB <input type="checkbox"/> Both
Supervising Provider Name/NPI:	
Service Information	
Primary Practice Address	
County/Countries Served:	
Mailing Address:	
Multiple Locations (Counties):	
Contact Information	
Contact Name:	
Title:	
Mailing Address:	
Contact Telephone:	
Contact Email:	

To be completed by MDwise Provider Relations:

- Approved
 Denied (see notes)
 Pending (see notes)
 Site Visit Need? Yes No

PR Rep: _____ PR Management: _____ Date: _____

Notes: