

**MDwise**  
 Behavioral Health Provider Enrollment/Update Form

Provider/Contract Information Change - please check all that are applicable	
<input type="checkbox"/> Are you a new provider? If yes, date of your provider site visit: _____	<input type="checkbox"/> Provider Status Change <input type="checkbox"/> Community Mental Health Center <input type="checkbox"/> Contracted provider adding new employee
Please check the program you are enrolling in: <input type="checkbox"/> HIP <input type="checkbox"/> HHW	
Rendering provider and Degree/Licensure:	Provider Gender: Provider Ethnicity: Provider Date of Birth:
Supervising Provider Name and Degree/Licensure (when applicable):	
Group DBA or Legal Name: (For groups, please include a group roster so we can validate all providers in the Group):	
CAQH Number:	
Rendering NPI:	NPI Group:
Rendering Social Security Number	LPI Number:
Rendering Provider Taxonomy:	License Number:
Credentialing Contact (if different than contact name):	
Credentialing Contact Email (if different than contact email):	
Person Submitting Form:	
Physical Service Location Change/Add:	
<input type="checkbox"/> Change	<input type="checkbox"/> Additional Office
Current Practice Address:	New Practice Address:
Current Billing Location:	New Billing Location:
Current Practice Phone:	New Practice Phone:
Current Billing/Mailing Phone:	New Billing/Mailing Phone:
Current Billing/Mailing Address:	New Billing/Mailing Address:
Communication Add/Change:	
Former fax number:	Former email:
New fax number:	New email:
Tax Identification Number Change:	
Current Group Tax ID:	New Group Tax ID
<i>Please contact MDwise Provider Relations as a change in your Tax ID Number may require a new contract.</i>	
Please send form to:	
Contact Name:	Phone number:
Contact Email:	
Mail to: MDwise, Inc. Attn: Provider Relations 2955 N. Meridian St. Suite 201 Indianapolis, IN 46208	Email to: <a href="mailto:prenrollment@mdwise.org">prenrollment@mdwise.org</a>

Please fill out additional information for each location being adding to the provider Tax ID.

Facility/Group Services			
<input type="checkbox"/> Substance Abuse Inpatient	<input type="checkbox"/> Detox Outpatient	<input type="checkbox"/> Group	<input type="checkbox"/> Residential 3.1
<input type="checkbox"/> Psychiatric Inpatient	<input type="checkbox"/> PHP	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Residential 3.5
<input type="checkbox"/> Detox Inpatient	<input type="checkbox"/> IOP	<input type="checkbox"/> OTP	
Specialty			
<input type="checkbox"/> Autism Specialist	<input type="checkbox"/> Child/Adolescent		
<input type="checkbox"/> Addictions	<input type="checkbox"/> Geriatric		
<input type="checkbox"/> Suboxone			
Location Services: (check all that apply to this location and provider)			
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Child/Adult	<input type="checkbox"/> Outpatient	<input type="checkbox"/> ABA
<input type="checkbox"/> Detox	<input type="checkbox"/> Adult	<input type="checkbox"/> PHP	<input type="checkbox"/> Detox
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Geriatric	<input type="checkbox"/> IOP (psych) (substance abuse)	<input type="checkbox"/> Suboxone
<input type="checkbox"/> Psychiatric		<input type="checkbox"/> Group	<input type="checkbox"/> Residential SUD
Additional Locations			
Provider/Group Name:			
<b>Location 2</b>			
Facility/Group Services			
<input type="checkbox"/> Substance Abuse Inpatient	<input type="checkbox"/> Detox Outpatient	<input type="checkbox"/> Group	<input type="checkbox"/> Residential 3.1
<input type="checkbox"/> Psychiatric Inpatient	<input type="checkbox"/> PHP	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Residential 3.5
<input type="checkbox"/> Detox Inpatient	<input type="checkbox"/> IOP	<input type="checkbox"/> OTP	
Specialty			
<input type="checkbox"/> Autism Specialist	<input type="checkbox"/> Child/Adolescent		
<input type="checkbox"/> Addictions	<input type="checkbox"/> Geriatric		
<input type="checkbox"/> Suboxone			
Location Services (check all that apply)			
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Child/Adult	<input type="checkbox"/> Outpatient	<input type="checkbox"/> ABA
<input type="checkbox"/> Detox	<input type="checkbox"/> Adult	<input type="checkbox"/> PHP	<input type="checkbox"/> Detox
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Geriatric	<input type="checkbox"/> IOP (psych) (substance abuse)	<input type="checkbox"/> Suboxone
<input type="checkbox"/> Psychiatric		<input type="checkbox"/> Group	<input type="checkbox"/> Residential SUD
LPI Number:		Practice Number:	
Practice Address:		Fax Number:	
		Email:	
Individual Provider Specialty:			

<b>Location 3</b>			
Facility/Group Services			
<input type="checkbox"/> Substance Abuse Inpatient	<input type="checkbox"/> Detox Outpatient	<input type="checkbox"/> Group	<input type="checkbox"/> Residential 3.1
<input type="checkbox"/> Psychiatric Inpatient	<input type="checkbox"/> PHP	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Residential 3.5
<input type="checkbox"/> Detox Inpatient	<input type="checkbox"/> IOP	<input type="checkbox"/> OTP	
Specialty			
<input type="checkbox"/> Autism Specialist	<input type="checkbox"/> Child/Adolescent		
<input type="checkbox"/> Addictions	<input type="checkbox"/> Geriatric		
<input type="checkbox"/> Suboxone			
Location Services (check all that apply)			
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Child/Adult	<input type="checkbox"/> Outpatient	<input type="checkbox"/> ABA
<input type="checkbox"/> Detox	<input type="checkbox"/> Adult	<input type="checkbox"/> PHP	<input type="checkbox"/> Detox
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Geriatric	<input type="checkbox"/> IOP (psych) (substance abuse)	<input type="checkbox"/> Suboxone
<input type="checkbox"/> Psychiatric		<input type="checkbox"/> Group	<input type="checkbox"/> Residential SUD
LPI Number:		Practice Number:	
Practice Address:		Fax Number:	
		Email:	
Individual Provider Specialty:			
<b>Location 4</b>			
Facility/Group Services			
<input type="checkbox"/> Substance Abuse Inpatient	<input type="checkbox"/> Detox Outpatient	<input type="checkbox"/> Group	<input type="checkbox"/> Residential 3.1
<input type="checkbox"/> Psychiatric Inpatient	<input type="checkbox"/> PHP	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Residential 3.5
<input type="checkbox"/> Detox Inpatient	<input type="checkbox"/> IOP	<input type="checkbox"/> OTP	
Specialty			
<input type="checkbox"/> Autism Specialist	<input type="checkbox"/> Child/Adolescent		
<input type="checkbox"/> Addictions	<input type="checkbox"/> Geriatric		
<input type="checkbox"/> Suboxone			
Location Services (check all that apply)			
<input type="checkbox"/> Inpatient	<input type="checkbox"/> Child/Adult	<input type="checkbox"/> Outpatient	<input type="checkbox"/> ABA
<input type="checkbox"/> Detox	<input type="checkbox"/> Adult	<input type="checkbox"/> PHP	<input type="checkbox"/> Detox
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Geriatric	<input type="checkbox"/> IOP (psych) (substance abuse)	<input type="checkbox"/> Suboxone
<input type="checkbox"/> Psychiatric		<input type="checkbox"/> Group	<input type="checkbox"/> Residential SUD
LPI Number:		Practice Number:	
Practice Address:		Fax Number:	
		Email:	
Individual Provider Specialty:			
Send form to:			

### Supervising Provider Form

Mid-level providers (MSW, MA, MS, LSW, LCSW, LMHC-A, LMHC, LMFT, MMFT, LCAC, BCBA, BCBA-D, BCaBA, RBT, Ph.D, Psy.D) that are not enrolled with the IHCP as a licensed behavioral health professional, must have a supervising provider (HSP or MD/DO) in order to submit claims for Managed Medicaid Programs. NP, CNS and APRN must have supervising physician only if they are not an IHCP provider. Please include collaborating agreement when submitting enrollment.

Please complete this form if you are a Mid-level Provider regarding your supervising provider:

Individual Provider:

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

License/Degree

- |                               |                                 |                                 |                                   |
|-------------------------------|---------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> MSW  | <input type="checkbox"/> LMHC-A | <input type="checkbox"/> BCBA   | <input type="checkbox"/> LAC      |
| <input type="checkbox"/> MA   | <input type="checkbox"/> LMHC   | <input type="checkbox"/> BCBA-D | <input type="checkbox"/> CADAC II |
| <input type="checkbox"/> MS   | <input type="checkbox"/> LMFT   | <input type="checkbox"/> BCaBA  | <input type="checkbox"/> CADAC IV |
| <input type="checkbox"/> LCSW | <input type="checkbox"/> MMFT   | <input type="checkbox"/> RBT    | <input type="checkbox"/> ICACII   |
| <input type="checkbox"/> LSW  | <input type="checkbox"/> LCAC   | <input type="checkbox"/> Ph.D   |                                   |

Individual Provider Specialty \_\_\_\_\_

Supervising Provider Information:  MD/DO  HSP

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

License Number: \_\_\_\_\_ Taxonomy Code \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

Email Address \_\_\_\_\_

IHCP# (Medicaid#) \_\_\_\_\_ NPI# \_\_\_\_\_

**Please provide the following information for each location the HSP/MD/DO supervises. You may copy additional sheets as needed.**

Group Name \_\_\_\_\_

Location/Address \_\_\_\_\_

Group NPI# \_\_\_\_\_ Company Tax ID# \_\_\_\_\_

Group IHCP# (Medicaid# + Location code) \_\_\_\_\_