Non-Contracted Provider Set-up Form

HIP☐ HHW☐

Please complete this form in its entirety to ensure accurate set-up.

Failure to provide information may result in claim payment delays.

New ☐ Update ☐ Tax ID #:_____

Request an Effective Date**: _____

**For Medicaid products this date may not be prior to enrollment date at IHCP for this Tax ID.
Only one TIN per form.

Group or Facility Information

Name: _____

Indiana Medicaid: _____ LOC Code: _____ NPI #: _____

Billing Address: _____

City, State ZIP: _____

Physical Address: _____

City, State ZIP: _____

Office Phone: _____ Office Fax: _____

Practitioner Information

Name: _____

Practitioner Email: _____

Provider Gender: Male ☐ Female ☐

Practitioner Indiana Medicaid: _____ NPI #: _____

Primary Taxonomy Code: _____

Contact Name: _____

Contact Email: _____

A completed W9 must accompany this form.

PLEASE RETURN via email the completed form, a sample claim & W9 to PRenrollment@mdwise.org.