MDwise 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)
- ☐ MDwise Hoosier Care Connect

Commercial
- ☐ MDwise Connect Marketplace

SPECIALTY:
- ☐ Primary Medical Provider (PMP)
- ☐ Ancillary
- ☐ Other, please specify*: _____
- ☐ Specialist
- ☐ Hospital

**Behavioral Health provider, please utilize the form found at www.mdwise.org/for-providers/forms/behavioral-health/*

Group/Provider Information	
Legal Name (W9):	
Tax ID Number (TIN):	
Group NPI:	
Bill Type:	☐ 1500 ☐ UB ☐ Both
Service Information	
Practice Location (Primary):	
County/Counties Serviced:	
Mailing Address:	
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: