INSTRUCTIONS FOR PROVIDER ENROLLMENT AND CREDENTIALING WITH IHCP MANAGED CARE ENTITIES

To enroll as a provider with one or more of the managed care entities (MCEs) administering Hoosier Healthwise, Healthy Indiana Plan (HIP), and Hoosier Care Connect, you must first be enrolled as a provider with the Indiana Health Coverage Programs (IHCP). See the Become a Provider page at indianamedicaid.com for an explanation of that process and to access application packets.

IHCP providers wishing to enroll with one or more of the MCEs must complete the following enrollment and credentialing process. **All applicable forms must be completed and submitted to each of the *MCEs with which you want to enroll.***

PRACTITIONERS

Practitioner Enrollment: You must complete the *IHCP MCE Practitioner Enrollment Form*. A separate enrollment must be completed and submitted to each of the MCEs with which you want to enroll.

Practitioner Credentialing: The State requires that you establish a universal credentialing application through the Council for Affordable Quality Healthcare (CAQH). CAQH is a credentialing data warehouse that allows you to keep all your credentialing information in a central location. This information can be accessed by a variety of credentialing entities and can save you time when seeking participation with multiple health plans.

- If you currently participate in CAQH, please add the IHCP MCEs with which you want to enroll as an authorized plan with CAQH, giving permission for the MCE to print your CAQH application.
- If you do not currently participate in CAQH, you must complete a CAQH application to establish your universal credentialing database. Go to the CACH application web page on the CAQH website at upd.caqh.org to complete the application online. Please add the IHCP MCEs with which you want to enroll as an authorized plan with CAQH, giving permission for the MCE to print your CAQH application.

OTHER PROVIDERS

Facilities such as hospitals, home health agencies, and providers other than practitioners are not eligible to participate in CAQH. Therefore, to complete the enrollment and credentialing process, these providers must fill out the *IHCP MCE Hospital/Ancillary Provider Enrollment and Credentialing Form*. The required documentation outlined on the form must be attached. A separate form with attachments must be completed and submitted to each of the MCEs with which the provider wants to enroll.

QUESTIONS

If you have questions about the enrollment or credentialing process, please contact the appropriate MCE at:

Anthem
Telephone: 1-800-455-6805
anthem.com

MDwise
Telephone: 1-800-356-1204
mdwise.org

Managed Health Services
Telephone: 1-877-647-4848
mhsindiana.com

IHCP MCE PRACTITIONER ENROLLMENT FORM

This form is used to enroll participating practitioners with any of the Indiana Health Coverage Programs (IHCP) managed care entity (MCE)

Please select the programs for which this form applies:
☐ Healthy Indiana Plan (HIP) ☐ Hoosier Healthwise ☐ Hoosier Care Connect
Please indicate if this is a new enrollment or an enrollment update: ☐ New enrollment ☐ Update (fill out updated information ONLY)
If an update, please explain what is being updated:

PRACTITIONER DATA

CAQH Number			
Practitioner First Name	MI	Last Name	Suffix
Degree (check one): ☐ MD ☐ DO ☐ DMD ☐ DPM ☐ CRNA ☐ NP ☐ CNM ☐ Other:			
SSN	Date of Birth	Gender: ☐ Male ☐ Female	
NPI	Taxonomies (list all)		
DEA #	CSR #		
License Number & State	UPIN	LPI (Medicaid) Number	
Enrolling as: ☐ PMP with Panel ☐ Physician Specialist ☐ NP Supporting a PMP ☐ Behavioral Health ☐ NP Supporting a Specialty ☐ Certified Mid-Wife ☐ Prenatal Care Coordinator ☐ Other			
Primary Specialty	Secondary Specialty	NP – Specialty-Supported	
Are you: ☐ A Locum Tenem? ☐ Hospital-Based Physician? ☐ Hospitalist?			
The National Committee for Quality Assurance (NCQA) requires that health plans assess the cultural, ethnic, racial, and linguistic needs of members of the practitioners in the network. Please provide the following information: Ethnicity: ☐ Asian ☐ African-American/Black ☐ Caucasian/White ☐ Hispanic/Latino ☐ Native American ☐ Pacific Islander ☐ Other (please specify)			
Practitioner Email	Fax	Phone	
Maximum membership (panel size) accepted (PMPs only): Hoosier Healthwise	HIP	Hoosier Care Connect	

Scope of Practice (OB/GYN PMPs only)

All Women (OB/GYN) ○ Yes ○ No
(Note: All Women indicates services exclusive to pregnant and nonpregnant members; Family Practitioners cannot select this category.)

OB Only (OB/GYN) ○ Yes ○ No

OB (Family Practitioners) ○ Yes ○ No

Age Restrictions (PMPs only) – Check one

☐	**None –** *Internal Medicine & OB/GYN Practitioners cannot select this category; only Family Practitioners and General Practitioners can select this category*
☐	**0 – 2 years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*
☐	**0 – 12 years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*
☐	**0 – 17 years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*
☐	**0 – 20 years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*
☐	**3+ years –** *Internal Medicine & OB/GYN Practitioners cannot select this category*

☐ **13+ years**	☐ **13 – 17 years**	☐ **13 – 20 years**	☐ **17+ years**	☐ **21+ years**	☐ **65+ years**

PRACTITIONER DATA – cont'd

Hospital Privileges ○ Yes ○ No	
Hospital	Address
Hospital	Address
Hospital	Address

If you do not have hospital privileges, state relationship privileges:

Relationship Privileges ○ Yes ○ No		
Physician	Hospital	Address

Any primary medical provider (PMP) that renders OB services must have delivery privileges and/or relationship privileges to deliver.

Delivery Privileges ○ Yes ○ No

Hospital Address

If you do not have delivery privileges, state relationship privileges:

Relationship Privileges ○ Yes ○ No

Physician Hospital Address

Indicate the type of practice associated with this enrollment:

☐ Individual ☐ Group ☐ FQHC ☐ RHC Clinic (Type) ☐ Urgent Care ☐ Health Department

PRIMARY PRACTICE INFORMATION

Practice Group Name							
Does this location use Nurse Practitioner or Physician Assistant? ☐ NP ☐ PA ☐ N/A							
Service Location Address (include ZIP + 4)							
Primary Phone	Primary Fax	If PMP, assign membership to this location? ○ Yes ○ No					
Office Contact Name	Office Contact Email						
County	Group IHCP Number (including alpha suffix)						
Group NPI	Taxonomies						
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible? ○ Yes ○ No On a bus route? ○ Yes ○ No							
Does the site: Offer weekend hours? ○ Yes ○ No Offer evening hours? ○ Yes ○ No Serve CSHCN (Children w/Special Needs)? ○ Yes ○ No							
Our office is fluent in the following languages other than English: ☐ Spanish ☐ Chinese ☐ French ☐ Burmese, dialect ☐ Russian ☐ Other (please specify)							

PAY-TO INFORMATION

Billing Name	TIN	
Billing (Pay-To) Address		
Billing Phone	Billing Contact Name	Billing Contact Email

MAILING ADDRESS

Mailing Address Same as Primary Practice Address ○ Yes ○ No	
Mailing Address	

OTHER PRACTICE LOCATIONS

Please list additional practice locations in which you will see IHCP members

Practice Group Name							
Does this location use Nurse Practitioner or Physician Assistant? ☐ NP ☐ PA ☐ N/A							
Service Location Address (include ZIP + 4)							
Primary Phone	Primary Fax	If PMP, assign membership to this location? ○ Yes ◉ No					
Office Contact Name	Office Contact Email						
County	Group IHCP Number (including alpha suffix)						
Group NPI	Taxonomies						
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible? ◉ Yes ◉ No	On a bus route? ◉ Yes ◉ No						
Does the site: Offer weekend hours? ◉ Yes ◉ No	Offer evening hours? ◉ Yes ◉ No	Serve CSHCN (Children w/Special Needs)? ◉ Yes ◉ No					
Our office is fluent in the following languages other than English: ☐ Spanish ☐ Chinese ☐ French ☐ Burmese, dialect ☐ Russian ☐ Other (please specify)							

Practice Group Name							
Does this location use Nurse Practitioner or Physician Assistant? ☐ NP ☐ PA ☐ /A							
Service Location Address (include ZIP + 4)							
Primary Phone	Primary Fax	If PMP, assign membership to this location? ○ Yes ◉ No					
Office Contact Name	Office Contact Email						
County	Group IHCP Number (including alpha suffix)						
Group NPI	Taxonomies						
Medicare Group Number							
Office Hours:	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Is this office: Handicap accessible? ◉ Yes ◉ No	On a bus route? ◉ Yes ◉ No						
Does the site: Offer weekend hours? ◉ Yes ◉ No	Offer evening hours? ◉ Yes ◉ No	Serve CSHCN (Children w/Special Needs)? ◉ Yes ◉ No					
Our office is fluent in the following languages other than English: ☐ Spanish ☐ Chinese ☐ French ☐ Burmese, dialect ☐ Russian ☐ Other (please specify)							

For additional practice locations, please copy and complete this page and submit with this form.

PRACTITIONER/PRACTICE DISCLOSURES

Has the practitioner or practice ever been excluded from Medicaid or Medicare? If so, provide explanation, including dates:

_____

_____

IHCP MCE
ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Indiana Health Coverage Programs (IHCP) managed care entity (MCE), its representatives, agents, or designees, to obtain from any source, information and/or documents regarding my professional credentials and qualification related to this application for new or continued network provider privileges (hereinafter referred to as "Credentialing Information").

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any IHCP MCE contracted network, and grants me no rights or privileges of participation until such time as I receive actual written notice of acceptance and participating provider status. Termination of my request for application is not an adverse action within the reporting requirements of the National Practitioner Data Bank and does not entitle me to any appeal or hearing.

I understand that the IHCP MCE will conduct an independent verification of this Credentialing Information and such information will be used to evaluate my credentials according to the IHCP MCE standards. I hereby consent to the release of Credentialing Information to the IHCP MCE, its agents, representatives, or designees. This authorization to release Credentialing Information shall include, but not be limited to, sources such as the medical staff office and/or Chief(s) of clinical Departments of any hospital or facility with which I have at any time been affiliated, all National Practitioner Data Bank and/or Peer Review Committee information and reports, including utilization review information, and information from professional boards, state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which I have obtained professional liability insurance. I hereby release all third party sources of Credentialing Information from any and all liability related to the release of such information that is provided in good faith and without malice.

I hereby release and hold harmless from any and all liability all members of the IHCP MCE, the Board of Directors, it officers, agents, peer review committee members and employees, for all activities executed in good faith and without malice regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any IHCP MCE contracted network or the IHCP MCE.

A photocopy of this authorization will serve as an original. I understand that the IHCP MCE, the Credentialing Committee, and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. I understand the IHCP MCE, its Credentialing Committee, and their designees will treat this information as confidential.

The undersigned certifies and attests that the forgoing is truthful, correct and complete in all respects, and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information is grounds for denial or immediate termination from the IHCP MCE provider networks. The undersigned hereby agrees to report to IHCP MCE any changes in the above information within thirty (30) days of change.

Printed Name _____ Title _____

Signature _____ Date _____

During the credentialing and re-credentialing process, the IHCP MCE will obtain information from various outside sources (e.g., state licensing agencies, National Practitioner Data Bank) to evaluate your application. You have the right to review any primary source information that the IHCP MCE collects during this process. These rights do not include information obtained as references, recommendations or other information that is peer review protected.

Should you believe any of the information used in the credentialing and re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by you, as the practitioner, you will have the right to correct any information and submit your comments and explanations for any other factual information.

Please keep a copy for your records.