IHCP MCE ENROLLMENT FORM FOR HCBS WAIVER PROVIDERS

This form is used to enroll participating Home- and Community-Based Services (HCBS) waiver providers with any of the Indiana Health Coverage Programs (IHCP) managed care entities (MCEs) that serve members in the Indiana PathWays for Aging program.

Please indicate if this is a new enrollment or an update to a prior enrollment: ☐ New enrollment ☐ Update (fill out updated information ONLY)

If an update, please explain what is being updated:

PROVIDER AGENCY OWNER AND DEMOGRAPHIC INFORMATION

Provider Agency Owner First Name:	MI:	Last Name:	Suffix:
Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female	
Provider Agency Owner Email:	Fax:	Phone:	

Please check all counties served by the agency:

☐ Adams	☐ Allen	☐ Bartholomew	☐ Benton	☐ Blackford	☐ Boone	☐ Brown	☐ Carroll
☐ Cass	☐ Clark	☐ Clay	☐ Clinton	☐ Crawford	☐ Daviess	☐ Dearborn	☐ Decatur
☐ DeKalb	☐ Delaware	☐ Dubois	☐ Elkhart	☐ Fayette	☐ Floyd	☐ Fountain	☐ Franklin
☐ Fulton	☐ Gibson	☐ Grant	☐ Greene	☐ Hamilton	☐ Hancock	☐ Harrison	☐ Hendricks
☐ Henry	☐ Howard	☐ Huntington	☐ Jackson	☐ Jasper	☐ Jay	☐ Jefferson	☐ Jennings
☐ Johnson	☐ Knox	☐ Kosciusko	☐ LaGrange	☐ Lake	☐ LaPorte	☐ Lawrence	☐ Madison
☐ Marion	☐ Marshall	☐ Martin	☐ Miami	☐ Monroe	☐ Montgomery	☐ Morgan	☐ Newton
☐ Noble	☐ Ohio	☐ Orange	☐ Owen	☐ Parke	☐ Perry	☐ Pike	☐ Porter
☐ Posey	☐ Pulaski	☐ Putnam	☐ Randolph	☐ Ripley	☐ Rush	☐ Scott	☐ Shelby
☐ Spencer	☐ St. Joseph	☐ Starke	☐ Steuben	☐ Sullivan	☐ Switzerland	☐ Tippecanoe	☐ Tipton
☐ Union	☐ Vanderburgh	☐ Vermillion	☐ Vigo	☐ Wabash	☐ Warren	☐ Warrick	☐ Washington
☐ Wayne	☐ Wells	☐ White	☐ Whitley				

Please check all the HCBS services that the agency will provide:

☐ Adult Day Service	☐ Adult Family Care	☐ Assisted Living
☐ Attendant Care	☐ Caregiver Coaching and Behavior Management	☐ Community Transition
☐ Home and Community Assistance	☐ Home Delivered Meals	☐ Home Modifications
☐ Home Modification Assessment	☐ Integrated Health Care Coordination	☐ Nutritional Supplements
☐ Participant Directed Home Care Service	☐ Personal Emergency Response System	☐ Pest Control
☐ Respite	☐ Specialized Medical Equipment and Supplies	☐ Structured Family Caregiving
☐ Transportation	☐ Vehicle Modifications	

The National Committee for Quality Assurance (NCQA) requires that health plans assess the cultural, ethnic, racial, and linguistic needs of members providers serve in the network. Please indicate the ethnicity of members served (select all that apply):

☐ Asian	☐ African American/Black	☐ Caucasian/White	☐ Hispanic/Latino
☐ Native American	☐ Pacific Islander	☐ Other (please specify):	

Maximum number of members your agency has capacity to serve upon enrollment:

PROVIDER AGENCY INFORMATION – LOCATION 1

Agency Name:							
Agency Location 1 Address (include ZIP + 4):							
Primary Phone:			Primary Fax:				
Office Contact Name:			Office Contact Email:				
License Number & State:							
County:			IHCP Provider ID/LPI:				
Hours of Operation:	Mon:	Tue:	Wed:	Thu:	Fri:	Sat:	Sun:

Does this site offer accessible accommodations for the following?

Building: ☐ Yes ☐ No Parking: ☐ Yes ☐ No Restroom: ☐ Yes ☐ No Other:

Does this site offer other services for people with disabilities?

Text Telephony (TTY): ☐ Yes ☐ No American Sign Language: ☐ Yes ☐ No Other:

If applicable, is this site accessible by public transportation?

Bus: ☐ Yes ☐ No Subway: ☐ Yes ☐ No Regional Train: ☐ Yes ☐ No Other:

This site has support professionals fluent in the following languages other than English:

☐ Spanish ☐ Mandarin ☐ French ☐ Burmese, dialect: ☐ Russian ☐ Other (please specify):

Does this site offer a language interpreter? ☐ Yes ☐ No

PAY-TO INFORMATION

Billing Name:		Taxpayer ID Number (TIN):
Billing (Pay-To) Address:		
Billing Phone:	Billing Contact Name:	Billing Contact Email:

MAILING ADDRESS

Use the Agency Location 1 Address as the Mail-To Address? ☐ Yes ☐ No

Mailing Address:

OTHER PROVIDER AGENCY LOCATIONS

Please list additional agency locations in which you will serve PathWays members.

Provider Agency Location 2

Agency Name:							
Agency Location 2 Address (include ZIP + 4):							
Primary Phone:			Primary Fax:				
Office Contact Name:			Office Contact Email:				
License Number & State:							
County:			IHCP Provider ID/LPI:				
Hours of Operation:	Mon:	Tue:	Wed:	Thu:	Fri:	Sat:	Sun:

Does this site offer accessible accommodations for the following?

Building: ☐ Yes ☐ No Parking: ☐ Yes ☐ No Restroom: ☐ Yes ☐ No Other:

Does this site offer other services for people with disabilities?

Text Telephony (TTY): ☐ Yes ☐ No American Sign Language: ☐ Yes ☐ No Other:

If applicable, is this site accessible by public transportation?

Bus: ☐ Yes ☐ No Subway: ☐ Yes ☐ No Regional Train: ☐ Yes ☐ No Other:

This site has support professionals fluent in the following languages other than English:

☐ Spanish ☐ Mandarin ☐ French ☐ Burmese, dialect: ☐ Russian ☐ Other (please specify):

Does this site offer a language interpreter? ☐ Yes ☐ No

Provider Agency Location 3

Agency Name:							
Agency Location 3 Address (include ZIP + 4):							
Primary Phone:			Primary Fax:				
Office Contact Name:			Office Contact Email:				
License Number & State:							
County:			IHCP Provider ID/LPI:				
Hours of Operation:	Mon:	Tue:	Wed:	Thu:	Fri:	Sat:	Sun:

Does this site offer accessible accommodations for the following?

Building: ☐ Yes ☐ No Parking: ☐ Yes ☐ No Restroom: ☐ Yes ☐ No Other:

Does this site offer other services for people with disabilities?

Text Telephony (TTY): ☐ Yes ☐ No American Sign Language: ☐ Yes ☐ No Other:

If applicable, is this site accessible by public transportation?

Bus: ☐ Yes ☐ No Subway: ☐ Yes ☐ No Regional Train: ☐ Yes ☐ No Other:

This site has support professionals fluent in the following languages other than English:

☐ Spanish ☐ Mandarin ☐ French ☐ Burmese, dialect: ☐ Russian ☐ Other (please specify):

Does this site offer a language interpreter? ☐ Yes ☐ No

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

PROVIDER DISCLOSURES

Has the provider agency or agency owner 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.