HOOSIER HEALTHWISE HEALTHY INDIANA PLAN HOSPITAL/ANCILLARY CREDENTIALING/ENROLLMENT FORM

Please select the program(s) for which this form applies:

☐ Healthy Indiana Plan (HIP) ☐ Hoosier Healthwise (HHW)

APPLICATION INSTRUCTIONS In order to be considered complete:
1. All information must be legible (please print or type)
2. Application must be completed in its entirety
3. Application must be signed and dated
4. Use a separate sheet of paper to provide additional information, if necessary
5. Current copies of all documents applicable to your organization MUST be submitted with this application:
   - State License
   - CMS site evaluation - if state site survey is not available
   - Indiana Department of Health Accreditation Certificate with site survey
   - Copy of Medicare certification letter
   - Copy of Medicaid certification letter
   - Liability coverage Face sheet
   - TIN W-9
   - CLIA
   - DEA

DEMOGRAPHIC INFORMATION

Entity Name		Medicaid Number
DBA Name or Legal Name	Indiana State License No.	Fed. Tax ID Number
NPI	Taxonomy Number	Medicare Number
Address	City, St., ZIP	County
Contact Name	Contact Title	

Accreditation Type:
- ☐ Joint Commission of Accreditation of Healthcare Organizations (JCAHO)
- ☐ National Commission of Quality Assurance (NCQA)
- ☐ Health Care Finance Administration (HCFA)
- ☐ Indiana State Department of Health (ISDH)
- ☐ Other ____

BILLING INFORMATION (if different from above)

Pay to:		
Street	City, St., ZIP	Phone
Contact Person	Fax	

COMPREHENSIVE/GENERAL/PROFESSIONAL LIABILITY

Liability Carrier	Coverage Limits
Policy Number	Expiration Date

ATTESTATION QUESTIONS

Please answer the following questions YES or NO. If YES, please provide full details on a separate sheet.

A. Has your organization's malpractice insurance ever been terminated or revoked except with your consent or request? ☐ YES ☐ NO

B. Is your organization currently or has been in the last five years under investigation by any government entity or peer review? ☐ YES ☐ NO

C. Has your organization been sanctioned by Medicaid or Medicare? ☐ YES ☐ NO

HOOSIER HEALTHWISE MANAGED CARE ORGANIZATION HOSPITAL/ANCILLARY CREDENTIALING/ENROLLMENT FORM – page 2

Indiana Health Coverage Program Managed Care Organization and or Care Management Organization (IHCP MCO/CMO)

ATTESTATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the Indiana Health Coverage Program Managed Care Organization and/or Care Management Organization (IHCP MCO/CMO), its representatives, agents or designees, to obtain from any source, information and/or documents regarding our entity's qualifications related to this application for new or continued network provider privileges (herein after referred to as "Credentialing Information"). We understand and agree that acceptance of this application does not constitute approval or acceptance of participating provider status for any IHCP MCO contracted network, and grants no rights or privileges of participation until such time as we receive actual written notice of acceptance and participating provider status. Termination of this request for application is not an adverse action within the reporting requirements of the Healthcare Integrity and Protection Data Bank and does not entitle us to any appeal or hearing. We understand that the IHCP MCO/CMO will conduct an independent verification of this Credentialing Information and such information will be used to evaluate our credentials according to the IHCP MCO/CMO standards. I hereby consent to the release of Credentialing Information to the IHCP MCO/CMO, its agents, representatives or designees. This authorization to release Credentialing Information shall include, but not be limited to, all Healthcare Integrity and Protection Data Bank and information from state regulatory and licensing agencies, professional societies, accrediting agencies, and any companies from which we have obtained professional liability insurance.

We 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. We hereby release and hold harmless from any and all liability all members of the IHCP MCO/CMO, the Board of Directors, IT officers, agents, peer review committee members and employees, for all activities regarding the evaluation of my credentials and qualifications or the denial or termination of participating provider status in any IHCP MCO/CMO contracted network or the IHCP MCO/CMO. A photocopy of this authorization will serve as an original. We understand that the IHCP MCO/CMO, the Credentialing Committee and/or their designees will utilize this information only in connection with my application for credentialing or re-credentialing purposes. We understand the IHCP MCO/CMO, 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 MCO/CMO provider networks. The undersigned hereby agrees to report to IHCP MCO/CMO any changes in the above information within thirty (30) days of change. During the credentialing and re-credentialing process, the IHCP MCO/CMO will obtain information from various outside sources (e.g., state licensing agencies, Healthcare Integrity and Protection Database) to evaluate your application. You have the right to review any primary source information that the IHCP MCO/CMO collects during this process. These rights do not include information obtained as references, recommendations or other information that is peer review protected.

Printed Name ______________________________ Title ______________________________

Signature ______________________________ Date ______________________________

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.