

MDwise Hoosier Alliance:

Please complete this form and print with office logo at top of form.

Fax this completed form to: 866-465-2985.

SECTION 1 - PLEASE MAKE THE NECESSARY CHANGES TO:

Provider Name		Group Name:	
Individual NPI		Group NPI:	
IHCP #		Group IHCP #:	
Tax ID for payment		Alpha suffix:	

PROGRAMS CHANGES WILL AFFECT (PLEASE CHECK ALL THAT APPLY):

<input type="checkbox"/> Hoosier Healthwise	<input type="checkbox"/> Health Indiana Plan (HIP)
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SECTION 2 - PLACE X IN BOX WHERE CHANGES NEED TO OCCUR:

Update Panel to reflect:	Requested Change
Phone # change to:	
Age restrictions:	
OB	Yes <input type="checkbox"/> No <input type="checkbox"/> (Check One)
All women	Yes <input type="checkbox"/> No <input type="checkbox"/> (Check One)
Place panel on hold	Reason:
Remove panel hold	
Increase panel size to:	
Decrease panel size to:	

SECTION 3

DIS-ENROLL AND RE-ENROLL (occurs when leaving any address and is remaining enrolled with MDHA) If the re-enrollment is a new location, please contact your Account Executive for the following supporting documents, Attachment A and Supplemental Enrollment Form.	
➤ Dis-enroll from IHCP#:	
➤ Alpha suffix:	
➤ Tax ID:	
➤ Re-enroll to IHCP#:	
➤ Alpha suffix:	
➤ Tax ID:	

SECTION 4 – Provider will be termed from location(s) in section 1

DIS-ENROLL/TERMINATION	Reason:	Date:
Move my members to Dr.:	➤ IHCP#:	
Dis-enroll of Nurse Practitioner Under Collaborative Agreement	Nurse Practitioner NPI #:	
Additional Information:		

Thank you,

Signature: _____ Date: _____