Anthem

Serving Hoosier Healthwise, Healthy Indiana Plan,
Hoosier Care Connect, and Indiana PathWays for Aging

Indiana PathWays for Aging Provider Application

Date of application (Month day, year)	
Section I. Provider identification	
Legal business name:	
Doing business as (if applicable):	
Manager name:	
Email:	
Phone:	
Tax identification number (TIN):	
Indiana Health Coverage Program (IHCP) provider ID number:	
Name of license or certification:	
License or certification #:	
Agency issuing license:	
Name listed on license:	
Section II. A. Service location/contact information	
Primary provider location name:	
Address:	
City:	State:
ZIP:	County:
Phone:	Fax:
Company email:	
Website URL:	
Primary contact:	
Email:	
Phone:	
Administrator (full name):	
Email:	
Phone:	
Does this office meet *Americans with Disabilities Act* (*ADA*) accessibility requirements? ☐ Yes ☐ No	
Office hours:	
Languages spoken:	
Select all that apply:	
Handicap accessible: ☐ Building ☐ Parking ☐ Restroom	
Services for disabled: ☐ TTY ☐ American Sign Language ☐ Mental/physical impairment	
Accessible by public transportation: ☐ Bus ☐ Subway ☐ Regional train	
Language/alternative formats: ☐ Interpretation Services ☐ Translation Services ☐ Braille ☐ Large print materials	
Accepting new individuals into your program: ☐ Yes ☐ No	
Section II. B. Pay to address	
Pay to name:	
Address:	
City:	State:
ZIP:	County:
Phone:	Fax:
Primary contact:	
Section II. C. Mailing address	
Address:	
City:	State:
ZIP:	County:

https://providers.anthem.com/in

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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Phone:	Fax:
Primary contact:	
Section II. D. Billing/claims contact information	
Name:	
Email:	
Address:	
City:	State:
ZIP:	Phone:
If there are additional office/service locations, please attach a separate sheet indicating the address and the phone/fax numbers.	
Section II. E. Additional agency support staff contact information	
1. Credentialing contact information	
Name:	
Email:	
Address:	
City:	State:
ZIP:	Phone:
2. Electronic visit verification contact information	
Name:	
Email:	
Address:	
City:	State:
ZIP:	Phone:
3. Clinical incident contact information	
Name:	
Email:	
Address:	
City:	State:
ZIP:	Phone:
4. Clinical contact information	
Name:	
Email:	
Address:	
City:	State:
ZIP:	Phone:
5. Referrals contact information	
Name:	
Email:	
Address:	
City:	State:
ZIP:	Phone:
6. Quality management contact information	
Name:	
Email:	
Address:	
City:	State:
ZIP:	Phone:
7. Value-based payment (VBP) contact information	
Name:	
Email:	
Address:	
City:	State:
ZIP:	Phone:
8. Other contact information	

Name:			
Email:			
Address:			
City:		State:	
ZIP:		Phone:	
Section III. A. Insurance (Attach a current *Certificate of Insurance* [*COI*] indicating general and professional coverage.)			
1. General liability coverage — property and personal liability insurance as required by *455 IAC 2-11-1*			
Current carrier name:			
Policy number:			
Coverage type: ☐ Occurrence-based ☐ Claims-based			
Effective date:		Expiration date:	
Each occurrence: $		Aggregate: $	
2. General liability coverage — vehicle insurance as required in *455 IAC 2-6-2, 455 IAC 2-12-1(4)*			
Current carrier name:			
Policy number:			
Coverage type: ☐ Occurrence-based ☐ Claims-based			
Effective date:		Expiration date:	
Each occurrence: $		Aggregate: $	
3. Professional liability coverage			
Current carrier name:			
Policy number:			
Coverage type: ☐ Occurrence-based ☐ Claims-based			
Effective date:		Expiration date:	
Each occurrence: $		Aggregate: $	
Section III. B. Accreditation/certification (Attach a copy of current accreditation certificate or survey.)			
☐ AAAHC ☐ AAAASF ☐ ACHC ☐ ACR ☐ AOA ☐ CAP ☐ CARF ☐ CCAC ☐ CHAP ☐ COA ☐ HCU ☐ HFAP ☐ JCAHO ☐ Not accredited			
Date of initial accreditation:			
Date of last survey:			
Has provider had an on-site survey by a state agency? ☐ Yes ☐ No*		Date of last state survey:	
Date of last recertification/annual state survey program review report:			
* If no, successful completion of an on-site visit is required to complete credentialing. You will be contacted to schedule the visit.			
Is provider participating in the Medicare program? ☐ Yes ☐ No			
Nursing Facility Licensure/operating certificate			
State:	Date of license:	License number:	Expiration date:
State:	Date of license:	License number:	Expiration date:

Section IV. A. Service(s) you plan to provide (Select all that apply.) — Attach a copy of *Division of Aging Waiver Service Certification* letter, if applicable.

☐ Adult day services	☐ Home modification assessment	☐ Personal emergency response system (PERS)
☐ Adult family care	☐ Home modifications	☐ Respite
☐ Assisted living	☐ Home delivered meals	☐ Specialized medical equipment and supplies
☐ Attendant care	☐ Home and community assistance service	☐ Structured family caregiving
☐ Case management	☐ Integrated healthcare coordination	☐ Transportation
☐ Caregiver coaching and behavior management	☐ Nursing Facility	☐ Vehicle modifications
☐ Community transition	☐ Nutritional supplements	
	☐ Pest control	

Section IV. B. County(ies) in which you plan to provide service(s) (Select all that apply.)

☐ 01 Adams	☐ 24 Franklin	☐ 47 Lawrence	☐ 70 Rush
☐ 02 Allen	☐ 25 Fulton	☐ 48 Madison	☐ 71 St. Joseph

☐ 03 Bartholomew	☐ 26 Gibson	☐ 49 Marion	☐ 72 Scott
☐ 04 Benton	☐ 27 Grant	☐ 50 Marshall	☐ 73 Shelby
☐ 05 Blackford	☐ 28 Greene	☐ 51 Martin	☐ 74 Spencer
☐ 06 Boone	☐ 29 Hamilton	☐ 52 Miami	☐ 75 Starke
☐ 07 Brown	☐ 30 Hancock	☐ 53 Monroe	☐ 76 Steuben
☐ 08 Carroll	☐ 31 Harrison	☐ 54 Montgomery	☐ 77 Sullivan
☐ 09 Cass	☐ 32 Hendricks	☐ 55 Morgan	☐ 78 Switzerland
☐ 10 Clark	☐ 33 Henry	☐ 56 Newton	☐ 79 Tippecanoe
☐ 11 Clay	☐ 34 Howard	☐ 57 Noble	☐ 80 Tipton
☐ 12 Clinton	☐ 35 Huntington	☐ 58 Ohio	☐ 81 Union
☐ 13 Crawford	☐ 36 Jackson	☐ 59 Orange	☐ 82 Vanderburgh
☐ 14 Daviess	☐ 37 Jasper	☐ 60 Owen	☐ 83 Vermillion
☐ 15 Dearborn	☐ 38 Jay	☐ 61 Parke	☐ 84 Vigo
☐ 16 Decatur	☐ 39 Jefferson	☐ 62 Perry	☐ 85 Wabash
☐ 17 DeKalb	☐ 40 Jennings	☐ 63 Pike	☐ 86 Warren
☐ 18 Delaware	☐ 41 Johnson	☐ 64 Porter	☐ 87 Warrick
☐ 19 Dubois	☐ 42 Knox	☐ 65 Posey	☐ 88 Washington
☐ 20 Elkhart	☐ 43 Kosciusko	☐ 66 Pulaski	☐ 89 Wayne
☐ 21 Fayette	☐ 44 LaGrange	☐ 67 Putnam	☐ 90 Wells
☐ 22 Floyd	☐ 45 Lake	☐ 68 Randolph	☐ 91 White
☐ 23 Fountain	☐ 46 LaPorte	☐ 69 Ripley	☐ 92 Whitley

Section V. Nursing Facilities	
Nursing Facility Disclosure questions	
• **If you answer yes to any of the following questions, attach a detailed explanation.** • **If any question does not apply, please answer no.** • Failure to answer or provide an explanation may result in a delay in processing the application. • Do not use whiteout to correct/change answers; if you need to correct/change an answer, cross out the incorrect answer, initial it, and then mark the correct answer.	
1. Does the business have evidence of:	
A. Professional liability claims history for each subcontractor?	☐ Yes ☐ No
B. Disciplinary action taken against any business or professional license held in this or any other state or surrender of a license in this or any state?	☐ Yes ☐ No
C. Any history of loss or limitation of privileges or disciplinary activity?	☐ Yes ☐ No
2. Has the business's general or professional liability insurance ever been denied, canceled, nonrenewed, or refused upon application for any reason other than by the facility's request?	☐ Yes ☐ No
3. Has the business, under any current or former name or business entity, ever:	
A. Had licensure to do business in any applicable jurisdiction ever been denied, revoked, reduced, suspended, or not renewed?	☐ Yes ☐ No
B. Been suspended or excluded from receiving payment under Medicare or Medicaid?	☐ Yes ☐ No
C. Had accreditation status reduced, terminated, suspended, or revoked?	☐ Yes ☐ No
D. Been under investigation by any government agency?	☐ Yes ☐ No
4. Is the business's professional liability insurance provided through a self-insurance trust or program?**	☐ Yes ☐ No
** If yes, an officer of the company (for example, president, vice president, chief financial officer, or chief operating officer) must sign the following attestation.	

This section is only applicable to Self-Insured Entities. **(**A Self-Funded, or Self-Insured plan means any person, business, partnership, corporation, or organization that sets aside funds to meet his, her, or its losses or to absorb fluctuations in the amount of loss)	
On behalf of the applicant, I represent and warrant the following with respect to the self-insurance program maintained by the applicant, or which provides professional liability insurance for the applicant:	
1. The self-insurance program is adequately funded to provide the minimum required limits of liability as required by plan.	☐ Yes ☐ No
2. The self-insurance program has an actuarially validated reserve adequate for incurred claims, for incurred but not reported claims, and future claims based on past experience.	☐ Yes ☐ No
3. The self-insurance program has a designated third-party administrator or other appropriately licensed claims professional or attorney serving the program.	☐ Yes ☐ No
4. The self-insurance program has a designated medical malpractice defense firm or more than one designated medical malpractice defense firm.	☐ Yes ☐ No
5. The self-insurance program maintains excess insurance/reinsurance above the self-funded level if the self-insured level alone is insufficient to meet required limits of the plan.	☐ Yes ☐ No
6. The self-insurance program maintains evidence of a surety bond or letter of credit as collateral to the self-insured limit or a captive, self-management of a large retention through a trust.	☐ Yes ☐ No
7. The self-insurance program maintains a total value of the program that at a minimum meets the required limit of liability as set forth by plan.	☐ Yes ☐ No
8. I have confirmed the foregoing with my auditor or the actuary for the self-insurance fund.	☐ Yes ☐ No
Attestation signature:	Date:
Printed name:	Title:
Note: Anthem Blue Cross and Blue Shield (Anthem) reserves the right to request documentation from the applicant to confirm the information disclosed in this attestation.	

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 termination. The undersigned certifies and attests that all required documents are included in the submission and are found to be accurate and truthful to the best of their knowledge. The undersigned certifies and attests that required policies and procedures outlined in the instructions for this document are complete, accurate, and truthful to the best of their knowledge, and available for Anthem Blue Cross and Blue Shield's review during an onsite visit to the provider's location.

_____
Printed name and title (owner/registered authorized agent)

_____
Signature (owner/registered authorized agent)

_____
Date

Anthem

Serving Hoosier Healthwise, Healthy Indiana Plan,
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Provider Entity Disclosure Form

Directions

Use this form if you are applying for network participation as a provider entity*, if you are recredentialing or recontracting the provider entity, or if there has been significant changes to the information required on this form (for example, an ownership change, the addition of a new managing employee, or the change of your business location).

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued and attach a sheet referencing the item number that is being continued. Please return the original form to Indiana PathWays for Aging and retain a copy for your files.

Completely answer the applicable questions. If a question is not applicable, please note N/A for that question. No questions should be left blank.

* A provider entity is defined as a business entity (for example, a partnership or corporation) that provides covered services to Indiana PathWays for Aging members.

I. Identifying information

Provider entity name:

Provider name (if different from provider entity name):

Provider federal tax ID:

IHCP provider ID number:

Provider phone:

Address (Please list all practice locations. Attach a separate sheet if needed. Note, at least one street address must be listed.):

Provider address:	City:	State:	ZIP:

II. Owner or control information

Please provide the following information for owners, persons with control interests, agents, and managing employees of the provider entity. Attach a separate sheet if needed:

- An **owner** is a person or business entity that owns 5% or more of the assets, stock, or profits of the provider entity. This 5% may be direct ownership or indirect ownership (for example, an individual might own 50% of a company that owns the actual provider entity meaning the indirect ownership is 50%). In addition to ownership of stock, an owner is also a person who owns a legal obligation, like a mortgage or loan, that is secured by the assets of the provider entity.
- A **person with control** is someone who directs the provider entity and includes directors, trustees, and officers of corporations, and partners in a partnership. If the provider entity is a nonprofit entity, mark N/A in the column for percent of ownership.
- A **managing employee** is someone who makes the day-to-day decisions for the provider entity. These individuals include office or billing managers for smaller providers, and for larger provider entities, the heads of the major operating groups of the provider are considered the managing employee (generally the line of individuals typically listed below the corporate officers on an organizational chart).
- An **agent** is an individual who has the legal ability to bind the provider entity (that is, the provider entity may use an agent to obtain contracts for it).

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A. Master list

Full name:	Address (including P.O. boxes) (For individuals, use home address. For business entities that might have ownership interest, list all street addresses.):	City:	State:	ZIP:	DOB:	SSN (for individuals/TIN (for business entities):	Percent ownership:	Title:

B. Specific questions

1. Is any person on the master list related to another person on the master list as a spouse, parent, child, or sibling? ☐ Yes ☐ No

If yes, provide the following information about the related persons:

Name:	Related to:	Type of relation:

2. Does any person or entity on the master list have an ownership or control interest in any other provider entity? ☐ Yes ☐ No

If yes, provide the following information about the other provider entity in which the person on the master list has an interest:

Name of other provider entity:	Address:	City:	State:	ZIP:	TIN:

3. Have any of the individuals or entities on the master list been convicted of a criminal offense related to that person's involvement in any program under Medicare or Medicaid since the inception of those programs? ☐ Yes ☐ No

If yes, provide the following information:

Name on court records:	SSN/TIN:	Matter of the offense:	Date of the conviction:	Exclusion period of the offense (if you were excluded by the Federal Office of the Inspector General [IOG]):

4. Have any of the individuals or entities on the master list ever been debarred from participation in federal government contracts? ☐ Yes ☐ No

Debarred means an individual is not allowed to participate in contracts paid for by the federal government whether or not those contracts are in the health care area.

If yes, provide the following information:

	When individual was debarred:	Length of debarment:	Reason for debarment:

5.	Has any person or entity on the master list ever been excluded from participation in federal health care programs (Medicare or Medicaid) in the past? Excluded means that a provider or entity has been told by the Department of Health and Human Services or OIG that they may no longer be a provider for any federally funded health care program.				☐ Yes ☐ No
	If yes, provide the following information:				
	Name of individual:	Beginning date of exclusion or termination:	End date of exclusion or termination:	Reason for exclusion or termination:	

6.	Has any person or entity on the master list ever been terminated from a state Medicaid program for reasons having to do with program integrity (fraud or abuse)? Terminated means the provider lost the right to bill a state Medicaid or SCHIP program for a cause related to fraud or abuse.				☐ Yes ☐ No
	If yes, provide the following information:				
	State of practice when terminated:	Reason for termination:	Date of termination:		

7.	Has any person or entity on the master list ever had civil monetary penalties (CMPs) assessed against them? A CMP is a type of fine assessed against a provider by a governmental agency that manages a federal health care program.				☐ Yes ☐ No
	If yes, provide the following information:				
	Name of individual:	State of practice when CMP assessed:	Reason for CMP:	Amount of CMP:	Date of CMP:

8.	Did anyone on the master list obtain ownership interest as a result of a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal health care program or was in fact excluded or terminated from participation in a federal healthcare program? Or did anyone on the master list obtain ownership interest where the original owner is or was a member of the current owner's immediate family or member of the current owner's household at the time of the transfer of ownership? Immediate family is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. Member of household is any individual with whom they are sharing a common abode as part of a single-family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.				☐ Yes ☐ No
	If yes, provide the following information:				
	Name of original owner:	SSN or TIN:	Place of transfer:	Date of transfer:	

8a.	Do any subcontractors for the provider entity have a direct or indirect ownership interest of at least 5%? A subcontractor is a person or company that this provider entity has contracted with to do some of the provider entities' management functions (for example, a billing agent or medical services provider like a medical lab).				☐ Yes ☐ No
	If yes, provide the following information:				
	Name of subcontractor:	Address:	City:	State:	ZIP:	TIN:
8b.	For each subcontractor(s) listed in 8a, please provide the following information for the individuals with an ownership or control interest in the subcontractor(s). (Attach a separate sheet if necessary.)					☐ N/A
	Full name:	Address:*	City:	State:	ZIP:	DOB:
	* For individuals, use home address. For business entities that might have ownership interest, list all street addresses and P.O. box addresses.					
8c.	Is any person listed in 8b related to a person on the master list?					☐ Yes ☐ No ☐ N/A
	If yes, provide the following information:					
	Name of first related person:		Name of second related person:		Type of relation:	

III. Business transactions

1.	Has the disclosing entity had a financial transaction with any subcontractors totaling more than $25,000 or had significant business transactions with any subcontractor?				☐ Yes ☐ No
	If yes, list the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the previous 12-month period. In addition, list any significant business transactions between this provider and any wholly owned supplier or between the provider and any subcontractor during the past five years:				
	Full name:	Address:	City:	State:	ZIP:
2.	Does the provider entity wholly own a supplier? Supplier means an individual, agency, or organization from which the provider entity purchases goods and services used in carrying out its responsibilities under Medicaid (for example, a commercial laundromat, a manufacturer of hospital beds or a pharmacy).						☐ Yes ☐ No
	If yes, provide the following information about the supplier:						
	Name:	Address:	City:	State:	ZIP:	NPI:	TIN:

IV. Signature
Indiana PathWays for Aging may refuse to enter into, renew, or terminate an agreement with a provider if it is determined that a provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws (*42 C.F.R. § 455.106*). The signature below must be the written signature of an individual who can legally bind this provider entity. In compliance with *42 CFR 455.104(c)*, providers shall deliver a disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement, at the time of recredentialing/reenrollment and within 35 days after any change in ownership of the disclosing entity. In compliance *with 42 CFR 455.105(b)*, a provider must submit full and complete ownership information outlined in section III within 35 days of request by the Secretary, Medicare, or Medicaid agency.
Owner/registered/authorized agent printed name:
Date:
Owner/registered/authorized agent signature:
Title:
Name of person completing form:
Phone number of person completing form: