Indiana PathWays for Aging Provider Application — instructions page

Indiana | Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Thank you for your interest in joining the Indiana PathWays for Aging network with Anthem. To begin the contracting and application/certification process, please complete this application in its entirety and submit it with all appropriate documentation. Below, you will find general instructions to guide you as you complete this application. If you have questions or need assistance, please contact INMLTSSProviderRelations@anthem.com or call Provider Services at 833-569-4739, Monday through Friday, 8 a.m. to 8 p.m. ET.

Who should complete this application?

A provider should complete this application if:

1. You are fully enrolled as a provider with the Indiana Health Coverage Programs (IHCP). Visit the Become a Provider page for an explanation of that process and to access application packets.
2. You are a provider type 32 — Waiver Provider enrolling as a billing provider with the IHCP.

Required documents

The provider is required to submit the following documents with their application:

- Copy of certification documents verifying the provider is approved/certified through the Office of Medicaid Policy and Planning
- Copy of current *Certificate of Insurance (COI)*
- Provider's primary email address and signatory name
- Copy of current *W-9* form

General instructions

The *Indiana PathWays for Aging Provider Application* is a PDF fillable application. If you prefer to complete a handwritten application, please download and print it. This application is not considered complete unless all required fields are complete and we receive all required documentation with your submission. If necessary, use a separate sheet of paper to provide additional information in needed sections. Your final application and supporting documents can be submitted via:

- Availity Essentials
- Email: INMLTSSProviderRelations@anthem.com
- Mail:
  Anthem

INBCBS-CD-071694-24 | March 2025

220 Virginia Ave.
Mail Stop IN204-C497
Indianapolis, IN 46204

Failure to provide correct information or required documents will delay the completion of your contracting and certification process. We conduct outreach within 24 hours to any provider that has an identified incomplete application for additional information to complete the application process. It is important that you reply to our requests to avoid any unnecessary delays in processing your application. We will process provider network application requests within 30 days from the date of a completed clean request. Upon receipt of the application and/or signed contract, Anthem will reach out to the provider directly to review and confirm the documents received.

Section 1: Provider identification

Legal entity name (name as it appears on *W9* form)	Double-check that the legal business name matches the legal business name on the federal*W-9* form.
Doing business as (if applicable)	Double-check that the doing business as (DBA) name matches the DBA name on the federal *W-9* form.
Manager name	Enter the name of the person who acts as the operating manager or administrator.
Email	Add business email address.
Phone	Enter the best contact number such as a cell phone number.
Tax identification number (TIN)	Double-check that the TIN matches exactly the TIN on the federal *W-9* form.
Indiana Health Coverage Program provider ID number (aka Medicaid number)	This is the number providers receive once they are enrolled as an Indiana healthcare provider through FSSA and are eligible to bill for Medicaid services.
Name of license or certification	List the name of the license or certification you are required to obtain when becoming an approved waiver provider. Examples include a PSA License or an HHA License.
License or certification number	Enter the identifying number associated with the license or certification.
Agency issuing license	Add which state or federal agency issued the license that is required for you to be a waiver provider. Examples include ISDH and Purdue University.
License issue date	List the date your license was issued. (This is only required if your license issue date is not populated in the Council for Affordable Quality Healthcare (CAQH) and is to ensure accurate information.)
Name listed on license	Add the agency name listed on the license or the employee's name if applicable.

Section 2a: Service location/contact information

Provider name	Enter the name of the provider who will be the primary contact for this company.
Address, city, state, ZIP, county	Enter the complete address for the primary location.
Phone, fax, company email, website URL	Enter the phone number of the primary location and the fax number if applicable. Include a generic email address for the primary location and the company's website URL.
Primary contact, email, phone	Enter the primary contact for this provider location. Include the email address and the cell phone number of this person.
Administrator, email, phone	Enter the name of the person who is identified and listed as the administrator with the Indiana State Department of Health for this provider location. Include the email address and cell phone number of this person.
Office hours (EST)	Enter the days of the week and the hours for operation and public access for this primary location.
Languages spoken	Enter additional languages you support through bilingual staff.
Does this office meet *Americans with Disabilities Act (ADA)* accessibility?	Select **Yes** or **No**. *ADA* accessibility means the office is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability. It must follow Indiana requirements for *ADA* accessibility. For more information visit adagreatlakes.org/adaindiana.
Handicap accessible	Select if the building entrance and doors meet *ADA* requirements. Select if the parking you provide has handicap parking spaces. Select if restrooms/bathrooms meet *ADA* requirements.
Services for disabled	Select any box that applies. Do you use TTY? Can you or someone on staff communicate using American Sign Language? Do you provide support or modifications to assist individuals with mental or physical impairments?
Accessible by public transportation	Select if your organization is accessible by public bus route, subway, or train.

Provider name	Enter the name of the provider who will be the primary contact for this company.
Language/alternative formats	Select if you provide any of the following: • Interpretation services (either face-to-face or through a language line) • Translation services (do you provide any of your written materials in languages other than English either by request or on an ongoing basis?) • Braille as an alternate format (do you provide your written materials in Braille if requested or on an ongoing basis?) • Large-print materials (do you provide written materials in large font for individuals with low vision when requested or on an ongoing basis?).
Accepting new Medicaid individuals into your program	Select **Yes** if you are accepting new individuals into your program. Select **No** if you are not currently accepting new individuals into your program.

Section 2b: Pay to address

Pay to name	Enter the name we should enter on the *Pay to* section of payment vouchers. (This includes checks for payment.)
Address, city, state, ZIP, county	Enter the address where we should send payment vouchers. (This includes a check for payment.)
Phone, fax, primary contact	Enter the phone number, fax number (if applicable), and primary contact regarding accounts receivable for us to contact regarding payments.

Section 2c: Mailing address

Address, city, state, ZIP, county	Enter the address where we should send payment vouchers. (This includes a check for payment.)
Phone, fax, primary contact	Enter the phone number, fax number (if applicable), and primary contact regarding mailing, shipping, and receiving.

Section 2d: Billing/claims contact information

Name, email	Enter the name of the person who is the main point of contact for the agency regarding billing and claims. Enter this person's email address.
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.

Section 2e: Additional agency support staff contact information

Additional agency support staff contact information	If a staff member covers more than one supporting position within the agency, please list their name and contact information under each supporting role.
1. Credentialing contact information	
Name, email	Enter the name of the person who is the main point of contact for the agency regarding credentialing. Enter this person's email address.
2. Electronic visit verification (EVV) contact information	
Name, email	Enter the name of the person who is the main point of contact for the agency regarding electronic visit verification. Enter this person's email address.
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.
3. Critical incident contact information	
Name, email	Enter the name of the person who is the main point of contact for the agency regarding critical incidents. Enter this person's email address.
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.
4. Clinical contact information	
Name, email (if applicable)	Enter the name of the person who is the main point of contact for the agency regarding the clinical program. Enter this person's email address.
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.
5. Referral contact information	
Name, email	Enter the name of the person who is the main point of contact for the agency regarding referrals for the agency's programs. Enter this person's email address.
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.

6. Quality management contact information	
Name, email	Enter the name of the person who is the main point of contact for the agency regarding quality management. Enter this person's email address.
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.
7. Value-based payment (VBP) contact information	
Name, email (if applicable)	Enter the name of the person who is the main point of contact for the agency regarding VBP and payments. Enter this person's email address.
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.
8. Other contact information	
Name, email	Add other contacts relevant to the application request for network participation. Enter this person's email address. *(If there are more names, please attach them to a separate sheet of paper.)*
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.

Section 3a: Insurance

Attach a current *Certificate of Insurance (COI)* indicating general and professional coverage. If insurance is set to expire in the next 30 to 60 days, please show renewal paperwork as proof that insurance will continue past the expiration date. The type of waiver service provided will determine which insurance is required.	
1. General liability coverage — property and personal liability insurance as required by *455 IAC 2-11-1*	
Current carrier name	Enter the name of the insurance company that provides your general liability insurance.
Policy number	Enter the full policy number listed on the *COI*.
Coverage type	Select the appropriate box that correlates with the coverage specified on your *COI*.
Effective date, expiration date	Enter the dates that correlate with the dates specified on your *COI*.
2. General liability coverage — vehicle insurance as required in 455 *IAC 2-6-2, 455 IAC 2-12-1(4)*	
Current carrier name	Enter the name of the insurance company that provides your automobile liability insurance and is listed on your *COI*.
Policy number	Enter the full policy number listed on the *COI*.

Coverage type	Select the appropriate box that correlates with the coverage specified on your *COI*.
Effective date, expiration date	Enter the dates that correlate with the dates specified on your *COI*.
Each occurrence, aggregate	Enter the amount the provider is insured for each occurrence and aggregate. Make sure these amounts correlate with the amounts listed on your *COI*.
3. Professional liability coverage	
Current carrier name	Enter the name of the insurance company that provides your professional liability insurance and is listed on your *COI*.
Policy number	Enter the full policy number listed on the *COI*.
Coverage type	Select the appropriate box that correlates with the coverage specified on your *COI*.
Effective date, expiration date	Enter the dates that correlate with the dates specified on your *COI*.
Each occurrence, aggregate	Enter the amount the provider is insured for each occurrence and aggregate. Make sure these amounts correlate with the amounts listed on your *COI*.

Section 3b: Accreditation/certification

Attach a copy of the current accreditation or certification.	
List of accreditation entities	Select the box next to the accreditation the provider possesses or check the box next to *Not accredited*.
Date of initial accreditation, date of last survey	Enter the date the provider received initial accreditation and the date of the last recertification survey.
Has provider had an on-site survey by a state agency?	Select **Yes** if the provider had an on-site state survey in the last 12 months. Select **No** if the provider has not had an on-site survey in the last 12 months.
Date of last survey	Enter the date of the last on-site state survey.
Date of last recertification/annual state survey program review report	Nursing facilities are to enter the date of the last recertification or annual state survey.
Is provider participating in the Medicare program?	Select **Yes** if the provider is also a certified Medicare provider. Select **No** if the provider is not a certified Medicare provider
Nursing facility licensure/operating certificate	Nursing facilities should complete this section and enter the date of the current operating certificate, license number, and expiration date.

Section 4a: Service(s) you plan to provide

Select the box(es) next to all the services the provider is certified to provide. Attach a copy of the Waiver Service Certification Letter from the Office of Medicaid Policy and Planning (OMPP) to this submission. Ensure the services you select correlate with the services approved on the *OMPP Waiver Service Certification*.

Section 4b: County(ies) in which you plan to provide service(s)

Select the box(es) next to all the counties where you currently provide services. Ensure the counties you select correlate with the counties listed on your state license and/or your waiver service certification.

Section 5: Nursing facilities

Nursing facilities are to complete the nursing facility disclosure questions in full and attest that the disclosure questions are correct, truthful, and complete. The signer must be an authorized agent to sign documents on behalf of the provider.

Attestation and signature

By signing this application, the provider certifies and attests all information is truthful, correct, and complete. The signer must be an authorized agent to sign documents on behalf of the provider.

Provider Entity Disclosure Form

This part of the application is for network participation as a provider. This form includes detailed instructions. Please read these instructions carefully before beginning this section. You will need the following information to ensure you can complete this section of the application:

- Provider legal name
- Federal ID number
- IHCP provider ID number
- Complete addresses for all locations under this provider
- Owner or control information: This includes who is an owner, person with control, managing employee, or agent, along with their DOB, SSN, and percentage of ownership.
- Criminal histories of anyone who is listed as an owner, person with control, managing employee, or agent on the Master List:
  - Include the name, SSN, nature of the offense, date of the conviction, and the Federal Office of the Inspector General (IOG) exclusion period if applicable.
- Relationship status of all individuals listed on the Master List
- Ownership information in any other provider entity:
  - Include the name, address, and TIN.
- OIG-excluded individuals listed on the Master List:
  - Include when, length, and reason.
- Information regarding individuals on the Master List who have been terminated from a state Medicaid program for reasons having to do with program integrity:
  - Include state, reason, and date.

- Information regarding individuals on the Master List who have had civil monetary penalties assessed against them:
  - Include the name, state, reason, amount, and date.
- Information regarding individuals on the Master List who obtained ownership as a result of someone who was about to be excluded or terminated or someone who was excluded or terminated:
  - Include the SSN, place of transfer, and date.
- Information regarding subcontractors owning at least 5% directly or indirectly: Include the name of the subcontractor, the address, and the TIN, as well as the full name, address, and DOB for individuals with an ownership interest:
  - Include if any of these individuals are related to any of the individuals on the Master List.
- Information regarding financial transactions with subcontractors totaling more than $25,000:
  - Include the ownership of any subcontractor with whom the provider has had business transactions in the last 12 months and significant business transactions in the past five years. Include the full name and address.
- Information regarding a provider owning a supplier:
  - Include the name, address, NPI, and TIN.

Signature: This form must be signed by an authorized agent for the provider. Include the name and phone number of the person completing this form.

Signature date

Date of final submission

Next steps

Provider agreement

Following the completion of the application, please review the *EPA HCBS Provider Agreement* and *Addendum*. This document is the contract used to add providers to the network. The contract is between Anthem and the provider and is specific to the Indiana PathWays for Aging program. If you have questions or need assistance, please contact our provider relations team by email at INMLTSSProviderRelations@anthem.com or contact Provider Services at 833-569-4733.