

## **Indiana PathWays for Aging Provider Application — instructions page**

Thank you for your interest in joining the Anthem Blue Cross and Blue Shield (Anthem) Indiana PathWays for Aging network. 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 our provider team at [INMLTSSProviderRelations@anthem.com](mailto:INMLTSSProviderRelations@anthem.com).

### **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). See the [Become a Provider](https://www.in.gov/medicaid/providers/451.htm) page at <https://www.in.gov/medicaid/providers/451.htm> 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**

Provider is required to submit the following documents with their application:

- Copy of certification documents verifying that the provider is approved/certified through the Division of Aging and Indiana Medicaid
- 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. 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 the Availity Essentials website at [Availity.com](https://www.availity.com), emailed to our provider email address at [INMLTSSProviderRelations@anthem.com](mailto:INMLTSSProviderRelations@anthem.com), or mailed to Anthem Blue Cross and Blue Shield 220 Virginia Ave. Mail Stop IN0204-C497 Indianapolis, IN. 46204. Failure to provide correct information or required documents will delay the completion of your contracting and credentialing process. Anthem conducts 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 timely to our requests to avoid any unnecessary delays in processing your application. Anthem will process provider network application requests within 30 days from the date of a completed clean request. Anthem will be notified upon receipt of the application and/or signed contract and will reach out to the provider directly to review and confirm documents received. We hope the instructions outlined below help you with the completion of your application.

### **<https://providers.anthem.com/in>**

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc., independent licensee of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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.

**Section I. Provider identification**

Legal business name	Double-check that the legal business name matches exactly the legal business name on the federal <i>W-9</i> form.
Doing business as (if applicable)	Double-check that the doing business as (DBA) name matches exactly the DBA name on the federal <i>W-9</i> form.
Manager name	Enter the name of the person who acts as the operating manager or administrator.
Email	Add an 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 <i>W-9</i> form.
Indiana Health Coverage Program provider ID 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 PSA License, HHA License, etc.
License or certification #	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, Purdue University, etc.
Name listed on license	Add the agency name listed on the license or the employee's name if applicable.

**Section II. A. Service location/contact information**

Primary provider location name	Enter the name the company uses for their primary location. It may be the same as the legal name or the DBA name.
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 for this person.
Administrator, email, phone	Enter 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 for this person.
Does this office meet <i>Americans with Disabilities Act (ADA)</i> accessibility	Select Yes or No. <i>ADA</i> accessibility means that it 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 <i>ADA</i> accessibility. For more information visit <a href="https://adaindiana.org/resources/guide.html">https://adaindiana.org/resources/guide.html</a> .
Office hours	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 bi-lingual staff.
Name listed on license	Agency name listed on the license or the employee's name if applicable.
Handicap accessible	Select if the building entrance and doors meet <i>ADA</i> requirements. Select if the parking you provide has handicap parking spaces. Select if restrooms/bathrooms meet <i>ADA</i> 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.
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 any other languages 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).
Are you accepting new 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 II. B. Pay to address**

Pay to name	Enter the name that should be entered on the <i>Pay to</i> section of payment vouchers. (This includes checks for payment.)
Address, city, state, ZIP, county	Enter the address where Anthem will send payment vouchers. (This includes check for payment.)
Phone, fax, primary contact	Enter the phone number, fax number (if applicable), and primary contact regarding accounts receivable for Anthem to contact regarding payments.

**Section II. C. Mailing address**

Pay to name	Enter the name that should be entered on the <i>Pay to</i> section of payment vouchers. (This includes checks for payment.)
Address, city, state, ZIP, county	Enter the address where Anthem will send payment vouchers. (This includes check for payment.)
Phone, fax, primary contact	Enter the phone number, fax number (if applicable), and primary contact regarding mailing, shipping, and receiving.

**Section II. D. 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 II. E. 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.
<b>1. Credentialing contact information</b>	
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.
<b>2. Electronic visit verification (EVV) contact information</b>	

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.
<b>3. Critical incident contact information</b>	
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.
<b>4. Clinical contact information</b>	
Name, email	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.
<b>5. Referrals contact information</b>	
Name, email	Enter the name of the person who is the main point of contact for the agency regarding referral 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.
<b>6. Quality management contact information</b>	
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.
<b>7. Value-based payment (VBP) contact information</b>	
Name, email	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.
<b>8. Other contact information</b>	
Name, email	Add other contacts relevant to the application request for network participation. Enter this person's email address. <i>(If there are more names please attach to a separate sheet of paper)</i>
Address, city, state, ZIP, phone	Enter the complete address and primary phone number to contact this person.

**Section III. Insurance**

Attach a current <i>Certificate of Insurance (COI)</i> 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.	
<b>1. General liability coverage — property and personal liability insurance as required by 455 IAC 2-11-1</b>	
Current carrier name	Enter the name of the insurance company who provides your general liability insurance.
Policy number	Enter the full policy number listed on the <i>COI</i> .
Coverage type	Select the appropriate box that correlates with the coverage specified on your <i>COI</i> .

Effective date, expiration date	Enter the dates that correlate with the dates specified on your <i>COI</i> .
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 <i>COI</i> .
<b>2. General liability coverage — vehicle insurance as required in 455 IAC 2-6-2, 455 IAC 2-12-1(4)</b>	
Current carrier name	Enter the name of the insurance company who provides your automobile liability insurance and is listed on your <i>COI</i> .
Policy number	Enter the full policy number listed on the <i>COI</i> .
Coverage type	Select the appropriate box that correlates with the coverage specified on your <i>COI</i> .
Effective date, expiration date	Enter the dates that correlate with the dates specified on your <i>COI</i> .
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 <i>COI</i> .
<b>3. Professional liability coverage</b>	
Current carrier name	Enter the name of the insurance company who provides your professional liability insurance and is listed on your <i>COI</i> .
Policy number	Enter the full policy number listed on the <i>COI</i> .
Coverage type	Select the appropriate box that correlates with the coverage specified on your <i>COI</i> .
Effective date, expiration date	Enter the dates that correlate with the dates specified on your <i>COI</i> .
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 <i>COI</i> .

**Section III. B. Accreditation/certification**

Attach a copy of 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.
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
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.
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 IV. A. 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 <i>Division of Aging Waiver Service Certification</i> to this submission. Ensure the services you select correlate with the services approved on the <i>Division of Aging Waiver Service Certification</i> .
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#### **Section IV. B. 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 V. 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 that 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 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 for 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 Anthem 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 team at [INMLTSSProviderRelations@anthem.com](mailto:INMLTSSProviderRelations@anthem.com) or call **833-310-3775**.