MDwise

Full Panel Add Request

Fax Form to MDwise 317.829.5530

**** All fields must be complete for processing** ** Please print legibly – except signatures****

Date of Request _____

Contact Name _____ Contact Telephone _____

Member Information

Hoosier Healthwise ID Number _____

Member Name _____

Social Security Number _____

Member Address _____

_____

Member (or parent/guardian signature) _____

Date Signed _____

Provider Information

As a PMP, I agree to add the above Hoosier Healthwise member to my full panel.

Physician Name (print) _____

Physician Signature _____

Physician Provider ID Number _____

AmeriChoice Use Only

Date Received _____

Date Approved _____

Date Denied _____

Return Code/Reason _____