Primary Medical Provider (PMP) Change Request Form

Provider/Facility Name:_____

Tax ID#: _____NPI: _____

Location Address: _____

Phone #: _____

Fax #: _____

Member Information:
Member name: (required)_____
Member ID Number OR DOB (required): _____

Other Family Members to move to this PMP:
Member name: _____ MID or DOB: _____
Member name: _____ MID or DOB: _____
Member name: _____ MID or DOB: _____

Reason for Change (required):

- ☐ Member Preference.
- ☐ Existing patient with this doctor or family member of an existing patient.
- ☐ Panel override: This is a patient whom I would like to add to my panel.

The required fields must be completed for the change to be processed. Members can continue to be treated by their requested PMP until the change is complete. All requests will be processed within five business days of receipt.

Member/Member Representative Signature: _____
Date: _____

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

Provider (staff) Signature:_____
Date: _____

Fax requests to the MDwise Customer Service department at 1-877-822-7190.

MDwise Use Only:

- ☐ PMP Change Complete.
- ☐ Not Processed: Member is not currently active with MDwise.
- ☐ Not Processed: Provider is not a PMP with MDwise.
  Please visit www.mdwise.org to complete the provider enrollment form.