Join our network in Indiana

Welcome!

This communication applies to the Commercial, Medicaid, and Medicare Advantage programs from Anthem Blue Cross and Blue Shield (Anthem) in Indiana.

Thank you for your interest in becoming a network provider with Anthem in Indiana. We seek to establish contracts with exceptional providers and look forward to working with you to provide quality service. Participation in our networks is based on member access and need. The process for joining our network may include contracting, credentialing, and enrollment. Each process is described in greater detail below:

- **Contracting/negotiating**: the process of the provider and managed care entity (MCE) formally executing an agreement for the provider to deliver medical services that outlines reimbursement rates, the scope of services, etc.
- **Credentialing**: the process of reviewing the qualifications and appropriateness of a provider to join the health plan’s network; credentialing requirements and processes will follow National Committee for Quality Assurance (NCQA) guidelines and company credentialing policy
- **Enrollment**: the process of loading a contracted and credentialed provider to all MCE internal systems, loading for claims payment, and loading to the provider directory (if applicable)

**Professional providers**

If you wish to become a contracted provider or add a provider to your existing group, please complete the online provider enrollment application hosted on the Availity* Portal. The online application automatically accesses CAQH Proview® to pull information you’ve already included in your account, so please update your profile and ensure it is in a complete or reattested status. Availity’s online application will guide you through the enrollment process, providing status updates using a dashboard so you know where you are in the process without having to call or email for a status update. Providers will be notified within five days via email in the event their network participation request is determined to be incomplete.

To access the provider enrollment application, log on to the Availity Portal and select Payer Spaces > Anthem Blue Cross and Blue Shield > Applications > Provider Enrollment to begin the enrollment process.

If your organization is not currently registered for the Availity Portal, the person in your organization designated as the Availity administrator should go to www.availity.com and select Register.

For organizations already using the Availity Portal, your organization’s Availity administrator should go to My Account Dashboard from the Availity homepage to register new users and update or unlock

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.
accounts for existing users. Staff who need access to the provider enrollment tool need to be granted the role of provider enrollment. (Availity administrators and user administrators will automatically be granted access to provider enrollment.)

If you are using Availity today and need access to provider enrollment, please work with your organization’s administrator to update your Availity role. Go to My Account Dashboard > My Administrators to determine who your administrator is.

The information provided will be used to determine contract eligibility and to draft legal documents for signatures, as needed. You will receive an application number following the successful completion of the provider enrollment application. Use this application number when contacting Anthem to check the status of your network participation request. You can contact Anthem via phone or email using the information on our Contact Us page.

**Effective dates (Commercial, Medicare Advantage HMO/PPO, Hoosier Healthwise, Hoosier Care Connect, and Healthy Indiana Plan [HIP])**

**Beginning January 1, 2022, the effective date policy is:**
The following network effective date policy is for all network participation requests. This effective date policy applies to all provider types. The same effective date policy will be in place, regardless of whether the network participation request is for a hospital/ancillary provider or a practitioner. Providers must be fully enrolled and effective as an Indiana Health Coverage Programs (IHCP) provider prior to becoming effective with an MCE.

Providers will be effective with an MCE on the first of the month following the receipt of a complete network participation request or contract execution as outlined in the additional guidance below:

- A brand-new provider who is not part of an existing contract or contract amendment with the MCE will be effective the first of the month following contract execution:
  - If a provider is unable to be credentialed with the MCE, the provider will not be effective with the MCE.
  - If a provider and MCE cannot come to terms with a contract, the provider will not be effective with the MCE. The network participation receipt date is the date the MCE receives the provider’s complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.

- A provider who is being added to an existing contract will be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the MCE receives the provider’s complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.

- To be able to render services, the contract or contract amendment must still be executed by both parties.

- MCEs are encouraged to use the standard out-of-network process for services rendered by providers prior to the effective date if needed for member access to care.

- The MCE network effective date must also be after the IHCP effective date. Providers must be enrolled and effective with IHCP prior to being effective with an MCE.
• Providers should hold all claims until the final welcome letter from the MCE is received confirming that they are effective with the MCE network. MCEs and providers are expected to complete all pieces of the network participation process timely. However, in instances where the network participation process extends for a time period longer than the standard time frame, MCEs will not hold providers to the timely filing limit for claims rendered before the provider was confirmed effective.

• The Office of Medicaid Policy and Planning (OMPP) is allowing the MCEs flexibility to deny the provider participation request if the contracting phase cannot be completed in an acceptable time frame that is no more than 60 days. This will allow the effective date policy to remain consistent but also hold all parties accountable for the turnaround of necessary items for the network participation process. A delay in signing a contract can have a significant impact on the process and may result in your request to join the network being denied.

**Credentialing**

Most providers require credentialing. Additional information on credentialing can be found in the Credentialing Program Summary and the Practitioner Credentialing Rights sections on Anthem’s website. Anthem accesses CAQH information. Once you’ve received your CAQH ID number and completed the CAQH application online, you may proceed with completing the online provider enrollment application hosted on the Availity Portal. Please verify that you have granted Anthem permission to access your CAQH application. If you have not previously granted such permission, please contact CAQH through its website or call 888-599-1771.

**Helpful tips for professional providers**

If you received an agreement in the mail for your signature, please see our Helpful Tips for Professional Providers. If you need assistance, you may contact us. If you have questions pertaining to the Availity provider enrollment application process, please contact your Provider Experience representative. If you have training and educational questions, please contact your Network Relations consultant. If you have contracting questions, please contact your Network Development manager.

**Ancillary providers**

The Provider Maintenance Form — Provider Application/Add Provider Form is for the following ancillary providers to apply for participation with Anthem in Indiana: ambulance, hearing aid supplier, durable medical equipment (DME), orthotics/prosthetics, and reference lab. Please access the Health Delivery Organizations (HDOs) Application for the ancillary application. The ancillary-specific application should be used for home health, hospice, skilled nursing facility, home infusion therapy, ambulatory infusion suites, and dialysis. Ancillary providers seeking credentialing for Medicaid/HIP also need to complete the Medicaid application, accessible here. Please see the HDOs Application for documentation to be submitted with the application. Once you have completed the application(s), please submit the application(s) to Ancillary_indiana-sm@anthem.com along with the necessary forms. If you have questions or need to check the status of your application, please contact Ancillary_indiana-sm@anthem.com. Upon receipt of your application, we will contact you via email to confirm receipt and advise whether any additional information is needed. Within five days of the initial request for network participation, provider surveys will be sent to the following specialties: home health, hospice, DME, orthotics/prosthetics, and skilled nursing facilities. The Disclosure of Ownership form will be required for all Medicaid ancillary providers.
**Credentialing**

Credentialing is the process Anthem uses to evaluate and select healthcare practitioners and health delivery organizations (HDOs) to provide care to members to help ensure that Anthem’s standards of professional conduct and competence are met.

Anthem’s *Credentialing Program Summary* includes a complete list of the provider types within Anthem’s credentialing scope. The credentials of healthcare practitioners and HDOs are evaluated according to Anthem’s criteria, standards, and requirements as set forth in the *Program Summary* and applicable state and federal laws, regulatory, and accreditation requirements and are not intended to limit Anthem’s discretion in any way to amend, change, or suspend any aspect of Anthem’s Credentialing Program nor is it intended to create rights on the part of practitioners or HDOs who seek to provide healthcare services to members.

Anthem further retains the right to approve, suspend, or terminate individual practitioners and HDOs in those instances where it has delegated credentialing decision-making. Anthem’s Credentialing Program also includes the recredentialing process, which incorporates re-verification and the identification of changes in the practitioner’s or HDO’s credentials that may reflect on the practitioner’s or HDO’s professional conduct and competence.

This information is reviewed to assess whether practitioners and HDOs continue to meet Anthem credentialing standards. All applicable practitioners and HDOs in Anthem’s network within the scope of the Credentialing Program are required to be recredentialed every three years unless otherwise required by applicable state contract or state regulations. Additional information regarding Anthem’s Credentialing Program can be found in the *Credentialing Program Summary*.

The provider agrees to hold all claims for health services provided to covered individuals enrolled in a plan included in the provider agreement until Anthem has notified the provider in writing that the new provider network participation has been entered into Anthem’s claims system. If the provider submits claims prior to the date set forth by Anthem in its notification, then the claims may not process correctly and Anthem will not be obligated to reprocess these claims, nor shall the provider request an adjustment on that basis. Additionally, the provider shall not be permitted to balance bill-covered individuals.

**Beginning January 1, 2022, the effective date policy is:**

The following network effective date policy is for all network participation requests. This effective date policy applies to all provider types. The same effective date policy will be in place, regardless of whether the network participation request is for a hospital/ancillary provider or a practitioner. Providers must be fully enrolled and effective as an IHCP provider prior to becoming effective with an MCE.

Providers will be effective with an MCE on the first of the month following the receipt of a complete network participation request or contract execution as outlined in the additional guidance below:

- A brand-new provider who is not part of an existing contract or contract amendment with the MCE will be effective the first of the month following contract execution:
  - If a provider is unable to be credentialed with the MCE, the provider will not be effective with the MCE.
  - If a provider and MCE cannot come to terms with a contract, the provider will not be effective with the MCE. The network participation receipt date is the date the MCE receives the provider’s complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required
supporting documentation provided, etc. for the network participation request to be considered complete.

- A provider who is being added to an existing contract will be effective the first of the month following receipt of the network participation request from the provider. The network participation receipt date is the date the MCE receives the provider’s complete network participation request electronically via an online portal, email, postal mail, or fax. All required fields must be completed, required supporting documentation provided, etc. for the network participation request to be considered complete.
- To be able to render services, the contract or contract amendment must still be executed by both parties.
- MCEs are encouraged to use the standard out-of-network process for services rendered by providers prior to the effective date if needed for member access to care.
- The MCE network effective date must also be after the IHCP effective date. Providers must be enrolled and effective with IHCP prior to being effective with an MCE.
- Providers should hold all claims until the final welcome letter from the MCE is received confirming that they are effective with the MCE network. MCEs and providers are expected to complete all pieces of the network participation process timely. However, in instances where the network participation process extends for a time period longer than the standard time frame, MCEs will not hold providers to the timely filing limit for claims rendered before the provider was confirmed effective.
- OMPP allows the MCEs flexibility to deny the provider participation request if the contracting phase cannot be completed in an acceptable time frame that is no more than 60 days. This will allow the effective date policy to remain consistent but also hold all parties accountable for the turnaround of necessary items for the network participation process. A delay in signing a contract can have a significant impact on the process and may result in your request to join the network being denied.

**Facility providers**

Please access the [HDOs Application](#) for the application for facility professionals. Facilities include acute, rehab, long-term acute care (LTAC), behavioral health, and surgery centers. Facility providers seeking credentialing for Medicaid/HIP also need to complete the Medicaid application, accessible [here](#). Please see the [HDO Application](#) for documentation to be submitted with the application. Once you have completed the application(s), please submit the application(s) to Pamela Zartman at pamela.zartman@anthem.com, along with the necessary forms. If you have questions or need to check the status of your application, please contact Pamela Zartman at pamela.zartman@anthem.com. Upon receipt of your application, we will contact you via email to confirm receipt and advise whether any additional information is needed. Providers will be notified within five days via email in the event their network participation request (PMF) is determined to be incomplete.

**Credentialing**

Credentialing is the process Anthem uses to evaluate and select healthcare practitioners and HDOs to provide care to members to help ensure that Anthem’s standards of professional conduct and competence are met.

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intended to limit Anthem’s discretion in any way to amend, change, or suspend any aspect of
Anthem’s Credentialing Program nor is it intended to create rights on the part of practitioners or
HDOs who seek to provide healthcare services to members. Anthem further retains the right to
approve, suspend, or terminate individual practitioners and HDOs in those instances where it has
degraded credentialing decision-making. Anthem’s Credentialing Program also includes the
recredentialing process, which incorporates re-verification and the identification of changes in the
practitioner’s or HDO’s credentials that may reflect on the practitioner’s or HDO’s professional
conduct and competence.

This information is reviewed in order to assess whether practitioners and HDOs continue to meet
Anthem credentialing standards. All applicable practitioners and HDOs in Anthem’s network within the
scope of the Credentialing Program are required to be recredentialled every three years unless
otherwise required by applicable state contract or state regulations. Additional information regarding
Anthem’s Credentialing Program can be found in the Program Summary available on
https://providers.anthem.com/in. The Credentialing Program Summary can also be viewed by
visiting https://providers.anthem.com/in, selecting Join our network, then Provider Manuals and
Guides under Provider tools and resources, then selecting the Credentialing Program Summary in
the Provider manuals and guides section.

The provider agrees to hold all claims for health services provided to covered individuals enrolled in a
plan included in the provider agreement until Anthem has notified the provider in writing that the new
provider network participation has been entered into Anthem’s claims system. If the provider submits
claims prior to the date set forth by Anthem in its notification, then the claims may not process
correctly and Anthem will not be obligated to reprocess these claims, nor shall the provider request
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online portal, email, postal mail, or fax. All required fields must be completed, required
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considered complete.

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**Anthem provider networks available in Indiana:**

- Blue Traditional
- Blue Access PPO
- Blue Preferred HMO/POS
- Medicare Advantage PPO
- Medicare Advantage HMO
- Indiana Workers’ Compensation
- Healthy Indiana Plan
- Medicaid (Hoosier Healthwise and Hoosier Care Connect)
- Pathway (Indiana Exchange)
- HealthSync

Participation in Anthem’s networks is based on credentialing, contracting, and procedural standards being met.