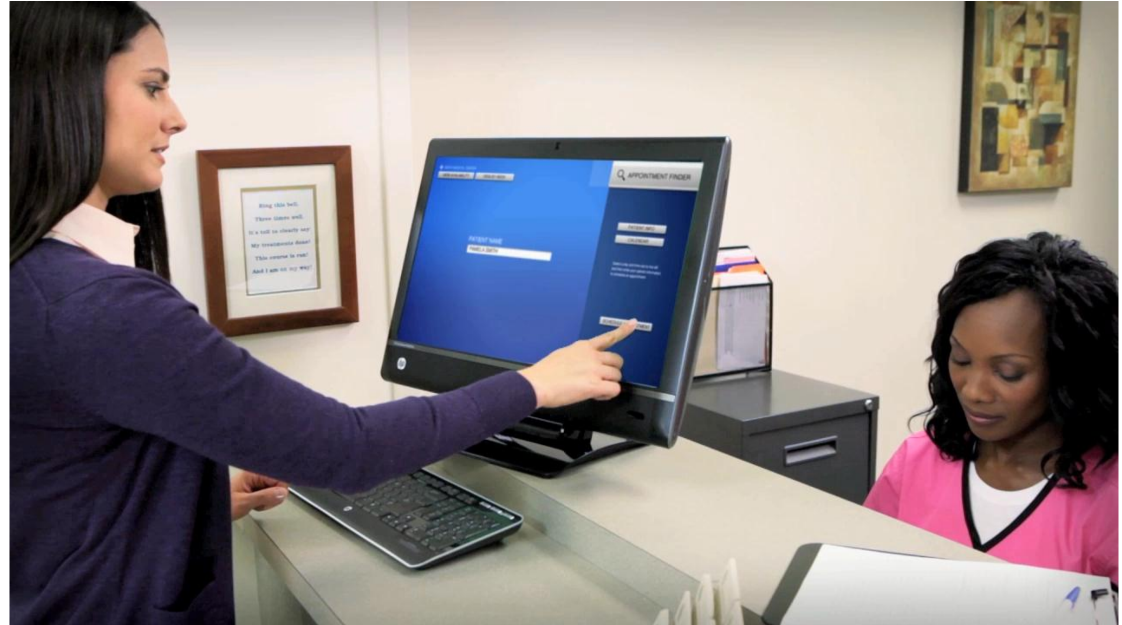
IHCP Profile Update

IHCP Provider Tax Identification Maintenance Form

HP Provider Relations / January 2013

Agenda

- Objectives
- Purpose of form
- Form facts
- Completion guidance



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Objectives

- Know when to use this form
- Understand its purpose
- Be able to complete the form successfully

Purpose

Purpose

IHCP Provider Tax Identification Maintenance Form

- Use this form to make changes to a business taxpayer identification number (TIN) for a service location
- May also use this form to change the TIN for all service locations

Did you know?

Form Facts

IHCP Provider Tax Identification Maintenance Form

- When the TIN has changed for some service locations, but not all locations, use one form per location
- Use a single form to change the TIN when the change applies to all locations
- Always include a new Form W-9
  - The address on Form W-9 must match the Home Office address entered onto the form
- Do not use this form when the change of TIN is due to a change of ownership
  - Complete a new *IHCP Provider Packet* when a change of ownership occurs

Form Facts

IHCP Provider Tax Identification Maintenance Form

- The form requires a signature from an owner, authorized official, or delegated administrator
  - Authorized officials must be identified on Schedule C.1 or C.3 of the enrollment application
  - Delegated administrators must be identified on the *IHCP Delegated Administrator Addendu*m
  - Forms signed by an unauthorized person are returned to the provider due to an invalid signature

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Form Facts

IHCP Provider Tax Identification Maintenance Form

- Complete the form on-screen, then print
- Save the form to your hard drive or other storage device for future reference

Guidance

| Maintenance Form

IHCP Provider Tax Identification Maintenance Form

indianamedicaid.com

Service Location Information

If the change is the result of a change of ownership, do not complete this form. For a change of ownership, complete and submit the appropriate IHCP provider packet; include supporting documentation and a copy of the purchase agreement or bill of sale.

1. Effective Date of New TIN:	2. New TIN: Must match Form W-9	3. Previous TIN:

4. Legacy Provider identifier (LPI): Enter the LPI	5. NPI:	6. Taxonomy:

7. Apply the TIN Change to (if the change applies to multiple service locations, but not all, submit one form per service location):

- ☐ Single service location – complete fields 8 – 27
- ☐ All service locations – skip fields 8-13; complete fields 14 – 27.

Does the change apply to all locations?

8. Service Location Alpha Suffix: Enter the LPI's alpha suffix only	9. Service Location Doing Business As (DBA) Name: Must match Line 2 of Form W-9

10. Service Location Street Address:

11. City:	12. State:	13. ZIP + 4: **(Nine digits Required)**

Legal Name and Home Office Address

Legal Name and Home Office Address

The information in this section is requested only to verify that the TIN changes are being made to the correct service location(s). You
Name and Home

Must match Line 1 of Form W-9 and be registered with the Secretary of State or county Recorder's office

14. Legal Name:		
15. Home Office Street Address: Must match the address on Form W-9		
16. City:	17. State:	18. ZIP + 4: **(Nine digits Required)**

Contact Information

The contact person is the person who answers questions about the information provided in this form.

19. Contact Name:	20. Telephone:
21. Contact Email:	

Enter the contact information of the person completing this form

Signature Authorization for Profile Maintenance

The undersigned, being the provider or having the specific authority to bind the provider to the terms of the provider agreement, does hereby agree to abide by and comply with all the stipulations, conditions, and terms set forth herein. The undersigned acknowledges that the commission of any Medicaid or CHIP-related offense, as set out in 42 USC 1320a-7b, *may be punishable by a fine of up to $25,000 or imprisonment of up to five years or both.*

The owner or an authorized official of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. The *IHCP Delegated Administrator Addendum/Maintenance Form* must be completed before a delegated administrator can sign forms. The delegated administrator can sign only for items expressly delegated. The IHCP can process provider maintenance requests only when the appropriate signature is present. **The form will be returned if the appropriate signatur**

22. Legal Name of Provider's Business (please print):

Must match Line 1 on Form W-9 and be registered with the Secretary of State or county Recorder's office

24. Authorized Official's Name (please print): This person must be listed on Schedule C.1 or C.3	25. Title:
26. Authorized Official's Signature:	27. Date:

Find Help

Helpful Tools

- IHCP website at indianamedicaid.com
- Form W-9 at irs.gov
- *IHCP Provider Manual, Chapter 4* (web, CD, or paper)
- Customer Assistance
  - 1-877-707-5750
- Provider field consultant
  - indianamedicaid.com > Contact Us > Provider Relations Field Consultants link

Q&A