Completing the Provider Enrollment Application

HP Provider Relations
September 2012

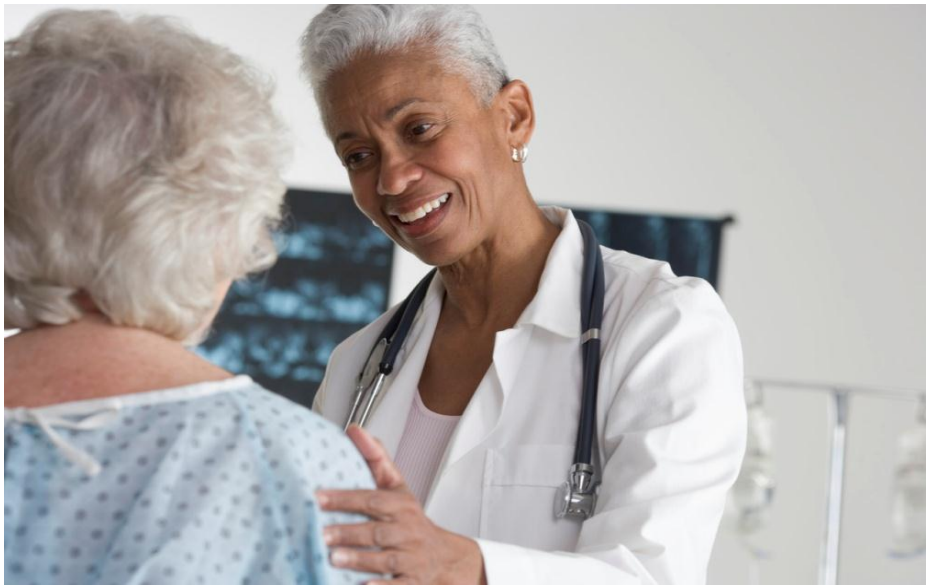
Virtual Room participants please call 1-866-409-2889 and use passcode 9866141025 to hear the presenter

Agenda

- Session Objectives
- Form W-9
- Provider Classifications
- Provider Enrollment Web Pages
- Helpful Tips
- Completing the Enrollment Application
  - Schedules
  - Addenda
  - Change of Ownership
  - Rendering Provider Application

Objectives

- Learn where to locate the provider enrollment application
- Present guidance to complete the application correctly for group entities and rendering practitioners
- Understand how to complete the Change of Ownership addendum




Explain
Form W-9 (irs.gov)

Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Enter the Legal Name on this line. This name must be registered with the Secretary of State or Recorder's Office

Business name/disregarded entity name, if different from above

Enter the "Doing Business As" name on this line. This name must be registered with the Secretary of State or Recorder

Check appropriate box for federal tax classification:

☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

This address must match the Home Office address

Requester's name and address (optional)

Select the tax classification for the business

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alie… e 3. For other entities, it is… ee *How to get a TIN* on page…

Note. If the… on whose number to e…

Some business structures require use of the owner's SSN. Read the instructions on this form to ensure the correct value is entered.

Social security number

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Employer identification number

[ ][ ] - [ ][ ][ ][ ][ ][ ][ ]

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all i… mortgage interest paid, acquisition or abandonm… ent (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

May be signed by a nonmanagement staff member

Sign Here	Signature of U.S. person ▶	Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are

Provider Classification

Billing, Group, Rendering, Dual

Provider Classifications

- **Billing Provider** - A practitioner or facility operating under a unique taxpayer identification number (TIN). The TIN may be the practitioner's Social Security number or a federal employer identification number.
- **Group Provider** - Any practice with one or more practitioners sharing a common corporate TIN. The group must have members linked to the business, and these members are identified as "rendering providers."
- **Rendering Provider** - A practitioner employed by a group provider. The rendering provider actually performs the service. The IHCP makes payment to the group.
- **Dual Provider** - A provider that is both a billing and a rendering provider.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WELCOME

Welcome to the Indiana Health Coverage Programs (IHCP) provider Web site. On this site, you will find complete program information and requirements, as well as online access to enroll as a provider, submit and check claims, verify member eligibility, register for provider training, and much more. If you have questions, comments, or suggestions, please take a few minutes to provide us with Web Site Feedback (**Contact Us** > **Web Site Feedback**) - or talk to your IHCP Provider Relations representative.

NEWS AND ANNOUNCEMENTS

HIPAA version 5010 IHCP Companion Guides Temporarily Removed

06/29/2012 - Several HIPAA version 5010 IHCP companion guides have been removed from the indianamedicaid.com website. IHCP guidance on 5010 will be published as quickly as possible. Please contact the EDI Help Desk at (317) 488-5160 or 1-877-877-5182 or by email at INXIXElectronicSolution@hp.com if assistance is needed.

HIPAA 5010 Deadline July 1, 2012

06/29/2012 - Beginning July 1, 2012, all incoming and outgoing electronic data interChange (EDI) transactions must be version 5010 compliant. EDI transactions sent to Indiana Medicaid in version 4010 on or after July 1, 2012, will be rejected.

NCPDP D.0 Deadline July 1, 2012

06/29/2012 - Beginning July 1, 2012, all pharmacy claims submitted to the Indiana Health

- Claims/Billing
- Electronic Data Interchange
- FAQs
- Fee Schedule
- Forms
- Manuals
- Pharmacy Services
- Prior Authorization
- Provider Enrollment
- Provider Search (non-OPR)
- OPR Providers
- Preferred Drug List
- Presumptive Eligibility
- Provider Education
- Verify Member Eligibility
- Access Provider Profile
- Check Claims Status

Subscribe to Email Notices

CP Provider Enrollment ansactions

CP Provider Enrollment ransactions

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pdate Your Provider Profile

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isenroll from the IHCP

ocations in Need of Providers

ational Provider Identifier (NPI)

IHCP PROVIDER ENROLLMENT TRANSACTIONS

In compliance with the Affordable Care Act (ACA) requirements (*42 CFR 455*), the Indiana Health Coverage Programs (IHCP) has made significant changes to provider enrollment policies and procedures effective January 1, 2012. Provider forms, instructions, and processes have been updated to reflect ACA requirements. Please familiarize yourself with the information on these web pages before proceeding with any enrollment-related transaction. Additional information can be found in Chapter 4 - Provider Enrollment, Eligibility, and Responsibility of the IHCP Provider Manual.

IHCP PROVIDERS - SELECT THE TRANSACTION THAT APPLIES

- Enroll as an IHCP Provider for the first time
- Add a service location to an existing IHCP provider
- Report a change of ownership for an existing IHCP provider
- Revalidate enrollment as an IHCP provider
- Update provider profile information of an existing IHCP provider
- Recertify enrollment licenses and other certifications
- Enroll as a provider with a managed care entity under IHCP:
  - MCE Provider Enrollment Form
  - MCE Provider Credentialing Form
- Disenroll from the IHCP

First-time enrollees click here

Note: If you are interested in participating as an IHCP provider only to be able to order, prescribe, or refer covered services and/or medical supplies for your Medicaid-eligible patients, go directly to the Ordering, Prescribing, or Referring Providers page.

Claims/Billing
Electronic Data Interchar
FAQs
Fee Schedule
Forms
Manuals
Pharmacy Services
Prior Authorization
Provider Enrollment
Provider Search (non-O
OPR Providers
Preferred Drug List
Presumptive Eligibility
Program Integrity
Provider Education
Verify Member Eligibilit
Access Provider Profile
Check Claims Status

Complete an IHCP Provider Packet

IHCP Provider Enrollment Transactions

Affordable Care Act (ACA) Requirements

Complete an IHCP Provider Packet

- 01 - Hospital
- 02 - Ambulatory Surgical Center
- 03 – Extended Care Facility
- 04 – Rehabilitation Facility
- 05 – Home Health Agency
- 06 – Hospice
- 08 – Clinic
- 09 – Advanced Practice Nurse
- 11 – Mental Health Provider
- 12 – School Corporation
- 13 – Public Health Agency
- 14 – Podiatrist
- 15 – Chiropractor
- 17 – Therapist

COMPLETE AN IHCP PROVIDER PACKET

Providers complete an Indiana Health Coverage Programs Enrollment and Profile Maintenance Packet (IHCP Provider Packet) to do any of the following:

- **Enroll as an IHCP provider for the first time** - When you enroll as a provider with the IHCP you will need to complete and submit the appropriate IHCP Provider Packet, in its entirety.
- **Add a service location to an existing IHCP provider** - When you add a service location to an existing IHCP provider, that service location is treated as a new enrollment. You will need to complete and submit the appropriate IHCP Provider Packet, in its entirety.
- **Report a change of ownership (CHOW) for an existing IHCP provider** - When you report a change of ownership for an entity that is already enrolled with IHCP, enrollment. You will need to complete and submit acket in its entirety, including new ownership information and signatures.
- **Revalidate enrollment as an IHCP provider** - When it is time to revalidate your enrollment as an IHCP provider, you will receive notice of the revalidation deadline. Revalidation is similar to a new enrollment. You will need to complete and submit the appropriate IHCP Provider Packet in its entirety, with all current information.
- **Update provider profile information of an existing IHCP provider** - Although many provider updates can be made online or with the submission of separate update forms, some updates may require you to complete and submit the relevant sections of the IHCP Provider Packet. Refer to the Update Your Provider

Select your provider type

Claims/Billing
Electronic Data Interchang
FAQs
Fee Schedule
Forms
Manuals
Pharmacy Services
Prior Authorization
Provider Search
Provider Enrollment
Preferred Drug List
Presumptive Eligibility
Provider Education
Verify Member Eligibility
Access Provider Profile
Check Claims Status

Subscribe to Email Notices

20 – Audiologist

21 – Case Manager

22 – Hearing Aid Dealer

24 – Pharmacy

25 – Durable Medical Equipment/Home Medical Equipment

26 – Transportation

27 – Dentist

28 – Laboratory

29 – Radiology

30 – End-Stage Renal Disease Clinic

31 – Physician

32 – Waiver

Ordering, Prescribing or Referring Providers

Update Your Provider Profile

Recertify Provider Enrollment Licenses and Other Certifications

Disenroll from the IHCP

Locations in Need of Providers

National Provider Identifier (NPI)

- 333 - Pathologist
- 334 - Pediatric Surgeon
- 335 - Pediatrician
- 336 - Physical Medicine and Rehabilitation Practitioner
- 337 - Plastic Surgeon
- 338 - Proctologist
- 339 - Psychiatrist
- 340 - Pulmonary Disease Specialist
- 341 - Radiologist
- 342 - Thoracic Surgeon
- 343 - Urologist
- 344 - General Internist
- 345 - General Pediatrician
- 346 - Dispensing Physician

2. Complete the appropriate IHCP Provider Packet based on your provider classification:
   - To enroll as a billing provider use the IHCP Billing Provider Enrollment and Profile Maintenance Packet.
   - To enroll as a group or clinic use the IHCP Group and Clinic Provider Enrollment and Profile Maintenance Packet.
   - To enroll as a rendering provider use the IHCP Rendering Provider Enrollment and Profile Maintenance Packet.
3. Detailed instructions are included in each packet. See Chapter 4 of the IHCP Provider Manual for more information.
   - For enrollment, adding a service location, reporting a change of ownership or revalidating a current IHCP enrollment, the entire packet must be completed and submitted.
   - To update an existing provider profile, use Web interChange for online updates, submit the appropriate provider profile maintenance form or complete the relevant sections and submit the IHCP Provider Packet, following the instructions provided. Refer to the Update Your Provider Profile page on this web site.
4. Refer to the Provider Type Application Fee and Risk Assignment Matrix for Non-Waiver providers on this web site to determine your risk level and whether you are required to pay an application fee. The enrollment/revalidation screening process is determined by the risk level that applies to your provider type. At its discretion, the State may assign a higher risk level to a provider which will supersede the

Detail

Enrollment Application for Group Entities

Helpful Tips

- The enrollment application requests certain information in multiple places throughout the document
  - Ensure information is reported consistently in every area where that information is requested (Examples: NPI, Tax ID)
- The Legal Name of the business must match Line 1 on Form W-9
- The Home Office address must match the address on Form W-9
- The Tax ID must match the Tax ID as indicated on Form W-9
- Providers enrolling in the IHCP for the first time do not indicate information in areas of the form asking for the Legacy Provider Identifier (LPI)
- Do not reuse older or saved versions of the enrollment forms
  - Always use the most current version of the forms found on the Provider Enrollment page of indianamedicaid.com

Schedule A

Business Names, Addresses, and Specialty

| Schedule A

IHCP Group and Clinic Provider Enrollment and Profile Maintenance Packet

indianamedicaid.com

Provider Information

1.Type of Request:

This packet is used for multiple purposes; select the purpose that applies:

- [x] **New Enrollment** – You are enrolling in the IHCP for the first time.
- [ ] **Change of Ownership** – The ownership of your business has changed.
- [ ] **New Service Location** – You are already enrolled in the IHCP and want to enroll an additional service location.
- [ ] **Revalidate Enrollment** – You received a letter indicating you must revalidate your IHCP enrollment.
- [ ] **Profile Update** – You are already enrolled in the IHCP and you need to change your provider profile information.

First-time enrollees

Provider Information

A **taxonomy code** identifies a healthcare provider type and specialty; it is not a UPIN, Medicare provider number, or an IHCP provider number. The full provider taxonomy code set can be found at wpc-edi.com under Reference. The taxonomy requested in field 4 is the taxonomy associated with the NPI in field 2.

2. National Provider Identifier (NPI):	3. ZIP + 4: **(Nine digits required)**	4. Taxonomy Code: Group taxonomy codes

5a. Are you currently enrolled as an IHCP provider? ☐ Yes ☐ No Choose one option	5b. If Yes, what is your Legacy Provider Identifier (LPI): If **yes**, enter the LPI of the entity, not the NPI
6a. Were you previously enrolled as an IHCP provider? ☐ Yes ☐ No Choose one option	6b. If Yes, what was your previous LPI: If **yes**, enter the LPI of the entity, not the NPI
7. Are you submitting this packet as the result of a change of ownership? (If Yes, complete the Change of Ownership Addendum and provide a copy of the purchase or sales agreement as an attachment to the packet.) ☐ Yes ☐ No	8. Requested Enrollment Effective Date: Enter desired date

Contact Information

Contact Information

- The contact name and email relate to the person who can answer questions about the information provided in this packet.
- Providers will be enrolled to receive email notifications when new information is published to indianamedicaid.com. Provide the email address where these notifications should be sent.
- Email addresses will be used for IHCP business only and will not be sold or shared for other purposes.

9. Contact Name:	10. Telephone:
Contact information of the person completing this application	

11. Contact Email Address:

12. Email Address for Provider Publications:

When listed, the IHCP will notify you by email when new publications are posted online

Service Location Name and Address

- The service location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.
- The service location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The service location name must match the business name on the W-9.
- If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State showing your filed business name and DBAs (405 IAC 1-19.1b) as an attachment to the packet.
- The service location address must be a physical location. A post office box is not a valid service location address.
- If you are using this packet to change your business name, you must include a revised W-9 form as an attachment to the packet. You must also submit registration documentation from the Secretary of State as an attachment, except when the business name is your nonregistered personal name.
- For a Personal Name change submit documentation showing proof of the name change. A provider's updated license or appropriate certification may be presented as proof of a name change. If a provider license does not show the new name, an official document showing the legal name change is required.
- If your legal name and business name change is the same, one set of attached documents will support both changes.
- Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their service location address.

13.Service Location (DBA) Name:

The DBA name must be registered with the Secretary of State or County Recorder's Office

14. Indiana County (Indiana providers):	15. Telephone:
County where the street address is located	

16.Service Location Street Address:

Must be a street address. This cannot be a P.O. Box.

17. City:	18. State:	19. ZIP + 4: **(Nine digits required)**

20. Is claim documentation kept at this location?	21. Are services provided in Indiana?
☐ Yes ☐ No	☐ Yes ☐ No

Example: Medical records

Legal Name and Home Office Address

Legal Name and Home Office Address

- The legal name is considered to be the entity maintaining ownership of the named business. The legal name must be the current name on tax, corporation, and other legal documents.
- The legal name and home office address must match the information currently registered with the Secretary of State, if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The legal name as well as the home office address and TIN must match the information on the W-9.
- If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State showing your filed business name and DBAs (*405 IAC 1-19.1b*) as an attachment to the packet.
- The home office address must be a physical location. A post office box is not a valid home office address.
- If you are using this packet to change your legal name or home office address, you must include a revised W-9 form as an attachment to the packet. You must also submit registration documentation from the Secretary of State as an attachment, except when the legal name is a nonregistered personal name.
- For a Personal Name change submit documentation showing proof the name change. A provider's updated license or appropriate certification may be presented as proof of a name change. If a provider license does not show the new name, an official document showing the legal name change is required.
- If your legal name and business name change is the same, one set of attached documents will support both changes.

22. Legal Name:

The legal name must be registered with the Secretary of State or Recorder's Office

23. Business Name (DBA):

If a DBA name is used, it must be registered with the Secretary of State or Recorder's Office

24. Home Office Street Address:

This address must match the business address listed on Form W-9

25. City:	26. State:	27. ZIP + 4: **(Nine digits required)**

28. Telephone:	29. Current TIN:	30. Former TIN (only required for reporting a TIN change):
	TIN = Tax ID Number	

Must match Form W-9

Mailing Name and Address

The mailing address is the location where the IHCP sends general correspondence. A post office box is acceptable for a mailing address.

31. Addressee:	32. Telephone:
Name to which mail should be addressed	

33. Mailing Street Address:
Address where mail should be sent (may be a P.O. Box)

34. City:	35. State:	36. ZIP + 4: **(Nine digits required)**

Pay To Name and Address

- The pay to address is the location where the IHCP sends checks and general claims payment information. If this is a billing agent's address, please provide the name, address, and telephone number of the billing agent. A post office box is acceptable for this address.
- The pay to name is the name that will appear as the payee on all checks.
- **If the provider is using a billing agent, proof of authorization for the billing agent must be included as an attachment to the packet.**

37. Pay To Name:
Enter the name to be used on payments

38. Billing Agent Name (if applicable):	39. Pay To Telephone:
Use only when contracting services of an outside billing company	Provider's Pay To phone #

40. Pay To Street Address:
Address where paper checks should be mailed (when EFT deposit function is not active)

41. City:	42. State:	43. ZIP + 4: **(Nine digits required)**

Provider Specialty Information

- Refer to the *IHCP Provider Type and Specialty Matrix* on indianamedicaid.com to determine the appropriate provider type, specialty codes, and supporting documentation requirements for enrollment.
- Only one provider type code is permitted per packet. Submit a separate packet for each additional provider type.
- Only one **primary** specialty is permitted per packet.
- A **taxonomy code** identifies a healthcare provider type and specialty; it is not a UPIN, Medicare provider number, or an IHCP provider number. The full provider taxonomy code set can be found at wpc-edi.com under Reference. You may enter up to 15 taxonomies; enter only those that apply to this service location.

44. Provider Type (two digit code):	45. Primary Specialty (three digit code):	46. Additional Specialties (three digit codes):

47. Taxonomy Codes associated with this specialty and used for billing:

Refer to the Provider Type and Specialty Matrix to find the Provider Type and Specialty codes. Also enter additional group taxonomy codes in field 47.

Indiana State Department of Health Certification or Licensure

If you are an Indiana provider type 04 – Rehabilitation Facility with specialty 041 - CORF or a provider type 08 – Clinic with specialty 081 – Rural Health Clinic or specialty 088 – Birthing Center, you must complete this section.

Institutional providers that are surveyed and certified or licensed by the Indiana State Department of Health (ISDH) are enrolled after the IHCP receives a completed *CMS-1539*, Certification and Transmittal Form (C&T) from the ISDH. The ISDH must survey each institutional provider to determine if the provider meets federal and state qualifications to participate in the IHCP. Providers that cannot answer YES to the following questions must contact the ISDH to complete the survey process prior to submitting IHCP enrollment packet.

48. Certified or Licensed by the ISDH?	49. Completed the ISDH survey process?
☐ Yes ☐ No	☐ Yes ☐ No

Facilities and businesses subject to ISDH survey, certification, and licensure must complete this section.

CLIA Certification

If your facility includes a laboratory, document your Clinical Laboratory Improvement Amendment (CLIA) Certificate information in this section. A copy of the CLIA certificate must be included as an attachment to the packet. A certificate is required for each location where laboratory testing is performed unless the lab qualifies for one of the CMS exemptions listed below:

- Laboratories that are not at a fixed location (that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations) may be covered under the certificate of the designated primary site or home base, using its address.
- Not-for-profit or Federal, State, or local government laboratories that engage in limited public health testing (not more than a combination of 15 moderately complex or waived tests per certificate) might have multiple CLIA certificates that apply to the service location; include all applicable CLIA certificates with the enrollment packet.
- Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction might have either a single or multiple CLIA certificates for the laboratory sites within the same physical location or street address. Include all applicable CLIA certificates with the enrollment packet.

50. CLIA Number:	51. Certification Type:	52. Effective Date:	53. Expiration Date:

Complete these fields directly from the information on the actual CLIA certificate

Schedule B

Business Structure, Other Programs, and Payers

IHCP Group and Clinic Provider Enrollment and Profile Maintenance Packet

indianamedicaid.com

Organizational Structure

- If your business is chain affiliated, the information about the company or organization must be included in the disclosure information in Schedule C.
- If your business is operated by a management c*ompany or leased* (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information in Schedule C.

1. Provider Entity Legally Organized and Structured As (Check only one) (This must match the information provided on the attached W-9.)

- ☐ Individual/sole proprietor
- ☐ C Corporation
- ☐ S Corporation
- ☐ Partnership
- ☐ Trust/estate
- Limited Liability Company; select tax classification:
  - ☐ C Corporation ☐ S Corporation ☐ Partnership
- ☐ Other; please explain (see instructions on Federal W-9 form):

Select your tax classification as stated on Form W-9

2. Registered with Secretary of State (Entities doing business in Indiana, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to www.in.gov/sos/ to find out how to complete the registration process.):

☐ Yes ☐ No

3. Date Business Started:	4. Entity Incorporated:	5. Incorporation Date (If answered Yes in 4):
	☐ Yes ☐ No	Refer to the Articles of Incorporation

6. Chain Affiliated	7. Operated by Management Company or Leased (Whole or Part) by Another Organization:
☐ Yes ☐ No	☐ Yes ☐ No

Other IHCP Program Participation

Other IHCP Program Participation

This packet is for enrollment to serve traditional Medicaid members and as the first step in the process of enrollment to serve members in the managed care programs. There is also the option to have this packet considered for enrollment as a provider in other IHCP programs, serving particular member populations. Please indicate if you are interested in enrolling as a provider in one or more of the following programs:

- The **590 Program** is a State medical assistance program ed medical services provided at offsite facilities to individuals who re annot be 590 providers: transportation, hospice, home health, DM annot enroll as 590 providers.
- The **Pre-Admission Screening Resident Review (PAS** rocess. The process assesses people with mental illnesses or dev sing facility placement or nursing facility residents that have a signifi ostic and Evaluation (D&E) teams must be contracted and approve Services (DDRS) and the Bureau of Developmental Disability Services (BDDS). Community Mental Health Centers (CMHCs) must be contracted and approved by the Indiana Division of Mental Health and Addiction (DMHA). If you are a D&E team or CMHC, please include the approval letter as an attachment.
- The **Medical Review Program** provides determination of an applicant's eligibility for Medicaid under the disability category. A provider enrolled in the Medical Review Program is authorized to complete a medical assessment of an applicant and submit the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT issues a favorable or unfavorable eligibility decision based on medical evidence that supports whether the applicant has a significant impairment. Once the documentation has been filed, the provider may submit claims for payment of certain examinations and reports. Services should not be performed unless the applicant has presented the pre-Medicaid eligibility form. There are three options for participation in the Medical Review Program:
  - Medical Review Program/IHCP – Providers that elect to enroll as an IHCP provider and choose to provide MRT assessment services.

Review these program descriptions to respond to these questions correctly

- Medical Review Program Only – Providers that do not elect to enroll as an IHCP provider but choose to provide MRT assessment services only.
- Medical Review Program – Medical Records Only – Providers that have been requested to supply MRT medical records only and want to bill for only those services.

8. Participate in the 590 Program:
☐ Yes ☐ No

9. Participate in the PASRR Program:
☐ Yes ☐ No

10. Medical Review Program Participation:
☐ Medical Review Program/IHCP
☐ Medical Review Program Only
☐ Medical Review Program – Medical Records Only
☐ None

Managed Care Program Provider

Once enrolled as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's Managed Care Program, you must apply directly with one or more of the managed care entities. Please refer to the Health Plan Contacts page at indianamedicaid.com for contact information.

Dental Providers Only

Dental groups/clinics must be owned by a licensed dentist. Licensing information must be provided and a copy of the license included as an attachment to the packet.

11. License Number	12. Effective Date
13. Expiration Date:	14. Issuing State
15. Accepting new patients: ☐ Yes ☐ No	16. Accepting patients with special needs: ☐ Yes ☐ No

Rendering Provider Packets

For a new enrollment and adding new service location, one or more Rendering Provider packets must be submitted with this packet to be linked to the group/clinic.

Medicare Participation

- If you are a Medicare provider, you must provide your Medicare identification numbers.
- Submit a copy of the Medicare number assignment letter or Medicare Remittance Notice associated with the Medicare numbers provided. The documentation helps the IHCP validate the numbers processed in Indiana*AIM*.
- Groups and clinics submit updated Medicare participation information for rendering providers linked to the groups' or clinics' service locations on the rendering provider packet included in this packet.

17. Medicare Number:	18. Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Number:

Medicare information permits claims to cross over automatically from Medicare

19. Address of Service Location to which the Medicare Number is Assigned:

Enter the street address where the Medicare number is assigned

Out-of-State Providers

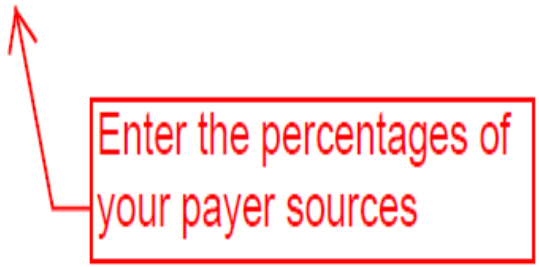
If you are an out-of-state provider and participate in your home state's Medicaid program, include proof of participation as an attachment to this packet.

20. Are you currently enrolled in your home state's Medicaid Program?

☐ Yes ☐ No

Patient Population Information

21. Percentage of patient population with the following payment sources: **(21 a, b, c, and d must add up to 100%)**	21a. Medicaid:	21b. Self-Pay:	21c. Medicare:	21d. Other Insurance:



Schedule C

Disclosed Individuals

Disclosure of Social Security numbers and dates of birth is required

IHCP Provider Schedule C - Disclosure Information

indianamedicaid.com

Overview

Please complete all four sections of this form. Nonprofit providers must provide information for the business entity that owns their tax identification number (TIN).

Disclosure Information: When completing this schedule to make changes to the list of disclosed individuals, make sure to include the names of all individuals that meet the disclosure requirements, even if the individuals had been previously disclosed. When an update is processed, any previously disclosed individuals that are not shown on the update form will be removed. In other words, the previous list of disclosed individuals will be **replaced** with the updated list of disclosed individuals.

Disclosure of Social Security Numbers: Schedule C is used to collect information required by State and federal regulations. Social Security numbers disclosed on this form are used to determine whether persons and entities named in an enrollment packet are federally excluded parties and to verify licensure. Refusal to provide a Social Security number will result in rejection of this enrollment packet.

Consent To Release Social Security Numbers: All persons whose names are written in boxes numbered 1a in sections C.1, C.2, and C.3, of this schedule are asked to place their signature in box 1b. A signature in box 1b indicates that the signatory agrees to the following statement regarding the disclosure of his or her Social Security number:

> My signature in box 1b in Schedule C, sections C.1, C.2, or C.3, indicates that I give my express consent to the Office of Medicaid Policy and Planning (OMPP) and its contractors to disclose my Social Security number for the sole purpose of verifying my eligibility to participate in the Medicaid program through the Office of the Inspector General, the Centers for Medicare & Medicaid Services, relevant licensing bodies, and other appropriate state and federal agencies.
>
> I further consent that the OMPP and its contractors may disclose my Social Security number to such appropriate organizations or agencies after this packet has been approved so that the office may review my ability to continue to participate in the Medicaid program.

C.1 - Disclosure Information - Ownership and Control, Provider Entity

(Attach additional copies of this page if space for additional names is needed.)

Disclosure of Ownership and Control, Provider Entity – List any PERSON OR ENTITY that has direct or indirect ownership interest equal to 5% or more of the value of the provider entity.

List any PERSON OR ENTITY that owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider entity if that interest equals 5% of the value of the property or assets of the provider entity.

If a corporation is publicly held and no person owns 5% or more of the corporation, or if the corporation is a not-for-profit entity, complete fields 1a and 3 in this section. Then, use section C.3 to list the Board of Directors.

1a. Legal Name: (Please Print)	1b. Signature:		
2. Title:	3. FEIN:	4. Social Security Number:	5. Date of Birth
6. Street Address:			
7. City:		8. State:	9. ZIP + 4: **(Nine digits required)**

1a. Legal Name: (Please Print)	1b. Signature:		
2. Title:			
6. Street Addres			
7. City:		8. State:	9. ZIP + 4: **(Nine digits required)**

If the entity is governed by a board of directors or government body, enter the legal name of the governing entity in field 1a, and include the entity's tax ID number in field 3. Leave all other fields blank.

C.1 - Disclosure Information - Ownership and Control, Provider Entity

(Attach additional copies of this page if space for additional names is needed.)

Disclosure of Ownership and Control, Provider Entity – List any PERSON OR ENTITY that has direct or indirect ownership interest equal to 5% or more of the value of the provider entity.

List any PERSON OR ENTITY that owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the provider entity if that interest equals 5% of the value of the property or assets of the provider entity.

If a corporation is publicly held and no person owns 5% or more of the corporation, or if the corporation is a not-for-profit entity, complete fields 1a and 3 in this section. Then, use section C.3 to list the Board of Directors.

1a. Legal Name: (Please Print)	1b. Signature:		
2. Title:	3. FEIN:	4. Social Security Number:	5. Date of Birth
6. Street Address: Enter the business address here. Do not enter a home address.			
7. City:		8. State:	9. ZIP + 4: **(Nine digits required)**

1a. Legal Name: (Please Print)	1b. Signature:		
2. Title:			
6. Street Addres			
7. City:		8. State:	9. ZIP + 4: **(Nine digits required)**

If the entity is governed by one or more individuals, enter the legal name, signature, title, SSN, DOB, and business address of each person with a 5% or more ownership interest. Do not complete field 3.

C.2 - Disclosure Information - Subcontractor Ownership, Control, and Relationships

(Attach additional copies of this page if space for additional names is needed.)

Disclosure of Subcontractor Ownership, Control, and Relationships – List any PERSON OR ENTITY that has an ownership or controlling interest in any subcontractor in which the provider entity has direct or indirect ownership of 5% or more.

1a. Legal Name: (Please Print)	1b. Signature:		
2. Title:	3. FEIN:	4. Social Security Number:	5. Date of Birth
6. Street Address:			
7. City:		8. State:	9. ZIP + 4: **(Nine digits required)**

Enter the business address here. Do not enter a home address.

1a. Legal Name: (Please Print)	1b. Signature:		
2. Title:			
6. Street Addr			
7. City:		8. State:	9. ZIP + 4: **(Nine digits required)**

Where the provider entity has at least a 5% ownership in a subcontractor entity, identify any person in your organization that has an ownership interest in that subcontractor business.

C.3 - Disclosure Information - Managing Individuals

(Attach additional copies of this page is space for additional names is needed.)

Managing Individuals – List ALL agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers must also list their managing individuals.

- An agent is any person who has express or implied authority to obligate or act on behalf of an entity.
- An officer is any person whose position is listed as an officer in the provider's articles of incorporation or corporate bylaws or is appointed as an officer by the board of directors or other governing body.
- A director is a member of the provider's board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word "director" in his or her job title, such as director of operations or departmental director.
- A managing employee is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of the provider entity.

1a. Legal Name: (Please Print)	1b. Signature:	
2. Title:	3. Social Security Number:	4. Date of Birth
5. Street Address:		
6. City:	7. State:	8. ZIP + 4: **(Nine digits required)**

Enter the business address here. Do not enter a home address.

1a. Legal Name: (Please Print)	1b. Signature:	
2. Title:		
5. Street Ad		
6. City:	7. State:	8. ZIP + 4: **(Nine digits required)**

Identify all owners, officers, members of the board of directors, government agency members, and office managers responsible for day-to-day operations.

C.4 - Disclosure Information - Relationships and Background Information

(Attach additional copies of this page if space is needed for additional names.)

1. Indicate if any of the individuals listed in Schedule C, sections C.1, C.2, or C.3, are related through blood or marriage, as spouse, parent, child, or sibling. Nonprofit providers must also complete section C.4. Use N/A as appropriate.

1a. Name of Person 1:	Name of Person 2:	Relationship:
1b. Name of Person 1:	Name of Person 2:	Relationship:
1		

Identify persons from Schedules C.1-C.3 who are related by blood or marriage. Indicate "N/A" if not applicable. Do not leave blank.

2. Indicate if any persons or entities listed in Schedule C, sections C.1, C.2, or C.3, or any secured creditors of the provider entity, have ever been sanctioned either through criminal conviction or exclusion from participation in any program under Medicare, Medicaid, or Title XX services since the inception of the programs.

2a. Name:	LPI or NPI:	Date of Sanction:
Type of Sanction:	Date Sanction Ended (please attach supporting documentation):	

Identify persons from Schedules C.1-C.3 who have ever been sanctioned related to past participation in Medicare, Medicaid, or Title XX programs. Indicate "N/A" if not applicable. Do not leave blank.

2c. Name:	LPI or NPI:	Date of Sanction:
Type of Sanction:	Date Sanction Ended (please attach supporting documentation):	

3. Indicate if any persons or entities listed in Schedule C, sections C.1, C.2, or C.3, or any secured creditors of the provider entity, have ever been placed on prepayment review.

3a. I

3b. I

3c. N

Identify persons from Schedules C.1-C.3 who have ever been placed on prepayment review. See Chapter 13 of the *IHCP Provider Manual* for an explanation of prepayment review. Do not leave blank.

4. Indicate if any persons or entities listed in Schedule C, sections C.1, C.2, or C.3, have an ownership or controlling interest in any other current or prospective IHCP provider.

4a. Name:	LPI or NPI:
4b. N	
4c. N	

Identify persons from Schedules C.1-C.3 who have an ownership interest in any current or prospective IHCP provider entity. Do not leave blank.

5. Indicate any former agent, officer, director, partner, or managing employee from Schedule C, sections C.1 through C.4, who has transferred ownership to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion.

5a. Name of Person 1:	Name of Person 2:	Relationship:
5b. N		
5c. N		

Identify if ownership has been transferred to a family member as per the instructions above. Do not leave blank.

Addendum

Mental Health Providers

This addendum is used by outpatient mental health providers only

IHCP Outpatient Mental Health Addendum

indianamedicaid.com

Supervising Physician or HSPP

Clearly identify the supervising practitioner's name, IHCP Legacy Provider Identifier (LPI), and National Provider Identifier (NPI). The supervising physician or HSPP must provide a copy of his or her license as an attachment to the packet.

1a. Supervising Physician or HSPP Name:	1b. IHCP Legacy Provider Indentifier (LPI):	1c. National Provider Identifier (NPI):
Name of psychiatrist, physician, or HSPP		
2a. Is Supervising Physician or HSPP: ☐ A Contractor ☐ An Employee	2b. Qualifications - License Number:	2c. Issuing State:

I, the undersigned, certify that I have read and understand the Outpatient Mental Health Addendum. I further certify that I am an employee or contractor of this clinic and supervise all plans of treatment as required by law and outlined in this addendum.

3a. Signature of Supervising Practitioner:	3b. Date:

Employees or Contracting Practitioners

You must complete the following information. Please list below the names, provider numbers (if available), provider types, and license information for all physician and/or other practitioners in your outpatient facility or clinic. For any midlevel practitioners, you must denote the provider type, such as psychologist, social worker, and so forth. Please attach an additional page if more space is needed. You must provide a copy of each practitioner's license.

Practitioner's Name (required)	LPI or NPI (if available)	Provider Type	Qualifications – License Number	Issuing State
1a.	1b.	1c.	1d.	1e.
2a.				2e.

Identify licensed mid-level practitioners here

Signature Section

An authorized official or owner of the provider entity must complete the Signature Section prior to submitting the addendum. A delegated administrator may sign this form. 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 on the *IHCP Delegated Administrator Addendum/Maintenance Form*. The IHCP can process provider maintenance requests only when the appropriate signature is present.

This form must be submitted with your IHCP Group and Clinic Provider Enrollment and Profile Maintenance Packet.

I, the undersigned on behalf of the provider, have read and understand the outpatient mental health addendum. I further certify that each practitioner listed on this list is an employee or contractor of our facility, each of these practitioners has been informed of the IHCP policy for reimbursement of outpatient mental health services, and each practitioner, whether employed or contracted, understands that he or she will be reimbursed for services by our facility. I further certify that all information provided is accurate to the best of my knowledge.

1. Legal Name of Outpatient Mental Health Clinic/Community Mental Health Center:	2. Taxpayer Identification Number (TIN):
Legal name must match Line 1 of Form W-9	

3. Clinic LPI:	4. Clinic NPI:	5. ZIP +4:	6. Taxonomy:
Group/Clinic LPI	Group/Clinic NPI		Group/Clinic Taxonomy

7. Authorized Official's Name (please print):	8. Title:
This person must be identified on Schedule C.1 or C.3	
9. Authorized Official's Signature: SIGN HERE	10. Date: Enter the date of signature

This signature page is used by outpatient mental health providers only

| Addendum

IHCP Provider Signature Authorization

indianamedicaid.com

Signature Authorization

The owner or an authorized official of the business entity, directly or ultimately responsible for operating the business, is the authorized signatory of this form. A delegated administrator may sign this form if it has been expressly indicated on an IHCP Delegated Administrator Addendum/Maintenance Form, on file or attached.

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 therein. The undersigned acknowledges that the commission of any Medicaid or Children's Health Insurance Program (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.

1. Legal Name of Provider's Business (please print):	2. Taxpayer Identification Number (TIN):
Legal name must match Line 1 on Form W-9	Must match Form W-9
3. Authorized Official's Name (please print):	4. Title:
This person must be identified on Schedule C.1 or C.3	
5. Authorized Official's Signature: SIGN HERE	6. Date: Enter the date of signature

This signature page is required for all providers

IHCP Provider Agreement

indianamedicaid.com

This agreement must be completed, signed, and returned to HP for processing.

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs. As an enrolled provider in the Indiana Health Coverage Programs, the undersigned entity agrees to provide covered services and/or supplies to Indiana Health Coverage Program members. As a condition of enrollment, this agreement cannot be altered and the Provider agrees to all of the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("FSSA").
2. To comply with all federal and state statutes and regulations pertaining to the Indiana Health Coverage Programs, as they may be amended from time to time.

Provider Agreement-Authorized Signature – All Schedules and Applicable Addenda	
The owner or an authorized representative of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. A delegated administrator must not sign this form.	
1. Legal Name of Provider's Business (Please Print): The legal name must match Line 1 on Form W-9	2. Taxpayer Identification Number (TIN):
3. Authorized Official's Name (Please Print): This person must be identified on Schedule C.1 or C.3	4. Title:
5. Authorized Official's Signature: SIGN HERE	6. Date: Enter the date of signature

This signature page is required for all providers. It cannot be signed by a "delegated administrator".

Addenda

Form W-9, Affordable Care Act, Electronic Funds Transfer, Signature on File

IHCP Provider Federal W-9 Addendum

indianamedicaid.com

W-9 Form

A W-9 must be completed and submitted with each provider enrollment, revalidation or change of ownership. A W-9 is also required when the legal name, home office address or taxpayer identification number changes. The name and address on the W-9 form must match the information in the Legal Name and Home Office Address section of the IHCP Provider Packet.

Follow these steps to complete the W-9:

1. Go to the irs.gov website.
2. Locate the W-9 form and click the link to download the form.
3. Complete the W-9 based on the instructions provided by the Internal Revenue Service.
4. Print the W-9 and mail it to HP Provider Enrollment with the rest of your IHCP Provider Packet.

Download Form W-9 from the irs.gov Web site. Instructions for completing Form W-9 are on the form itself

IHCP Provider Affordable Care Act Application Fee Addendum

indianamedicaid.com

Overview

The *Affordable Care Act* requires certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment and change of ownership, as required, and is assessed in full for each service location enrolled in the IHCP. See the Affordable Care Act (ACA) Requirements page on indianamedicaid.com for more information and payment options.

See the following documents to determine if you must pay a fee:

- IHCP Provider Enrollment Risk Category and Application Fee Matrix for non-waiver providers
- IHCP Provider Enrollment Risk Category and Application Fee Matrix for waiver providers

If a provider's service location is enrolled in Medicare or the provider pays an enrollment application fee to another state's Medicaid agency for a specific service location, the provider is not required to pay the IHCP an additional fee for that same service location.

On this form, please list your method of payment or reason for exemption. Submit this form with your IHCP Provider Packet.

1. Legal Name:

Must match Line 1 on Form W-9

2. Does the application fee apply to your provider type? Use the matrix linked above to verify whether you are required to pay a fee. If "NO," skip the rest of this form.

☐ Yes ☐ No

3. Is the service location enrolled in Medicare?

☐ No ☐ Yes – If yes, make certain all Medicare information is provided, as requested, in your IHCP Provider Packet. A fee payment is not required to the IHCP for this service location.

4. Have you paid an application fee to **another state's Medicaid program** for the service location?

☐ No ☐ Yes – If yes, please submit proof of payment with the IHCP Provider Packet. A fee payment is not required to IHCP for this service location.

5. Have you received a waiver of the application fee from **Medicare or another state's Medicaid program** because of financial hardship?

☐ No ☐ Yes – If yes, please submit a copy of the waiver letter with the IHCP Provider Packet. A fee payment is not required to IHCP for this service location.

6. Are you requesting a waiver of the application fee because of financial hardship?

☐ No ☐ Yes – If yes, please submit a letter explaining the financial hardship with the IHCP Provider Packet, including proof of inability to pay and a list of all attempts made to raise the required fee from outside sources, such as a loan denial.

7. If you answered **YES** to question 2 and **No** to questions 3, 4, 5, and 6, you are required to remit an application fee to the IHCP. Please select the method of payment below. Refer to Affordable Care Act (ACA) Requirements page on indianamedicaid.com for more detailed instructions about the payment process.

☐ Electronic payment made by phone or online, including credit card, debit card, or electronic funds transfer from your checking account. Please enter the electronic payment confirmation number:

☐ Check or Money Order – Please include a check or money order, made out to Indiana Health Coverage Programs with your IHCP Provider Packet. Make certain to include identifying information on the check or money order.

IHCP Affordable Care Act Provider Screening Addendum

indianamedicaid.com

Overview

(Attach additional copies of this page if space for additional names is needed.)

The Affordable Care Act requires that providers in the high risk category submit to fingerprinting and criminal background checks. You can determine the risk category of your provider type/provider specialty at enrollment and at revalidation by referencing the appropriate document below.

- IHCP Provider Enrollment Risk Category and Application Fee Matrix for non-waiver providers
- IHCP Provider Enrollment Risk Category and Application Fee Matrix for waiver providers

At its discretion, the State may assign a higher risk level to a provider which will supersede the CMS-assigned risk level noted on these documents. In these instances, the State-assigned risk level will apply to all enrollment-related transactions.

If you are assigned to the high-risk category, this addendum must be submitted with your IHCP Provider Packet. List the individuals from Schedule C, sections C.1 through C.3, who have at least 5% direct or indirect ownership interest in the business and provide the confirmation number they received at the fingerprint collection center as proof of compliance.

1. Business Legal Name:

Legal name must match Line 1 on Form W-9

2. Business Address:

Enter the Service Location address

3.Business Phone Number:	4. Email Address of Individual Who Can Answer Questions About This Form: Email address of person completing this form

Individuals Subject to Fingerprinting

5a. Legal Name of Disclosed Individual: Person must be identified on Schedule C.1 or C.3	5b. Fingerprint Confirmation Number:
5c. Social Security Number:	5d. Date of Birth:
5a. Legal Name of Disclosed Individual: Person must be identified on Schedule C.1 or C.3	5b. Fingerprint Confirmation Number:
5c. Social Security Number:	5d. Date of Birth:
5a. Legal Name of Disclosed Individual: Person must be identified on Schedule C.1 or C.3	5b. Fingerprint Confirmation Number:
5c. Social Security Number:	5d. Date of Birth:

| Addendum/Maintenance Form

IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form | indianamedicaid.com

Electronic Funds Transfer Overview

The Indiana Health Coverage Programs (IHCP) will establish a direct deposit account with your bank for claims payment. After you have established electronic funds transfer (EFT), the IHCP will electronically transfer payments into the account you specify on this form. Please read the instructions on this form carefully and ensure that the appropriate signature and attachment are included.

All claims successfully processed by Wednesday at 4:30 p.m. will appear on the weekly Remittance Advice, which is available on Monday of the following week. EFT payments occur each Wednesday.

It takes approximately 18 days for the bank to process and completely establish your EFT account. If you bill claims prior to your EFT activation, paper checks are mailed to the *Pay To* address documented on Schedule A of the IHCP Provider Packet. When your EFT account becomes active, direct deposits begin.

Thank you for considering EFT as a payment option.

The preferred method of receiving Medicaid payments is by Electronic Funds Transfer (EFT) deposits. Complete the next two pages to elect the EFT function

IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form

indianamedicaid.com

General Information

Complete all fields on form, and follow attachment instructions below. Confirm bank's ABA transit routing number.

1. Provider Legal Name:	2. Legacy Provider Identifier (LPI):	3. Service Location (alpha suffix):
Legal name must match Line 1 of Form W-9	Group LPI	

4. Provider Taxpayer Identification Number (TIN):	5. National Provider Identifier:	6. Taxonomy	7. Provider Location ZIP + 4:
	Group NPI	Group Taxonomy	

8. Name on Bank Account:	9. Bank Name:	10. TIN of Account Holder:

11. ABA Transit Routing Number:	12. Bank Account Number:
Nine-digit number found on the bottom left of checks	Located beside the routing number

13. Bank Address:

Refer to checks for this information, NOT a deposit slip

14. Bank City:	15. Bank State:	16. Bank ZIP + 4:

17. Bank Telephone Number:	18. Type of Account
	☐ Savings ☐ Checking — Choose one

19. Type of Authorization:	20. Transaction request is due to Change of Ownership
☐ Start ☐ Cancel ☐ Change	☐ Yes ☐ No — Choose one

Contact Information

The contact name and email relate to the person who can answer questions about the information provided in this packet.

21. Contact Name:	22. Telephone:
Name and email address of person completing this form	

23. Contact Email Address:

Authorized Signature Section

ATTACHMENT Required: Please include one of the following documents with this form for verification of account owner and account number: (1) voided check or (2) a signed letter from your bank that lists the account holder's name, taxpayer identification number (TIN), and the appropriate account and routing numbers.

On behalf of the provider entity named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of claim payments received from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept, as payment in full, the amount paid by the IHCP for claims submitted with the exception of authorized cost sharing by members. I understand payment of IHCP claims is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. I ensure that this EFT request complies with the regulation set forth in *42 CFR 447.10*, which prohibits State payments for any IHCP service to be made to anyone other than an enrolled provider, a non-cash member, or to one of the listed exceptions. I understand that an IHCP payment may be sent via EFT to an account held by the following only: (1) to an enrolled provider; (2) a non-cash member; (3) a government agency on reassignment by an enrolled provider (IRS); (4) a third party by court order on reassignment by an enrolled provider (child support); (5) a business agent (billing service, account firm) if three specific criteria are met (see Billing Agent Information); (6) the employer of a practitioner (if a contract so requires); or (7) a health care facility, or a health care delivery system (if a contract so requires), if the organization itself submits the claim directly to the IHCP.

I authorize the electronic transfer of IHCP payments (including 590, Medicaid, and Package C) be made to the above provider number. I understand that I am responsible for the validity of the above information. I agree to notify IHCP within ten days of any change in any of the information included on this form.

This section must be completed by an authorized official or owner of the billing provider. A delegated administrator may sign this form. 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 requests only when the appropriate signature is present.

24 Authorized Official's Name (please print):	25. Title:
This person must be identified on Schedule C.1 or C.3	
26. Authorized Official's Signature: SIGN HERE	27. Date: Enter the date of signature

Billing Agent Information

28. Does account belong to billing agency? If yes, please complete this section. If no, this section is not required:

☐ Yes ☐ No

Complete this section only when contracting with an outside billing company

The following sectio… …o a bank account belonging to a billi…

The exception for a… …e name of the provider, and the service provided by the agent is: (1) related to the cost of processing the bill; (2) not related to a percentage or other basis to the amount billed or collected; and (3) not dependent upon the collection of payment. Further, a payment for a

| Addendum/Maintenance Form

IHCP Claim Certification Statement for Signature on File Addendum/ Maintenance Form

indianamedicaid.com

IHCP Claim Certification Statement for Signature On File Overview

UB billers are required to submit the IHCP Claims Certification Statement for Signature on File

All UB billing providers that submit paper claims are required to complete this form. All other providers that submit claims electronically are not required to complete the form but should do so to cover instances in which submission of a paper claim is necessary. Rendering providers are not required to complete this form. After your request is processed, paper claims will not need a signature to be adjudicated, because the signature will be "on file." An owner, authorized official, or delegated administrator with the business must sign this form. The IHCP Delegated Administrator Addendum/Maintenance Form must be completed before a delegated administrator can sign. The delegated administrator can sign only for items expressly delegated. The IHCP can process provider maintenance requests only when the appropriate signature is present. **An original signature is required.**

IHCP Claim Certification Statement for Signature on File (please read carefully)

This is to certify that any and all information contained on any Indiana Health Coverage Programs (IHCP) billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (either by myself, my staff, and/or a third party acting on my behalf, such as a service bureau). I fully recognize that any billing intermediary or service bureau that submits billings to the Indiana Family and Social Services Administration (FSSA) or its Fiscal Agent Contractor is acting as my representative and not that of the FSSA or its Fiscal Agent Contractor. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for the purposes of submission of IHCP claims.

I understand that the standard paper claim form may include a signature line. I understand that all the stipulations, conditions, and terms of the provider agreement apply in the event that I fail, for any reason, to sign the paper claim, and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature in no way absolves me of the terms stated in the provider agreement that I have signed.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS CERTIFICATION STATEMENT, AND HAVING READ THIS CERTIFICATION STATEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL STIPULATIONS, CONDITIONS, AND TERMS SET FORTH THEREIN.

Authorized Signature Section

1. Legacy Provider Identifier (LPI):	2. Service Locations:	3. National Provider Identifier (NPI):
Enter the group LPI	Alpha suffix	Enter the group NPI
4. ZIP + 4: **(Nine digits required)**		5. Taxonomy: Enter the group taxonomy
6. Provider or Authorized Official's Name (Printed): This person must be identified on Schedule C.1 or C.3		7. Title:
8. Provider or Authorized Official's Signature: SIGN HERE		9. Date: Enter the date of signature

Contact Information

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

10. Contact Name:	11. Telephone:
Name and email address of person completing this form	
12. Contact Email Address:	

Change of Ownership

IHCP Provider Change of Ownership Addendum

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Change of Ownership Overview

Use the *IHCP Change of Ownership Addendum* to let the IHCP know when a change of ownership occurs or is anticipated. A change of ownership would include, but is not limited to, any of the following circumstances:

- For a sole proprietorship – When a provider of services is an entity owned by a single individual, and transfers title and property belonging to the enterprise to another person or firm, whether or not including a transfer of title to the real estate; or if the former sole proprietor becomes one of the members of a business entity succeeding him or her as the new owner.
- For a partnership – A new partnership, or the removal, addition, or substitution of an individual partner in an existing partnership, in the absence of an express statement to the contrary in the partnership agreement that dissolves the old partnership and creates a new partnership.
- For a corporation – A new corporation; the merger of the applicant or provider corporation into another corporation; the consolidation of two or more corporations; or any change resulting in the creation of a new corporation. In an incorporated provider entity, the corporation is the owner. The governing body of the corporation is the group having direct legal responsibility under state law for operation of the corporation's entity, whether that body is: a board of trustees; a board of directors; the entire membership of the corporation; or known by some other name.

A Rendering Provider Application is required for each rendering practitioner associated with the new (purchasing) entity. A separate enrollment packet is required for each service location individually.

New Ownership Document Requirements

When a change of ownership occurs the IHCP Change of Ownership Addendum must be completed as part of the overall IHCP Provider Packet. An entire packet must be completed for each service location, including the submission of licenses and other supporting documentation and payment or proof of payment of an application fee. The new owner must also submit a copy of the purchase agreement, bill of sale, or other documentation to verify the change of ownership.

Addendum Detail

The *IHCP Change of Ownership Addendum* is divided into the following sections:

- New Owner Information – Helps the IHCP identify the person or entity that is acquiring a currently enrolled provider business. If the new owner is currently enrolled with the IHCP, he or she completes all fields. If the new owner is not currently enrolled, he or she completes all fields except the provider IHCP provider number field.

IHCP Provider Change of Ownership Addendum

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Change of Ownership Information

1. Has a Change of Ownership Occurred?	1a. Actual Date of Change:	1b. Date of Expected Change:
☐ Yes ☐ No - Anticipated	See sales contract	

New Ownership Information

2. Legal Business Name:

Legal name must be registered with the Secretary of State and be listed on Line 1 of Form W-9

3. Taxpayer Identification Number (TIN):	4. Legacy Provider Identifier (LPI) (if currently enrolled):
New owner tax ID number	New owner LPI with alpha suffix

5. National Provider Identifier (NPI):	6. ZIP + 4: **(Nine digits required)**	7. Taxonomy:
New owner NPI		New owner taxonomy code

Previous Ownership Information

8. Legal Business Name:

Legal name must be on file with the IHCP and be listed on Line 1 of Form W-9

9. DBA Name for Service Location Being Acquired:

If a DBA is used, the name listed here must match the DBA name on file with the IHCP

10. Service Location Address:

Identify the service location street address of the selling entity

11. City:	12: State:	13. Service Location ZIP + 4: **(Nine digits required)**

14. Taxpayer Identification Number (TIN):	15. LPI:	16. Familial Relationship to Previous Owner:
Selling entity tax ID	Selling entity LPI	

17. National Provider Identifier (NPI):	18. ZIP + 4 associated with NPI: **(Nine digits required)**	19. Taxonomy:
Selling entity NPI		Selling entity taxonomy

Long Term Care Information

Submit the IHCP Provider Packet or send an impending change of ownership notification letter at least 45 days prior to the

Delegated Administrator

Complete this form only when utilizing a Delegated Administrator to perform tasks on behalf of persons identified on Schedule C.1 or C.3

| Addendum/Maintenance Form

IHCP Provider Delegated Administrator Addendum/Maintenance Form

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Overview

An authorized official may establish, change or revoke signature authority for a delegated administrator. The authorized official that is listed in field 9 and signs in field 11 must be identified on Schedule C, sections C1 through C3 of the IHCP Provider Packet.

Note: Signature authority for the *IHCP Provider Agreement* cannot be delegated. An authorized official is required to sign the *IHCP Provider Agreement*.

What is an authorized official? An authorized official must be a general partner, agent, officer, director, or managing employee who has expressed or implied authority to obligate or act on behalf of the provider entity. An authorized official also includes any individual who has operational or managerial control over, or who directly or indirectly conducts the day-to-day operations for the provider entity. An authorized official includes such individuals as a general manager, business manager, administrator, or director. Authorized officials are identified on Schedule C, sections C.1 through C.3 of the IHCP Provider Packet.

What is a delegated administrator? A delegated administrator is a person or entity (such as billing agency) to whom the enrolling provider's authorized official has granted the legal authority to do any or all of the following:

- Sign the IHCP Provider Enrollment and Maintenance Packet
- Make changes or updates to the organization's status in the IHCP
- Accept payment for services
- Submit claims for payment on behalf of the enrolled entity
- Commit the organization to the laws and regulations of the IHCP

1. Type of Request:

☐ **Establish a delegated administrator** – You are delegating authority to specific individual.

☐ **Change a delegated administrator's authority** – An individual has been previously set up as a delegated administrator and you are changing the tasks the individual is allowed to perform.

1. Type of Request:

- ☐ **Establish a delegated administrator** – You are delegating authority to specific individual.
- ☐ **Change a delegated administrator's authority** – An individual has been previously set up as a delegated administrator and you are changing the tasks the individual is allowed to perform.
- ☐ **Revoke a delegated administrator's authority** – An individual has been previously set up as a delegated administrator and you are cancelling all signature authority.

2. To establish or change a delegated administrator's authority, select tasks from this list (to revoke authority, skip to field 3):

As an authorized official of the provider entity, I assign signature authority to the delegated administrator named herein for the following. Any authority previously assigned to this individual is superseded by this authorization:

- ☐ Change Mail To (Non Check-Related info) Address
- ☐ Change Home Office Address
- ☐ Submit Name Change
- ☐ Change Tax ID, Submit W-9
- ☐ Submit Provider Specialty Change
- ☐ Add, Change, or Stop EFT
- ☐ IHCP Provider Signature Authorization
- ☐ Change Pay To (Checks and RAs) Address
- ☐ Change Service Location (Cert Code Letters) Address
- ☐ Submit License or Certification Updates
- ☐ Submit Updates to Rendering Provider Information
- ☐ Submit IHCP Outpatient Mental Health Addendum
- ☐ Submit the IHCP Provider Disenrollment Form for specific service location or to disenroll rendering provider linkages from a provider group only

3. Revoke all authority from the delegated administrator (when adding or changing authority, skip this field):

- ☐ As an authorized official of the provider entity, I revoke all authority from the delegated administrator named herein. Any authority previously assigned to this individual is superseded by this revocation.

Check the boxes to identify the tasks that the delegated administrator is authorized to perform. Update accordingly after staffing changes.

Contact Information

The contact name and email relate to the person who can answer questions about the information provided in this packet.

4. Contact Name:	5. Telephone:

6. Contact Email Address:

Authorized Signature Section

The undersigned, being the provider or having the specific authority to bind the provider to the terms of the provider agreement, and the named delegated administrator do 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 Children's Health Insurance Program (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.

7. Provider or Business Entity Legal Name:	8. Taxpayer Identification Number (TIN):
Legal name must match Line 1 of Form W-9	

9. Legacy Provider Identifier (LPI):	10. National Provider Identifier (NPI):	11. Taxonomy:	12. ZIP + 4: **(Nine digits required)**
Group LPI	Group NPI	Group Taxonomy	

13. Authorized Official's Name (please print):	14. Authorized Official's Title (please print):
Person identified on Schedule C.1 or C.3	

15. Authorized Official's Signature:	16. Date:
SIGN HERE	Date of signature

17. Delegated Administrator's Name (please print):

Name of the delegated administrator

18. Delegated Administrator's Signature (only required to establish or change a delegated administrator's authority):	19. Date:
SIGN HERE	Date of signature

Please submit one form per delegated administrator.

Rendering Practitioners

This portion of the application is to enroll and/or link rendering practitioners to the group

IHCP Rendering Provider Enrollment and Profile Maintenance Packet

indianamedicaid.com

Who Uses This Packet

Use this packet if you are a new or existing group or clinic to link practitioners, or rendering providers, to your business. Group or clinic providers complete and submit this enrollment packet on behalf of rendering providers associated with the group or clinic. The following provider types may be enrolled as rendering providers linked to groups or clinics.

09 – Advanced Practice Nurse

11 – Mental Health Provider (specialty 114)

14 – Podiatrist

15 – Chiropractor

17 – Therapist

18 – Optometrist

19 – Optician (with Optometry groups only)

20 – Audiologist

21 – Case Manager

27 – Dentist

31 – Physician

32 – Waiver

General Instructions

- This enrollment and maintenance packet can be used to do the following:

Check the box to:
•Enroll a rendering practitioner for the first time, or
•Link a currently enrolled rendering to your group

Schedule A

IHCP Rendering Provider Enrollment and Profile Maintenance Packet | indianamedicaid.com

To enroll multiple rendering providers, complete a separate Schedule A and Schedule B for each.

Type of Request

1.Type of Request:

- This form can be used for multiple purposes; select the purpose that applies:

☑ **New enrollment** – You are enrolling the rendering provider for the first time.

☑ **Profile Update** – The rendering provider is already enrolled and you need to change the provider's profile information.

☐ **Terminate Linkage** – The rendering provider is already enrolled and you need to terminate the provider's linkage to a service location.

- Only groups and clinics have rendering providers. The group or clinic's service location must be enrolled before the rendering provider can be linked to the service location.
- Groups and clinics do not need to submit rendering provider packets during revalidation. See the revalidation instructions of the *IHCP Group and Clinic Provider Enrollment and Profile Maintenance Packet*.

Group or Clinic Information

2. Group or Clinic's Legal Name:	3. Group or Clinic's Taxpayer Identification Number (TIN):
Legal name must match Line 1 of Form W-9	Group Tax ID

4. Mailing Address:	5. City:	6. State:	7. ZIP + 4 **(Nine digits required)**:

8. Group or Clinic's Legacy Provider Identifier (LPI) and Alpha Suffix: (If currently enrolled)	9. Group or Clinic's Medicare Number:
Group LPI with alpha suffix	Group Medicare number

10. Group or Clinic's National Provider Identifier (NPI):	11. NPI ZIP + 4 (Nine digits required):	12. Taxonomy Code:
Group NPI		Group Taxonomy

Rendering Provider Information

- Refer to the *IHCP Provider Type and Specialty Matrix* on indianamedicaid.com to determine the appropriate provider type, specialty codes, and enrollment requirements for this packet.
- Only one provider type code is permitted per packet. Only one **primary** specialty code is permitted per packet. Submit a separate packet for each additional provider type or primary specialty.
- A **taxonomy code identifies** a healthcare provider type and specialty; it is not a UPIN, Medicare provider number, or IHCP provider number. The full provider taxonomy code set can be found at wpc-edi.com under Reference. You may enter up to 3 taxonomies per form.
- By entering the rendering provider's Social Security number, you are providing consent to the Office of Medicaid Policy and Planning and its contractors to use the Social Security number for the sole purpose of verifying initial and continuing eligibility to participate in the Medicaid program with the Office of the Inspector General, the Centers for Medicare & Medicaid Services, licensing bodies, and other appropriate state and federal agencies.
- Submit documentation showing proof of the name change. A provider's updated license or appropriate certification may be presented as proof of a name change. If a provider license does not show the new name, an official document showing the legal name change is required. Rendering provider name changes do not require a new W-9.
- If the rendering provider is a qualified provider (QP) for Presumptive Eligibility (PE), terminating any specialties that qualified the provider may result in termination of QP PE status.

13. Rendering Provider's Current Name (Please Print):	14. Rendering Provider's Former Name (only required for name changes):

15. Rendering Provider's LPI (If currently enrolled):	16. Social Security Number:	17. Date of Birth:
Rendering provider LPI (no alpha suffix)	Required	Required

18. Rendering Provider's NPI:	19. NPI ZIP + **4 (Nine digits required):**	20. Taxonomy Code:
Rendering NPI (required)	ZIP Code + 4 of the group	Rendering taxonomy code

21. Provider Type (two digit code):	22. Primary Specialty Code (three digit code):	23. Additional Specialty Codes: (three digit codes)
See the Type/Specialty Matrix	See the Type/Specialty Matrix	

24. Rendering Provider's Taxonomies (maximum of 3 per form):

Additional rendering provider taxonomy codes

Group Service Location Linkage Information

A rendering provider may be linked to more than one service location. Also, because rendering providers can perform services across state lines for those groups that are in multiple states, the license number for each service location is required. If all the service locations are in the same state, fill in the license number one time and indicate "same" for the remaining linkage lines.

25a. Group Service Location Alpha Suffix:	25b. Group Service Location NPI:	25c. ZIP + 4 for Service Location: (Nine digits required)	25d. Requested Start Date at Service Location:	25e. Termination Date at Service Location:	25f. Rendering Provider Medicare # for Service Location:	25g. Rendering Provider License # for Service Location:	25h. Issuing State of License at Service Location:

Leave field 25e blank

Date the rendering began at this location

Enter the Group NPI for the service location

New enrollees and new service locations leave field 25a blank

The licensing or certification requirements for all rendering provider types are listed in the *IHCP Provider Type and Specialty Matrix* located on indianamedicaid.com. A copy of the license or certificate from the appropriate board or authority must be included as an attachment to the packet.

Additional Programs Requested

This packet is for enrollment to serve traditional Medicaid members and as the first step in the process of enrollment to serve members in the managed care programs. There is also the option to have this packet considered for enrollment as a provider in other IHCP programs, serving particular member populations. Please indicate if you are interested in enrolling as a provider in one or more of the following programs:

- The **590 Program** is a State medical assistance program providing reimbursement for medically necessary covered medical services provided at offsite facilities to individuals who reside in State institutions. The following provider types cannot be 590 providers: transportation, hospice, home health, DME, and long-term care facilities. Out-of-state providers cannot enroll as 590 providers.
- The **Pre-Admission Screening Resident Review (PASRR)** is a federally mandated screening and evaluation process. The process assesses people with mental illnesses or developmental disabilities who are being considered for nursing facility placement or nursing facility residents that have a significant change in their physical or mental condition. Diagnostic and Evaluation (D&E) teams must be contracted and approved by the Indiana Division of Disability and Rehabilitative Services (DDRS) and the Bureau of Developmental Disability Services (BDDS). Community mental health centers (CMHCs) must be contracted and approved by the Indiana Division of Mental Health and Addiction (DMHA). If you are a D&E team or CMHC, please include the approval letter as an attachment.
- The **Medical Review Program** provides determination of an applicant's eligibility for Medicaid under the disability category. A provider enrolled in the Medical Review Program is authorized to complete a medical assessment of an applicant and submit the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT issues a favorable … has a significant impairme… certain examinati… edicaid eligibility form. The…
  - **Medical Review Program/IHCP** – Providers that elect to enroll as an IHCP provider and choose to provide MRT assessment services.
  - **Medical Review Program Only** – Providers that do not elect to enroll in IHCP but choose to provide MRT assessment services only.

Ensure the Group and the Rendering practitioners are enrolled in the same programs

26. 590 Program Participation:	28. Participate in the Medical Review Program:
☐ Yes ☐ No	☐ Medical Review Program/IHCP
27. PASRR:	☐ Medical Review Program Only
☐ Yes ☐ No	☐ None

Managed Care Information

Once the rendering provider is enrolled as an IHCP provider, to subsequently enroll the provider with the IHCP's Managed Care Program, you must apply directly with one or more of the managed care entities. Please refer to the Health Plan Contacts page at indianamedicaid.com for contact information.

IHCP Rendering Provider Enrollment and Profile Maintenance Packet

indianamedicaid.com

To enroll multiple rendering providers, complete a separate Schedule A and Schedule B for each.

Contact Information

- The contact name and email relate to the person who can answer questions about the information provided in this packet.
- Providers will be enrolled to receive email notifications when new information is published to indianamedicaid.com. Provide the email address where these notifications should be sent.
- Email addresses will be used for IHCP business only and will not be sold or shared for other purposes.

1. Contact Name:	2. Telephone:
Name of person completing this form	

3. Contact Email Address:
Email address of person completing this form

4. Email Address for Provider Publications:
When listed here, the IHCP will send an email to alert when new publications are posted online

Authorization Signature

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.

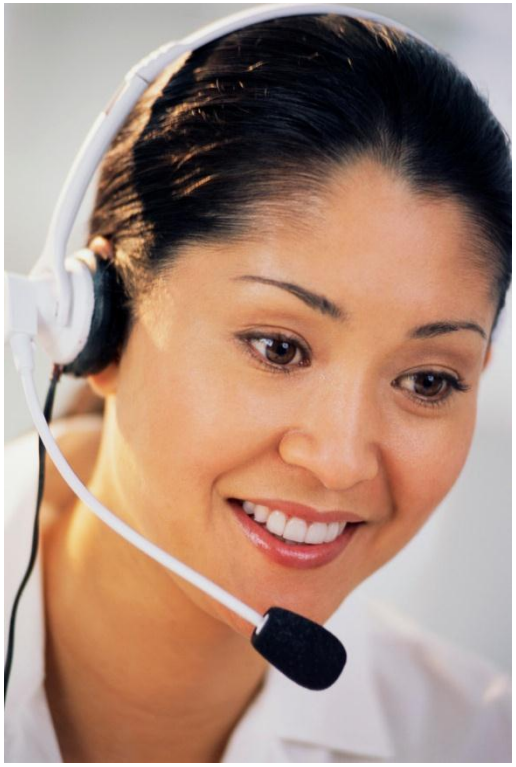
The owner or an authorized official of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. The *IHCP Delegated Administrator Addendum/Maintenance Form* must be completed before a delegated administrator can sign forms. The delegated administrator can only sign for items expressly delegated. The IHCP can only process provider maintenance requests when the appropriate signature is present. **The form will be returned if the appropriate signatures are not submitted.**

5. Group or Clinic's Business Name (please print):	6. Tax ID:
The business name must be listed on Line 1 of Form W-9	Group Tax ID (See Form W-9)
7. Authorized Official's Name (please print):	8. Title:
This person must be identified on Schedule C.1 or C.3	
9. Authorized Official's Signature: SIGN HERE	10. Date: Enter the date of signature


Find Help
Resources Available

Helpful Tools

Avenues of resolution



- Provider Enrollment page at indianamedicaid.com
- *IHCP Provider Manual, Chapter 4* (web, CD, or paper)
- Provider Enrollment Phone Line
  - 1-877-707-5750
- Provider field consultant directory
  - provider.indianamedicaid.com/contact-us/provider-relations-field-consultants.aspx

Q&A