FAMILY AND SOCIAL SERVICES ADMINISTRATION (FSSA)
OFFICE OF MEDICAID POLICY AND PLANNING (OMPP)

AGREEMENT

BETWEEN 590 FACILITIES AND OMPP

Based on the execution of this agreement, the undersigned entity (state facility) is assigned an Indiana Health Coverage Programs (IHCP) Provider ID for the exclusive purpose of obtaining 590 Program eligibility information. Eligibility information is available using the phone-based virtual assistant (GABBY), IHCP Provider Healthcare Portal or 270/271 Eligibility Benefit Inquiry and Response electronic transactions using approved vendor software – collectively referred to as the Eligibility Verification System (EVS). The EVS allows providers to verify member eligibility for members residing in state-operated facilities under the authority of the Indiana Department of Health (IDOH) and the Division of Mental Health and Addiction (DMHA). As a condition to the assignment of an IHCP Provider ID, the facility agrees to the following requirements:

- To safeguard information about 590 Program members obtained through the EVS, including but not limited to:
  - Any information received about a member's 590 Program eligibility
  - Any information received to verify a member's amount of medical assistance payments and/or benefit limitation
  - Any information received about third-party liability
  - Any information received about prior authorization for medical services for a member provided under the 590 Program
- Information about 590 Program members should be released only to the Indiana FSSA, an agent of the intended provider of service, and only when in connection with the following:
  - Providing services for members
  - Conducting or assisting an investigation prosecution, or civil or criminal proceeding related to the provision of 590 Program-covered services

THE UNDERSIGNED, HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH ABOVE.

Facility Name

Name of Authorized Representative – Signature

Title

Date of Signature

Facility Address Phone Number