IHCP Medicare-Only Provider Enrollment and Profile Maintenance Packet

in.gov/medicaid/providers

Before You Begin!

You are encouraged to use the Provider Healthcare Portal for submitting enrollment transactions to the Indiana Health Coverage Programs (IHCP). You will find the online process quick and easy, with online help features to guide you. When you complete your transaction, the Portal will provide a paper confirmation of your enrollment transaction that you will be able to print for your records.

For additional help using the Portal, online web-based training for the new Provider Healthcare Portal is available on the *Provider Healthcare Portal Training* page at in.gov/medicaid/providers.

If you are not able to use the Portal, you may use paper forms.

Who Uses This Packet

You should use this packet if you are a provider that is enrolling in the IHCP for the sole purpose of billing for Qualified Medicare Beneficiary (QMB) reimbursement from Indiana Medicaid, and will not be billing Indiana Medicaid for reimbursement of services.

If you intend to bill the IHCP for reimbursement of costs other than Medicare copayment and coinsurance for QMB-Only members, you must instead enroll under the appropriate provider type and specialty, using the applicable provider enrollment packet available from the Complete an IHCP Provider Enrollment Application webpage (or electronic equivalent on the IHCP Provider Healthcare Portal).

General Instructions

This enrollment and maintenance packet can be used for the following tasks:

- **Enrolling in the Indiana Health Coverage Programs (IHCP) for the first time** – Complete all fields in each section unless a section is optional and does not apply to you.
- **Submitting a change of ownership (CHOW)** – Complete all fields in each section, unless a section is optional and does not apply to you.
- **Adding a new service location to your business** – Complete all fields in each section unless a section is optional and does not apply to you.
- **Revalidating your current enrollment in the IHCP** – Complete all fields in each section unless a section is optional and does not apply to you.
- **Making updates to information about your business**, also known as your *provider profile* – Do not complete the entire packet; complete and submit only the pages of the packet and the supporting documentation that apply to the update. Only the following sections are required when using the packet to update your profile:
    - Schedule A – *Type of Request*
    - Schedule A – *Provider Information*
    - Schedule A – *Contact Information*
    - *IHCP Provider Signature Authorization Addendum*
    - Any section where the information has changed; if the information in a section has not changed, leave the section blank. For example, if the mailing address has changed but the pay-to address has not, complete the mailing address section and leave the pay-to address blank.

Provider Profile Updates and Revalidations

Providers that use the IHCP Provider Healthcare Portal (accessible from the home page at in.gov/medicaid/providers) to revalidate their enrollment or update their provider profile will find the process much quicker and easier than sending paper forms. Delegates with the proper authorization can also access the IHCP Portal to make profile changes.

Tips for Completing This Packet

- Read the instructions in each section of the packet carefully.
- Required addenda are included with this packet and must be submitted with the packet.
- Where sections of the packet request supporting documentation (such as a *W-9* form), the required documentation must be included as an attachment to the packet.
- All packet documents are interactive PDF files, allowing users to enter information into the fields directly from the computer. This information can then be saved to a file and printed for mailing. Using these interactive features facilitates both the packet's completion and review processes.

Next Steps

1. After completing this packet, including all applicable addenda, and collecting the necessary supporting documentation, perform a quality check using the following checklist. The quality check helps ensure that your packet can be processed in a timely manner. Incomplete packets cannot be processed. Failure to include all the required information will significantly delay your enrollment.

For Provider Use Only	Quality Checklist
	If you are updating your existing provider profile, do not complete the entire packet; double-check that only the following sections have been completed: Schedule A – *Type of Request* Schedule A – *Provider Information* Schedule A – *Contact Information* *IHCP Provider Signature Authorization Addendum* Any section where the information has changed; if the information in a section has not changed, leave the section blank. Submit only the pages of the packet and the supporting documentation that apply to the update.
	If you are enrolling for the first time, submitting a change of ownership, adding a service location or revalidating your enrollment, double-check that **all sections** of this packet have been completed and signed. If a question or section is not applicable, you should indicate N/A to attest that it does not apply.
	Although the Medicare-Only Provider type is designated "limited risk" by default, the risk level assignment of an individual provider may be increased at any time at the discretion of the state. If you have been notified by the IHCP that you are considered "high risk," be sure to include the ***IHCP Provider Screening Addendum***. You should complete Medicaid fingerprint activities for all required individuals before submitting your packet. For detailed instructions, see the *Provider Enrollment Risk Levels and Screening* page at in.gov/medicaid/providers.
	Make sure you have attached a completed, current *Form W-9* from the Internal Revenue Service (IRS) website at irs.gov. Failure to use the most current version of *Form W-9* available at the time of submission may result in the application being returned to the provider.
	Double-check that you have provided the proper type of NPI based on the organizational structure of your business. (Practitioners doing business as an individual or a sole proprietor must enroll using a Type 1 NPI; facilities enrolling as a business entity must enroll using a Type 2 NPI.)
	Ensure that you have indicated whether you are recognized by the IRS as a disregarded entity (select Yes or No). If you are recognized as a disregarded entity, ensure that you have entered the correct provider name and taxpayer identification number (TIN), according to the instructions provided on the back of the W-9.
	Double-check that the service location name, or doing business as (DBA) name, in the *Service Location Name and Address* section of Schedule A **exactly** matches the business name on the attached *W-9* form (see line 2 of the *W-9*).
	Double-check that the name and address in the ***Provider Name and Address (As Entered on the W-9)*** section of Schedule A **exactly** match the information on the attached *W-9* form (see lines 1, 5 and 6 of the *W-9*).

For Provider Use Only	Quality Checklist
	Double-check that the **Medicare-Only Provider Agreement** has been signed by an owner or authorized official of the business who is directly or ultimately responsible for operating the business and who is listed in Schedule C. (Note: If the person named as the delegated administrator is not reported as having ownership or controlling interest, that person cannot sign the Medicare-Only Provider Agreement.)
	Double-check that the required addenda, as applicable, are completed and included with the packet: *IHCP Provider Signature Authorization Addendum* (all) *IHCP Medicare-Only Provider Agreement* (all) Current version of the federal *W-9* form (all) *IHCP Provider Screening Addendum* (as applicable) *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form* (as applicable) *IHCP Provider Change of Ownership Addendum* (as applicable) *IHCP Provider Delegated Administrator Addendum/Maintenance Form* (as applicable)
	If you are registered with the Secretary of State or the county recorder's office, please include documentation as an attachment to the packet.
	If you are submitting the ***IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form***, double-check to ensure that all fields have been completed appropriately; that the account number and routing numbers are correct; and that the *Authorized Signature* section has been signed by an authorized official or owner of the billing provider or a delegated administrator.
	If you are completing this packet to report a **change of ownership** (CHOW), complete the ***IHCP Provider Change of Ownership Addendum*** and include a copy of the purchase or sales agreement as an attachment to the packet.

2. Print the completed packet. It is important to return all pages in the packet, in the correct page number order, with all required documents.
3. Make a copy of the packet for your records.
4. Mail the packet, including all required addenda and supporting documentation, to the following address:

   IHCP Provider Enrollment Unit
   P.O. Box 7263
   Indianapolis, IN 46207-7263
5. If the packet needs correcting or is missing required documentation, the IHCP Provider Enrollment Unit will contact you by telephone, email, fax or mail. This contact is intended to communicate what needs to be corrected, completed and submitted before the IHCP can process your enrollment transaction. If an application is rejected for missing or incomplete information, a letter will be sent indicating what needs to be corrected or attached. When submitting the correction or missing information, providers MUST return the entire packet, along with a copy of the letter explaining the errors or omissions as a cover sheet.
6. You will be notified via regular mail after your application has been approved. Please allow 15 business days plus mailing time before inquiring about the status of your application.

Type of Request

1. Type of request:

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

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.

Provider Information

- The **National Provider Identifier (NPI)** must be the proper NPI type based on the organizational structure of the enrolling service location (individual or entity). A healthcare provider that is conducting business as an **individual** or as a **sole proprietor** (including single-member Limited Liability Companies [LLCs] electing to do business as individuals), even if the individual operates under a doing business as (DBA) designation, must use a **Type 1 NPI**. A healthcare provider that is conducting business as an **organization** or distinct subpart of an organization (including single-member LLCs electing to do business as corporations), must use a **Type 2** NPI.
- The **ZIP Code** entered in this section should be the ZIP Code associated with the service location for the provider. The full, nine-digit code is required.
- The **taxonomy code** requested in field 4 is the taxonomy associated with the NPI in field 2. A taxonomy code identifies a healthcare provider type and specialty. The taxonomy code set is maintained by the National Uniform Claim Committee (NUCC), which provides an online lookup tool at taxonomy.nucc.org.
- For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "**disregarded entity**." See *Code of Federal Regulations* section *301.7701-2(c)(2)(iii)*. Select Yes in field 5 only if you are recognized by the IRS as a disregarded entity; otherwise, you must select No.

2. National Provider Identifier (NPI):	3. ZIP + 4 (nine digits required):	4. Taxonomy code:	5. Are you a disregarded entity? Yes No

6a. Are you currently enrolled as an IHCP provider? Yes No	6b. If yes, what is your IHCP Provider ID?
7a. Were you previously enrolled as an IHCP provider? Yes No	7b. If yes, what was your previous IHCP Provider ID?
8. 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	9. Requested enrollment effective date:

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 signed up to receive email notifications when new information is published to in.gov/medicaid/providers. Enter 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.

10. Contact name:	11. Title:
12. Contact email address:	13. Contact telephone:

14. Preferred method of communication:

Email Phone Mail

Service Location Name and Address

- The service location name is the name of the entity (individual or business) providing services:
  - If you are operating under a **doing business as (DBA)** designation different from the name in line 1 of the *W-9* form, enter the DBA name as your service location name. The name entered must match the business name in line 2 of the attached *W-9* form. You must also attach copies of registration documentation from the Secretary of State or your county recorder's office showing the DBA (*405 IAC 1-19.1b*) has been registered.
  - If you are recognized by the IRS as a **disregarded entity**, you may enter the name of the disregarded entity as the service location name. The name entered must match the business name in line 2 of the attached *W-9* form.
- The service location is generally the site where members obtain services and is either owned or rented by the provider; it is usually where supporting documentation related to claims is maintained.
  - Providers that provide services at a "place-of-service site," such as at a hospital, nursing facility or member's home, should enter their home/business office as their service location address.
  - **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 **update** a service location name currently on file with the IHCP, the following apply:
  - 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 or your county recorder's office 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 name change is required.
  - If the same change applies to both your provider name (see the *Provider Name and Address* section) and your service location/DBA name, one set of attached documents will support both changes.

15. Service location/DBA name:		
16. Indiana county (Indiana providers):		17. Telephone:
18. Service location street address:		
19. City:	20. State:	21. ZIP + 4 (nine digits required):
22. Is claim documentation kept at this location? Yes No	23. Are services provided in Indiana? Yes No	

Provider Name and Address (As Entered on the W-9)

- The name, address and taxpayer identification number (TIN) entered in this section must match **exactly** the information reported on the *W-9* form attached to your IHCP enrollment.
- In this section, the provider name is considered to be the entity maintaining ownership of the business. The provider name must be the name in line 1 of the current *W-9* form, which is the name on the tax return on which the income should be reported:
  - **If you are conducting business as an individual or sole proprietor** (even if you have a registered DBA), enter **your personal name** as the provider name. You may use **your Social Security number (SSN) or federal employer identification number (EIN)** as the TIN associated with the enrollment.
  - **If you are an organization conducting business as an entity**, such as a corporation or partnership, enter **your business name** as the provider name. You must use **the business' federal EIN** as the TIN associated with the enrollment.
  - **If you are recognized by the IRS as a "disregarded entity"** (an entity that is disregarded as an entity separate from its owner), you must enter the **name of the owner** (individual or entity) as the provider name. If the direct owner of the entity is also a disregarded entity, enter the first owner that is **not** disregarded for federal tax purposes; the provider name should never be a disregarded entity. Disregarded entities must enter **the owner's EIN (or SSN, if the owner has one)** as the TIN. Do not enter the disregarded entity's EIN.
- The provider address is the address of the entity that maintains ownership of the business. For most providers, the provider address is the home office address.
- If you are using this packet to update your provider name or address currently on file with the IHCP, the following apply:
  - You must include a revised *W-9* form as an attachment to the packet.
  - For a personal name change, attach 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 the provider name changes on the *W-9* form, a new *W-9* must be submitted.
  - If the same change applies to both your provider name and your service location/DBA name, one set of attached documents will support both changes.

24. Provider name (as it appears on the *W-9*):				
25. Provider street address (as it appears on the *W-9*):				
26. City:			27. State:	28. ZIP + 4 (nine digits required):
29. Telephone:	30. Current TIN:		31. Former TIN (required only for reporting TIN change):	

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.

32. Mail-to name (addressee):		33. Telephone:
34. Mailing street address:		
35. City:	36. State:	37. ZIP + 4 (nine digits required):

Pay-To Name and Address

- The pay-to address is the location where the IHCP sends checks and general claim-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.**

38. Pay-to name (payee):		
39. Billing agent name (if applicable):		40. Pay-to telephone:
41. Pay-to street address:		
42. City:	43. State:	44. ZIP + 4 (nine digits required):

Provider Specialty Information

45. Provider type (two-digit code):	46. Provider specialty (three-digit code):	47. Taxonomy code associated with specialty and used for billing:
37	**370**	

Organizational Structure

- Check the appropriate box for the federal tax classification of the provider. See instructions on the *W-9* form, including special instructions for disregarded entities.
- 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 company 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 or single-member LLC
C Corporation
S Corporation
Partnership
Trust/estate
Limited liability company (LLC); select tax classification:
C Corporation S Corporation Partnership Reset
Other (please explain; see instructions on *W-9* form):

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 in.gov/sos to find out how to complete the registration process.):
Yes No

3. Date business started:	4. Entity incorporated: Yes No	5. Incorporation date (if answered yes in 4):
6. Chain affiliated: Yes No	7. Operated by management company or leased (whole or part) by another organization: Yes No	

Medicare Participation

You must provide your Medicare identification numbers.

8. Medicare number:	9. Medicare durable medical equipment, prosthetics orthotics and supplies (DMEPOS) number:
10. Address of service location to which the Medicare number is assigned:	

Patient Population Information

11. Percentage of patient population with the following payment sources: **(11 a, b, c and d must add up to 100%)**	11a. Medicaid:	11b. Self-pay:	11c. Medicare:	11d. Other insurance:

IHCP Provider Schedule C – Disclosure Information

Overview

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

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

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 this form are federally excluded parties. Refusal to provide a Social Security number will result in rejection of this enrollment maintenance form.

Consent to Release Social Security Numbers: Submission of information on this schedule indicates that consent has been given to the Indiana Family and Social Services Administration (FSSA) and its contractors to use the information, including the Social Security number, for the sole purpose of verifying 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. It is further understood that the FSSA and its contractors may use a Social Security number so the office may determine eligibility for continued participation in the Medicaid program.

C.1 – Disclosure Information – Individuals and/or Corporations with an Ownership or Controlling Interest in the Applicant

Section C.1.(A) – Individuals with an Ownership or Controlling Interest

Please list **all** individuals with an ownership or controlling interest in the applicant. Include each person's name, address, the individual's date of birth and Social Security number. Also indicate the title (for example, chief executive officer, owner, board member) and, if an owner, the percent of ownership. Attach additional pages as needed.

* Please refer to *42 CFR 455.101* for the definition of "person with an ownership or control interest" to ensure that all individuals are included. This should also include officers, directors or partners as defined in sections *455.101(e)* and *(f)*.

1a. Name of individual:			
2a. Address:			
3a. Title:	4a. % of ownership (if applicable):	5a. Social Security number:	6a. Date of birth:
1b. Name of individual:			
2b. Address:			
3b. Title:	4b. % of ownership (if applicable):	5b. Social Security number:	6b. Date of birth:
1c. Name of individual:			
2c. Address:			
3c. Title:	4c. % of ownership (if applicable):	5c. Social Security number:	6c. Date of birth:
1d. Name of individual:			
2d. Address:			
3d. Title:	4d. % of ownership (if applicable):	5d. Social Security number:	6d. Date of birth:
1e. Name of individual:			
2e. Address:			
3e. Title:	4e. % of ownership (if applicable):	5e. Social Security number:	6e. Date of birth:
1f. Name of individual:			
2f. Address:			
3f. Title:	4f. % of ownership (if applicable):	5f. Social Security number:	6f. Date of birth:

Section C.1.(B) – Corporations with an Ownership or Controlling Interest

If a corporation, please list **all** corporations with an ownership or controlling interest in the applicant. Include the percent of ownership in the applicant, taxpayer identification number (TIN), whether the corporation is recognized by the IRS as a disregarded entity, the primary business address, every business location and P.O. Box address(es). Attach additional pages if needed.

1a. Name of corporation:		
2a. % of ownership:	3a. TIN:	4a. Is this corporation a disregarded entity? Yes No
5a. Primary business address:		
6a. Every business location:	7a. P.O. Box address(es):	

1b. Name of corporation:		
2b. % of ownership:	3b. TIN:	4b. Is this corporation a disregarded entity? Yes No
5b. Primary business address:		
6b. Every business location:	7b. P.O. Box address(es):	

1c. Name of corporation:		
2c. % of ownership:	3c. TIN:	4c. Is this corporation a disregarded entity? Yes No
5c. Primary business address:		
6c. Every business location:	7c. P.O. Box address(es):	

Section C.1.(B) – Corporations with an Ownership or Controlling Interest *(continued)*

If a corporation, please list **all** corporations with an ownership or controlling interest in the applicant. Include the percent of ownership in the applicant, taxpayer identification number (TIN), whether the corporation is recognized by the IRS as a disregarded entity, the primary business address, every business location and P.O. Box address(es). Attach additional pages if needed.

1d. Name of corporation:		
2d. % of ownership:	3d. TIN:	4d. Is this corporation a disregarded entity? Yes No
5d. Primary business address:		
6d. Every business location:	7d. P.O. Box address(es):	

1e. Name of corporation:		
2e. % of ownership:	3e. TIN:	4e. Is this corporation a disregarded entity? Yes No
5e. Primary business address:		
6e. Every business location:	7e. P.O. Box address(es):	

1f. Name of corporation:		
2f. % of ownership:	3f. TIN:	4f. Is this corporation a disregarded entity? Yes No
5f. Primary business address:		
6f. Every business location:	7f. P.O. Box address(es):	

C.2 – Disclosure Information – Subcontractors

(Attach additional copies of this page if you need space for additional names.)

Subcontractors – Please list all subcontractors in which the applicant has a 5% or more ownership or controlling interest Include any subcontractor and their address and taxpayer identification number (TIN). Attach additional pages as needed.

Name of subcontractor	Address	TIN

C.3 – Disclosure Information – Managing Individuals

(Attach additional copies of this page if you need space for additional names.)

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 and government-owned businesses must also list their managing individuals.**

- An agent is any person who has express or implied authority to obligate or act on behalf of the 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 persons who have the word director in their 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. Name of individual:		
2a. Address:		
3a. Title:	4a. Social Security number:	5a. Date of birth:
1b. Name of individual:		
2b. Address:		
3b. Title:	4b. Social Security number:	5b. Date of birth:
1c. Name of individual:		
2c. Address:		
3c. Title:	4c. Social Security number:	5c. Date of birth:
1d. Name of individual:		
2d. Address:		
3d. Title:	4d. Social Security number:	5d. Date of birth:
1e. Name of individual:		
2e. Address:		
3e. Title:	4e. Social Security number:	5e. Date of birth:
1f. Name of individual:		
2f. Address:		
3f. Title:	4f. Social Security number:	5f. Date of birth:

C.4 – Disclosure Information – Relationships and Background Information

(Attach additional copies of this page if you need space for additional names.)

1. Are any parties listed in C.1 or C.3 related to each other as a spouse, parent, child or sibling? If "Yes," please list their names and the relationship.

Name of person 1	**Name of person 2**	**Relationship**

2. Are any parties listed in C.1 or C.3 related to any individuals with an ownership or controlling interest in any of the subcontractors listed in C.2? If "Yes," please list their names and the relationship.

Name of person 1	**Name of person 2**	**Relationship**

3. Do any of the owners included in C.1. have an ownership or controlling interest in another organization(s) that would qualify as a disclosing entity?

As defined under 42 CFR 455.101, "other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII or XX of the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic or health maintenance organization that participates in Medicare (title XVIII);

b) Any Medicare intermediary or carrier; and

c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid providers, "other disclosing entity" can include entities that are not enrolled in Medicaid.

Yes No

If yes, please list the name of each owner and the name of the other disclosing entity(ies) in which they have an ownership or controlling interest. If the entity is a non-profit organization and does not have any "owners," please check NA .

Owner's name	**Disclosing entity(ies)**

4. Please list any party with an ownership or controlling interest, or who is an agent or managing employee, who has ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid or Title XX services programs.	
Name of convicted party	**Date of conviction**

5. Indicate any former agent, officer, director, partner or managing employee 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.		
Name of person 1	**Name of person 2**	**Relationship**

IHCP Provider Signature Authorization

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. Provider name (as it appears on the *W-9*):	2. Taxpayer identification number (TIN):
3. Authorized official's name:	4. Title:
5. Authorized official's signature:	6. Date:

| Overview

IHCP Medicare-Only Provider Agreement

in.gov/medicaid/providers

IHCP Medicare-Only Provider Agreement Overview
The **Medicare-Only** Provider Agreement details the requirements for participation in the Indiana Health Coverage Programs (IHCP). Included are provider responsibilities regarding updating provider information and protecting patient health information as well as requirements for claim processing, overpayments and record retention. In addition, the Agreement details obligations regarding the appeals process; civil rights regulation compliance; and utilization, control and disclosure rules. The entire Agreement must be read, signed and returned with the application. A signed copy must be retained by the provider.

| Medicare-Only Provider Agreement

IHCP Provider Agreement

in.gov/medicaid/providers

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

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a Medicare-Only provider in the Indiana Health Coverage Programs ("IHCP") for the sole purpose of billing for Qualified Medicare Beneficiary (QMB) reimbursement from Indiana Medicaid, and will not be billing Indiana Medicaid for reimbursement of services. As an enrolled provider in the IHCP, the undersigned entity agrees to provide covered services and/or supplies to Indiana Health Coverage Program members ("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 IHCP, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.
4. To notify FSSA or its agent within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.
5. To safeguard information about members including at a minimum:
   a. members' name, address, and social and economic circumstances;
   b. medical services provided to members;
   c. members' medical data, including diagnosis and past history of disease or disability;
   d. any information received for verifying members' income eligibility and amount of medical assistance payments;
   e. any information received in connection with the identification of legally liable third party resources.
6. To release information about members only to the FSSA or its agent and only when in connection with:
   a. providing services for members; and
   b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of IHCP covered services.
7. To maintain a written contract with all subcontractors, which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.
8. To notify the IHCP in writing of the name, address, and phone number of any entity acting on Provider's behalf for electronic submission of Provider's claims. Provider understands that the State requires 30 days prior written notice of any changes concerning Provider's use of entities acting on Provider's behalf for electronic submission of Provider's claims and that such notice shall be provided to the IHCP.
9. To submit claims, using only the billing number assigned to it by FSSA or its fiscal agent, for services rendered by the Provider or employees of the Provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital, ICF-IID, or nursing home), or a government agency with a contract that meets the requirements described in item 7 of this Agreement.
10. To abide by the *IHCP Provider Reference Modules* as amended from time to time, as well as all provider bulletins, banner pages, and notices.
11. To submit timely billing on IHCP-approved electronic or paper claims, as outlined in the policy manual, reference modules, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.
12. To certify that any and all information contained on any IHCP billings submitted on the Provider's behalf by electronic, telephonic, mechanical, or standard paper means of submission shall be true, accurate, and

complete. The Provider accepts total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (whether by the Provider, the Provider's employees, agents, or a third party acting on the Provider's behalf, such as a service bureau). The Provider fully recognizes that any billing intermediary or service bureau that submits billings to the FSSA or its fiscal agent contractor is acting as the Provider's representative and not that of the FSSA or its fiscal agent contractor. The Provider further acknowledges that any third party that submits billings on the Provider's behalf shall be deemed to be the Provider's agent for the purposes of submission of the IHCP claims. The Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable federal and state laws.

13. To submit claim(s) for IHCP reimbursement only after first exhausting all other sources of reimbursement as required by the policy manual, reference modules, bulletins, and banner pages.
14. To submit claims that can be documented by Provider as being strictly for:
    a. medically necessary medical assistance services;
    b. medical assistance services actually provided to the person in whose name the claim is being made; and
    c. compensation that Provider is legally entitled to receive.
15. To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for IHCP covered services provided to members. Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for IHCP covered services, excluding any co-payment permitted by law.
16. To refund duplicate or erroneous payments to FSSA or its fiscal agent within fifteen (15) days of receipt.
17. To make repayments to FSSA or its fiscal agent, or arrange to have future payments from the IHCP withheld, within sixty (60) days of receipt of notice from FSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. Outstanding overpayments made under prior provider agreements will remain collectable under this provider agreement.
18. To pay interest on overpayments in accordance with *Indiana Code (IC) 12-15-13-3, IC 12-15-21-3*, and *IC 12-15-23-3*.
19. To make full reimbursement to FSSA or its fiscal agent of any federal disallowance incurred by FSSA when such disallowance relates to payments previously made to Provider under the IHCP.
20. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
21. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of IHCP payments made to Provider, to assure the proper administration of the IHCP and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 Indiana Administrative Code (IAC) 1-5* and in the policy manual, reference modules, bulletins, and banner pages, and shall include, without being limited to, the following:
    a. medical records as specified by *42 United States Code (USC) 1396(a)(27)*, and any amendments thereto;
    b. records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs, or services;
    c. any records determined by FSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the IHCP;
    d. documentation in each patient's record that will enable the FSSA or its agent to verify that each charge is due and proper;
    e. financial records maintained in the standard, specified form;
    f. all other records as may be found necessary by the FSSA or its agent in determining compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the FSSA; and
    g. any other information regarding payments claimed by the provider for furnishing services to the plan.
22. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
    a. the petitioner is the person to whom the order is specifically directed;
    b. the petitioner is aggrieved or adversely affected by the order; or
    c. the petitioner is entitled to review under the law.
23. Provider must file a statement of issues within the time limits listed below, setting out in detail:
    a. the specific findings, actions, or determinations of FSSA from which the Provider is appealing; and
    b. with respect to each finding, action, or determination, all statutes or rules supporting the Provider's contentions of error and why the Provider believes that the office's determination was in error.

24. Time limits for filing an appeal and the statement of issues are as follows:
    a. A provider must file an appeal of any of the following actions within sixty days of receipt of FSSA's determination:
        (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
        (2) A notice of overpayment.

       The statement of issues must be filed with the request for appeal.
    b. All appeals of actions not described in (a) must be filed within 15 days of receipt of FSSA's determination. The statement of issues must be filed within 45 days of receipt of FSSA's determination.
25. To cooperate with FSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.
26. To comply with the advance directives requirements as specified in *42 Code of Federal Regulations (CFR) Part 489, Subpart I*, and *42 CFR 417.436(d)*, as applicable.
27. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of an IHCP covered service.
28. The Provider and its agents shall abide by all ethical requirements that apply to persons who have a business relationship with the State, as set forth in *IC § 4-2-6 et seq.*, *IC § 4-2-7, et seq.*, the regulations promulgated thereunder, and *Executive Order 04-08*, dated April 27, 2004.
29. To disclose information on ownership and control, information related to business transactions, information on change of ownership, and information on persons convicted of crimes in accordance with *42 CFR, Part 455, Subpart B*, and *405 IAC 1-19*. Pursuant to *42 Code of Federal Regulations, part 455.104(c)*, OMPP shall terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
30. To furnish to FSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in the IHCP Provider Application and maintenance forms, which are incorporated here by reference, and to update this information as it may be necessary.
31. The effective date of this Agreement will be the date set out in the provider enrollment notification letter. This Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider. This Agreement shall remain in effect until terminated in accordance with item 32 below.
32. That this Agreement may be terminated as follows:
    a. By FSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by FSSA pursuant to *405 IAC 1-1-6*; or
    b. By FSSA or its fiscal agent, or by Provider, without cause upon 60 days' written notice.
33. To verify and maintain proof of verification that no employee or contractor is an excluded individual or entity with the Health and Human Services (HHS) Office of the Inspector General (OIG). Providers shall review the HHS-OIG List of Excluded Individuals/Entities (LEIE) database for excluded parties. This LEIE database is accessible to the general public at http://www.oig.hhs.gov/fraud/exclusions.asp.

AS A CONDITION OF PAYMENT AND CONTINUED ENROLLMENT IN THE IHCP THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND 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 HEREIN. THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY INDIANA HEALTH COVERAGE PROGRAM 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.

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):	2. Taxpayer Identification Number (TIN):
3. Authorized official's name (please print):	4. Title:
5. Authorized official's signature:	6. Date:

IHCP Provider Federal *W-9* Addendum

W-9 Form

A *W-9* form must be completed and submitted with each provider enrollment, revalidation, or change of ownership. Providers must use only the **current version** of the *W-9,* available on the Internal Revenue Service (IRS) website. Failure to submit the current version may result in the application being rejected and returned to the provider.

A *W-9* is also required when the provider name, legal (home office/owner) address, or taxpayer identification number (TIN) changes.

The name in line 1 and the address in lines 5 and 6 of the *W-9* form must match the information in the *Provider Name and Legal Address* section of the Indiana Health Coverage Programs (IHCP) provider packet. If the service location name or doing business as (DBA) name is different from the provider name, it must match the name in line 2 of the W-9.

Follow these steps to obtain and complete the current version of the IRS *W-9* form:

1. Go to the IRS website at irs.gov.
2. Locate the *W-9* form and click the link to download the form.
3. Complete the *W-9* form based on the instructions provided by the IRS, including special instructions for disregarded entities, if applicable.
4. Print the *W-9* form and mail it to the IHCP Provider Enrollment Unit along with your completed IHCP provider packet or maintenance form.

| Addendum

IHCP Provider Screening Addendum

in.gov/medicaid/providers

Overview

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

Federal and State laws require that Indiana Health Coverage Programs (IHCP) providers in the high-risk category submit to Medicaid 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 *IHCP Provider Enrollment Risk Category and Application Fee Matrix*.

Please note that the risk level assignment of an individual provider may be increased at any time at the discretion of the State. In these instances, the provider is notified by the IHCP, and the new risk level will apply to processing enrollment-related transactions.

If you are assigned to the high-risk category, this addendum must be submitted with your IHCP provider packet when enrolling or revalidating by mail. List the individuals from Schedule C, sections C.1 through C.3, who have at least 5% direct or indirect ownership or controlling interest in the business, including the board of directors if the business is a nonprofit entity, and provide the confirmation number they received at the fingerprint collection center as proof of compliance.

1. Provider name	
2. Business address	
3. Business telephone number	4. Email address of individual who can answer questions about this form

Individuals Subject to Fingerprinting

5a. Legal name of disclosed individual	5b. Fingerprint confirmation number
5c. Social Security number	5d. Date of birth
6a. Legal name of disclosed individual	6b. Fingerprint confirmation number
6c. Social Security number	6d. Date of birth
7a. Legal name of disclosed individual	7b. Fingerprint confirmation number
7c. Social Security number	7d. Date of birth
8a. Legal name of disclosed individual	8b. Fingerprint confirmation number
8c. Social Security number	8d. Date of birth
9a. Legal name of disclosed individual	9b. Fingerprint confirmation number
9c. Social Security number	9d. Date of birth
10a. Legal name of disclosed individual	10b. Fingerprint confirmation number
10c. Social Security number	10d. Date of birth

| Addendum/Maintenance Form

IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form

in.gov/medicaid/providers

Electronic Funds Transfer Overview
The Indiana Health Coverage Programs (IHCP) will establish a direct deposit account with your financial institution 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 information and signature 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 before 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.

Electronic Funds Transfer Form Instructions	
1. Provider name	Enter the legal name of the IHCP provider (institution, corporate entity, practice, or individual practitioner).
2. Street address	Enter the street address of the provider's home office.
3. City	Enter the city associated with provider's home office address.
4. State/province	Enter the two-character state code associated with the provider's home office address.
5. ZIP Code/postal code	Enter the U.S. postal-zone code (ZIP + 4) associated with the provider home office.
6. Provider tax ID (Social Security number or federal employer identification number)	Enter the taxpayer identification number (tax ID) used to identify the business entity. The tax ID is either a Social Security number (SSN) or a federal employer identification number (EIN), depending on the type of business entity.
7. National Provider Identifier (NPI)	The NPI is a unique identification number for registered healthcare providers; enter the provider's NPI.
8. IHCP Provider ID	Enter the provider's IHCP Provider ID.
9. Provider contact name	Enter the name of a contact in the provider's office who handles EFT issues.
10. Telephone number	Enter the telephone number associated with the EFT contact person.
11. Email address	Enter the electronic mail address associated with the EFT contact person.
12. Does account belong to a provider agent (billing agency)?	**Select "Yes" if the EFT for the provider named on this document will be sent to an account belonging to a billing agency and not to the account of the provider.** Select "No" if the EFT for the provider named on this document will be sent to an account belonging to the provider.
13. Provider agent name	Enter the name of provider's billing agent.
14. Street	Enter the street address for the provider's billing agent.
15. City	Enter the city associated with the street address for the provider's billing agent.
16. State/province	Enter the two-character code for the state associated with the provider's billing agent.
17. ZIP Code/postal code	Enter the U.S. postal-zone code (ZIP+4) associated with the provider's billing agent.
18. Provider agent contact name	Enter the name of a contact in the provider's billing agent office who handles EFT issues.
19. Title	Enter the title of the contact in the provider's billing agent office.
20. Telephone number	Enter the telephone number associated with the contact in the provider's billing agent office.
21. Email address	Enter the email address associated with the contact in the provider's billing agent office.
22. Financial institution name	Enter the official name of the financial institution where the provider maintains an account where payments are to be deposited.
23. Financial institution telephone number	Enter a contact telephone number at the financial institution where the provider maintains an account where payments are to be deposited.
24. Financial institution routing number	Enter the nine-digit identifier of the financial institution where the provider maintains an account where payments are to be deposited.
25. Type of account at financial institution	Enter the type of account the provider will use to receive EFT payments; for example, checking or savings.
26. account number with financial institution	Enter the account number at the financial institution where EFT payments are to be deposited.
27. Account number linkage to provider identifier – provider tax ID	Enter the nine-digit tax ID (SSN or EIN) that ties the provider to his or her EFT account where payments are to be deposited.
28. Reason for submission	Select **New Enrollment**, **Change Enrollment**, or **Cancel Enrollment** to indicate the reason or type of EFT transaction being submitted.
Authorized signature: Written signature of authorized official	This signature must be an authorized official or owner of the provider, per the instructions outlined in the *Authorized Signature* section of the form.
Printed name of authorized official	Enter the name of the person signing the form.
Printed title of authorized official	Enter the title of the person signing the form.
Submission date	Enter the date on which the enrollment is submitted.

General Information

Complete all fields on this form according to the instructions. Confirm financial institution routing number.

1. Provider name	2. Street address	3. City

4. State/province	5. ZIP Code/postal code	6. Provider tax ID (Social Security number or federal employer identification number)	7. National Provider Identifier (NPI)

8. IHCP Provider ID	9. Provider contact name	10. Telephone number	11. Email address

Provider Agent Information

12. Does account belong to a provider agent (billing agent)? If yes, please complete this section. If no, this section is not required:

Yes No

The following section must be completed if the EFT for the provider named on this document will be sent to an account belonging to a provider billing agent and not an account of the provider.

The exception for a provider billing agent is limited to agents who furnish statements and receive payments in the 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 on the collection of payment. Further, a payment for a provider may not be made to or through an individual or organization (collection agency or service bureau), or by power of attorney thereof, that advances money for accounts receivable a provider has assigned, sold, or transferred to the individual or organization for a fee or deduction of accounts receivable.

13. Provider agent name	14. Street	15. City

16. State/province	17. ZIP Code/postal code	18. Provider agent contact name	19. Title

20. Telephone number	21. Email address

Financial Institution Information

22. Financial institution name	23. Financial institution telephone number	24. Financial institution routing number	25. Type of account at financial institution Checking Savings

26. Account number with financial institution	27. Account number linkage to provider identifier–provider tax ID	28. Reason for submission New enrollment Change enrollment Cancel enrollment

Authorized Signature

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 noncash 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) an enrolled provider; (2) a noncash 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 *Provider Agent Information* section); (6) the employer of a practitioner (if a contract so requires); or (7) a healthcare facility, or a healthcare delivery system (if a contract so requires), if the organization itself submits the claim directly to the IHCP.

I authorize that electronic transfer of IHCP payments (including those for 590 Program, 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 10 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.

Authorized signature: _______________________________ Written signature of authorized official	_______________________________ Printed title of authorized official
_______________________________ Printed name of authorized official	Submission date: _______________________

| Addendum

IHCP Provider Change of Ownership Addendum

in.gov/medicaid/providers

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.

Note: *A change of ownership can result in the assignment of a new provider number. Extended care facilities (provider type 03) with provider specialties 030 (Nursing Facilitiy), 031 (Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID]), 032 (Pediatric Nursing Facility), and 033 (Residential Care Facility) retain their provider number and service location when a change of ownership occurs. When these provider specialties change ownership, the new owner shall accept the responsibilities of the previous owner, as listed in the previous owner's provider agreement, and as required by 42 CFR 442.14. All providers under new ownership, including extended care facilities, are required to submit an entire IHCP provider packet, including a signed copy of the provider agreement.*

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 Ownership 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, all fields in this section must be completed. If the new owner is not currently enrolled, all fields except the IHCP Provider ID field must be completed.
- Previous Ownership Information – Helps the IHCP identify the business and specific service location being acquired.

| Addendum

IHCP Provider Change of Ownership Addendum

in.gov/medicaid/providers

Change of Ownership Information					
1. Has a change of ownership occurred? Yes No – Anticipated				1a. Actual date of change	1b. Date of expected change
New Ownership Information					
2. Business name					
3. Taxpayer identification number (TIN)				4. IHCP Provider ID (if currently enrolled)	
5. National Provider Identifier (NPI)	6. ZIP + 4 **(Nine digits required)**			7. Taxonomies	
Previous Ownership Information					
8. Business name					
9. DBA name for service location being acquired					
10. Service location address					
11. City			12: State	13. Service Location ZIP + 4 **(Nine digits required)**	
14. Taxpayer identification number (TIN)	15. IHCP Provider ID			16. Familial relationship to previous owner	
17. National Provider Identifier (NPI)	18. ZIP + 4 associated with NPI **(Nine digits required)**				19. Taxonomies

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 expected transfer date. A pay hold will be initiated on the expected date of transfer to ensure appropriate payee information for claim payments.

View the Long-Term Care Providers' Change of Ownership regulations at *405 IAC 1-20*.

Long-Term Care Record Retention

The following *Indiana Administrative Code* outlines the requirements for record retention:
405 IAC 1-20-5

Authority: *IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3*

Affected: *IC 12-13-7-3; IC 12-15; 405 IAC 1-20-5*

A transferee shall take possession of the Medicaid records of the transferor and safeguard them for no less than three years from the date of the last claim reimbursed by the office or until any pending administrative or judicial appeal is closed, whichever is longer. (Office of the Secretary of Family and Social Services; *405 IAC 1-20-5*)

Licensure or Certification Information

If a provider is licensed or certified by the Indiana State Department of Health (ISDH), the effective date of the change of ownership is determined by the date indicated on the ISDH Certificate and Transmittal form and amended by the ISDH, if necessary, to correspond with the transferor or transferee agreement of sale or transfer.

| Addendum/Maintenance Form

IHCP Provider Delegated Administrator Addendum/Maintenance Form

in.gov/medicaid/providers

Use this form to grant authority to a specific individual to submit documents on behalf of the provider for enrollment, profile maintenance, and claims submission. Please read the instructions carefully. Delegated administrators perform only those tasks specifically indicated on the form. The signature of an authorized official, as defined on the form, is required to delegate authority to the administrator. For example, a credentialing coordinator cannot delegate authority to himself or herself or to another party. The information on this form is logged by the Indiana Health Coverage Programs (IHCP) and is used to verify that the individuals who sign requests are authorized to do so.

A delegated administrator may submit a provider enrollment packet; however, the delegated administrator may not sign the IHCP Provider Agreement. This form must contain the authorized official's and delegated administrator's original signatures.

You can also use this form to change or revoke the authority that was previously delegated to an individual. When a change is processed, any authority previously granted to the delegated administrator is removed and replaced with the authority indicated on the change form. In other words, the previous list of tasks the delegated administrator can sign for will be replaced with the list from the update form. When a delegated administrator's authority is revoked, all signature authority previously granted is removed.

Next Steps

1. After completing this form, perform a quality check using the following checklist. The quality check helps to ensure that your maintenance request can be processed and that it does not have to be returned for corrections.

For Provider Use Only	Quality Check
	In field 1, confirm that the type of request being made has been selected.
	Confirm that either field 2 or field 3 has been completed, as follows: • If establishing or changing a delegated administrator's authority, double-check field 2 to ensure that only those items that the delegate is authorized to perform are checked. Note that any existing list on file for the delegated administrator will be replaced with this new list, so select all items that apply, even if they have been selected for the same administrator in the past. • If revoking a delegated administrator's authority, ensure that the box in field 3 has been selected.
	In fields 4–6, ensure that contact information has been entered.
	In fields 7–12, double-check that all applicable fields are completed to clearly identify the provider.
	In fields 13–16, check that the authorized official's name and title have been entered, and that his or her original signature has been included along with the signature date.
	In fields 17–19, check that the delegated administrator's name and title have been entered, and that his or her original signature has been included along with the signature date.

2. Make a copy of the form and other documentation for your records.

3. Submit this form as an addendum to your IHCP provider packet or separately to report changes to your provider profile.

4. Submissions should be mailed to the IHCP at the following address:

   IHCP Provider Enrollment Unit
   P.O. Box 7263
   Indianapolis, IN 46207-7263

| Addendum/Maintenance Form

IHCP Provider Delegated Administrator Addendum/Maintenance Form

in.gov/medicaid/providers

Overview

An authorized official may establish, change or revoke signature authority for a delegated administrator. The authorized official that is listed in field 13 and signs in field 15 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.

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 pay-to (checks and remittance advice [RA]) address
Change legal (owner/home office) address	Change service location (cert code letters) address
Submit name change	Submit license or certification updates
Change taxpayer identification number (TIN), submit *W-9*	Submit updates to rendering provider information
Submit provider specialty change	Submit the *IHCP Outpatient Mental Health Addendum*
Add, change, or stop electronic funds transfer (EFT)	Submit the *IHCP Provider Disenrollment Form* for specific service location or to disenroll rendering provider linkages from a provider group only
Submit the *IHCP Provider Signature Authorization*	

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.

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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 name (as it appears on tax returns)		8. Taxpayer identification number (TIN)	
9. IHCP Provider ID	10. National Provider Identifier (NPI)	11. Taxonomies	12. ZIP + 4 **(Nine digits required)**
13. Authorized official's name (please print)		14. Authorized official's title (please print)	
15. Authorized official's signature			16. Date
17. Delegated administrator's name (please print)			
18. Delegated administrator's signature (required only to establish or change a delegated administrator's authority)			19. Date

Please submit one form per delegated administrator.