**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 choose not to use the Portal, you may use paper forms.

## Which Providers Should Use This Packet to Enroll in the IHCP?

- You should use this packet only if you are an ordering, prescribing, or referring (OPR) provider **and** are not otherwise enrolled as a provider with the Indiana Health Coverage Programs (IHCP).
- OPR providers do not bill the IHCP for services rendered to members; they only order, prescribe, and/or refer services and supplies for their IHCP-eligible patients. If you are already enrolled in the IHCP as another type of provider, you do not need to complete this form.
- This form should not be used to enroll as a billing, group, or rendering provider with the intent to submit claims for reimbursement. To enroll as a billing, group, or rendering provider, see the *Complete an IHCP Provider Application* page at in.gov.medicaid/providers.
- **OPR organizations** – Practitioners within your organization who might order, prescribe, or refer services or supplies for IHCP-eligible members will need to enroll separately as individual OPR providers.
- **Opioid Treatment Programs (OTPs)** – OTPs enrolling only to order, prescribe, or refer for services, and that do not intend to submit claims for reimbursement, should use this packet to identify their entity/organization or an individual as an OPR provider with an OTP specialty. To bill for services, OTPs should see the *Complete an IHCP Enrollment Application* page at in.gov.medicaid/providers and enroll using the packet appropriate for their provider type and specialty.

## General Instructions

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

- **Enrolling in the IHCP as an OPR provider for the first time** – Complete all sections of the form unless the section does not apply to you. Follow the instructions in each section carefully.
- **Converting from a rendering provider to an OPR provider** – Complete all sections of the form unless the section does not apply to you. Follow the instructions in each section carefully.
- **Making updates to your information, also known as your *provider profile*.** When your profile information, such as license information, contact information, name or address, changes, or the disclosed individuals for organizations change, you are **required** to submit an update. Complete only the following:
  - Field 1: Type of request
  - Field 5: Name of enrolling individual or entity
  - Field 36: NPI
  - Any other fields with information that needs to be updated
  - Fields 45-47: Provider Signature/Attestation
- **Revalidation** – OPR providers are required to revalidate provider enrollment in the IHCP. Providers will receive notification letters when it is time to revalidate.

- **Disenrolling from the IHCP –** Complete only the following:
  - Field 1: Type of request
  - Field 3: Requested enrollment effective date
  - Field 5: Name of enrolling individual or entity
  - Field 36: NPI
  - Fields 45-47: Provider Signature/Attestation

**You will need the following information to complete your enrollment request:**

- National Provider Identifier (NPI), unless you are an atypical provider type (for instance, a transportation or waiver provider)
- IHCP Provider ID if updating or revalidating an existing enrollment
- Address, including ZIP Code/postal code + 4
- Provider taxonomy code, unless you are an atypical provider type (for instance, transportation or waiver)
- Provider license number, if applicable to your provider type
- Provider Social Security number and date of birth for OPR and disclosed individuals (owners, board members, and managers)
- Opioid treatment programs must attach certification from the Division of Mental Health and Addiction (DMHA) and a copy of their Drug Enforcement Agency (DEA) license.

## Next Steps

1. After completing this packet, double-check that all required information has been completed. This quality check helps ensure that your packet can be processed and does not have to be returned for corrections.
2. Print the completed packet.
3. Make a copy of the packet for your records.
4. Mail the packet to the IHCP at the following address:

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

## 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 Indiana Health Coverage Programs (IHCP) for the sole purpose of ordering, prescribing, or referring services and/or medical supplies for your Medicaid-eligible patients.
- ☐ **Conversion from rendering to OPR –** You are currently enrolled in the IHCP as a rendering provider and are applying to convert your enrollment classification to OPR provider. Upon conversion, the effective date of the OPR enrollment will be the same as the end date of the rendering enrollment, with no enrollment gap.
- ☐ **Profile Update** – You are already enrolled as an OPR provider with the IHCP and need to change your provider profile information.
- ☐ **Revalidating –** You are revalidating your OPR provider enrollment with the IHCP.
- ☐ **Disenroll** – You are disenrolling from the IHCP as an OPR provider.

## Provider Enrollment Request Information

### Initial Enrollment Information

| 2. Provider classification | 3. Requested enrollment effective date |
|---|---|
| **Ordering, Prescribing, Referring (OPR)** | |

### OPR Organization

4. Are you an organization serving as an OPR provider? ☐ Yes ☐ No

### Provider Identification

The provider name should match what is listed on the provider's license or certificate when one is required. The taxpayer identification number (Social Security number [SSN] for an individual practitioner or federal employer identification number [EIN] for a business entity) disclosed on this form is used to determine whether the person or entity named in this enrollment application is a federally excluded party and to verify licensure/certification. Refusal to provide an SSN or EIN will result in rejection of this enrollment packet.

5. Name of enrolling individual or entity

6. Social Security number or federal employer identification number

| 7a. Are you currently enrolled as an IHCP provider? | 8a. Were you previously enrolled as an IHCP provider? |
|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7b. If yes, what is your Provider ID? | 8b. If yes, what is your previous Provider ID? |

| Enrollment Transaction Contact | |
|---|---|
| The contact person may be contacted to answer any questions regarding the information provided in this enrollment application. Email addresses will be used for IHCP business only and will not be shared for other purposes. | |
| 9. Last name, first name | 10. Title |
| 11. Telephone number with extension | 12. Fax number |
| 13. Contact email address | 14. Preferred method of communication<br>☐ Email<br>☐ Phone<br>☐ Mail |

| Provider Mailing Address and Contact Information | | | |
|---|---|---|---|
| Enter a mailing address for the OPR provider for correspondence related to this enrollment. | | | |
| 15. Last name, first name | | | |
| 16. If enrolling an entity, provide business name | | | |
| 17. Street address | | 18. City | 19. State |
| 20. ZIP Code | 21. County | 22. Email address | |
| 23. Telephone number with extension | 24. Fax number with extension | | |

## Provider Enrollment Specialties

**Physician specialties**: Physicians must complete fields 25 and 26.
If you are a physician, designate your specialties. **Please select all specialties that apply**. A physician must meet all federal and State requirements for the specialties selected. You must also identify which specialty is primary in field 25. Only one primary specialty is allowed.

**Nonphysician specialties**: Nonphysicians must complete field 27.
If you are a nonphysician provider, add the appropriate specialty. **Select only one specialty**. All nonphysician providers must meet specific licensing, certification, educational, and work experience requirements.

### Physician Specialties

25. Physicians, indicate your primary specialty (select from the following list): _____

26. **Physician specialties**: If you are a physician, designate your specialties. **Check all of the following that apply**:

- ☐ Addiction medicine
- ☐ Allergy/Immunology
- ☐ Anesthesiology
- ☐ Cardiac electrophysiology
- ☐ Cardiac surgery
- ☐ Cardiovascular disease (cardiology)
- ☐ Colorectal surgery (proctology)
- ☐ Critical care (intensivists)
- ☐ Dermatology
- ☐ Diagnostic radiology
- ☐ Emergency medicine
- ☐ Endocrinology
- ☐ Family practice
- ☐ Gastroenterology
- ☐ General practice
- ☐ General surgery
- ☐ Geriatric medicine
- ☐ Geriatric psychiatry
- ☐ Gynecological oncology
- ☐ Hand surgery
- ☐ Hematology
- ☐ Hematology/Oncology
- ☐ Hospice
- ☐ Infectious disease
- ☐ Internal medicine
- ☐ Interventional pain management
- ☐ Interventional radiology
- ☐ Maxillofacial surgery
- ☐ Medical oncology
- ☐ Nephrology
- ☐ Neurology
- ☐ Neuropsychiatry
- ☐ Neurosurgery
- ☐ Nuclear medicine
- ☐ Obstetrics/Gynecology
- ☐ Ophthalmology
- ☐ Oral surgery (dentist only)
- ☐ Orthopedic surgery
- ☐ Osteopathic manipulative medicine
- ☐ Otolaryngology
- ☐ Pain management
- ☐ Palliative peripheral vascular disease
- ☐ Pediatrician
- ☐ Physical medicine and rehabilitation
- ☐ Plastic and reconstructive surgery
- ☐ Podiatry
- ☐ Preventive medicine
- ☐ Psychiatry
- ☐ Pulmonary disease
- ☐ Radiation oncology
- ☐ Rheumatology
- ☐ Sports medicine
- ☐ Surgical oncology
- ☐ Thoracic surgery
- ☐ Urology
- ☐ Vascular surgery
- ☐ Unlisted physician type – specify:

## Nonphysician Specialties

27. **Nonphysician specialties**: If you are a nonphysician provider, check the appropriate box to indicate your specialty.
**Check only one of the following:**

- ☐ Certified nurse midwife with prescriptive authority
- ☐ Certified nurse midwife without prescriptive authority
- ☐ Certified registered nurse anesthetist (CRNA) with prescriptive authority
- ☐ Certified registered nurse anesthetist (CRNA) without prescriptive authority
- ☐ Clinical nurse specialist with prescriptive authority
- ☐ Clinical nurse specialist without prescriptive authority
- ☐ Clinical pharmacist
- ☐ Clinical psychologist
- ☐ Clinical social worker
- ☐ Dentist
- ☐ Genetic counselor
- ☐ Mental health practitioner
- ☐ Nurse practitioner
- ☐ Occupational therapist
- ☐ Opioid treatment programs
- ☐ Optometrist
- ☐ Physical therapist
- ☐ Physician assistant
- ☐ Psychologist billing independently
- ☐ Registered dietician
- ☐ Unlisted nonphysician provider type – specify:

# Provider Enrollment: Provider Identification

## Provider Legal Name

Please enter the provider's legal name.

| | | |
|---|---|---|
| 28. Last name, first name, middle initial | | |
| 29. If enrolling an entity, provide business name | | |
| 30. Legal address | 31. City | 32. State |
| 33. ZIP Code | 34. Title (if individual) | 35. Birth date (if individual) |

## National Provider Identifier

The NPI is the standard, unique healthcare identifier for healthcare providers and is assigned by the National Plan and Provider Enumeration System (NPPES). As an enrolling provider, you must have obtained an NPI. Applying for the NPI is a process separate from IHCP enrollment. To obtain an NPI, you may apply online at nppes.cms.hhs.gov. For more information about NPI enumeration, visit cms.gov/NationalProvIdentStand.

- A healthcare practitioner enrolling as an OPR provider must enroll using a Type 1 NPI.
- An opioid treatment program (OTP) must enroll using a Type 2 NPI.

36. NPI:

## License/Certificate Information

List all professional licenses for all states. At least one license must be entered. List required certifications. Opioid treatment programs must list and attach certification from the Division of Mental Health and Addiction (DMHA). Note: Drug Enforcement Administration (DEA) license should not be listed here but should be listed in the next section so labeled.

37a. License type – enter at least one license

Professional license:

| | |
|---|---|
| 37b. License number | 37c. Issuing state |
| 37d. Effective date | 37e. Expiration date |
| 37f. Name as it appears on the license | |

38a. Other license/certificate type

Professional license:

Certificate:

| | |
|---|---|
| 38b. License/certificate number | 38c. Issuing state |
| 38d. Effective date | 38e. Expiration date |
| 38f. Name as it appears on the license/certificate | |

39a. Other license/certificate type

Professional License

Certificate:

| | |
|---|---|
| 39b. License/certificate number | 39c. Issuing state |
| 39d. Effective date | 39e. Expiration date |
| 39f. Name as it appears on the license/certificate | |

## Drug Enforcement Administration (DEA) License

| | | |
|---|---|---|
| 40. Drug Enforcement Administration (DEA) number | 41. Effective date | 42. End date |

## Provider Disclosure Information (for organizations only)

This section must be completed by organizations that serve as OPR providers**.**

The purpose of this section is to disclose to the IHCP information about individuals and entities with ownership or control interests or with management responsibilities for the OPR organization. Please complete all sections of this form. Nonprofit providers must provide information for the business entity that owns their taxpayer identification number.

**Disclosure Information**
When completing this section to make changes to the list of disclosed individuals, make sure to include the names of **all** individuals who 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**
This section 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. Refusal to provide a Social Security number will result in rejection of this enrollment packet.

**Consent to Release Social Security Numbers**

Submission of information in this section 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.

| **Individuals or Corporations with an Ownership or Control Interest and Managing Individuals (for organizations only)** | | | |
|---|---|---|---|
| Please list **all** individuals and corporations with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers must also list their managing individuals: 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.<br>Include each person's or entity's name, address, date of birth (if individual), and Social Security number or federal employer identification number (EIN). 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. | | | |
| 1a. Name of individual or corporation | | | |
| 2a. Address | | | |
| 3a. Title (if individual) | 4a. % of ownership (if applicable) | 5a. Social Security number or EIN | 6a. Date of birth (if individual) |
| 1b. Name of individual or corporation | | | |
| 2b. Address | | | |
| 3b. Title (if individual) | 4b. % of ownership (if applicable) | 5b. Social Security number or EIN | 6b. Date of birth (if individual) |
| 1c. Name of individual or corporation | | | |
| 2c. Address | | | |
| 3c. Title (if individual) | 4c. % of ownership (if applicable) | 5c. Social Security number or EIN | 6c. Date of birth (if individual) |
| 1d. Name of individual or corporation | | | |
| 2d. Address | | | |
| 3d. Title (if individual) | 4d. % of ownership (if applicable) | 5d. Social Security number or EIN | 6d. Date of birth (if individual) |
| 1e. Name of individual or corporation | | | |
| 2e. Address | | | |
| 3e. Title (if individual) | 4e. % of ownership (if applicable) | 5e. Social Security number or EIN | 6e. Date of birth (if individual) |
| 1f. Name of individual or corporation | | | |
| 2f. Address | | | |
| 3f. Title (if individual) | 4f. % of ownership (if applicable) | 5f. Social Security number or EIN | 6f. Date of birth (if individual) |
| 1g. Name of individual or corporation | | | |
| 2g. Address | | | |
| 3g. Title (if individual) | 4g. % of ownership (if applicable) | 5g. Social Security number or EIN | 6g. Date of birth (if individual) |

## Relationships and Background Information (for organizations only)

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

**1. Indicate whether any of the individuals listed are related through blood or marriage, as spouse, parent, child, or sibling.**

| | | |
|---|---|---|
| 1a. Name of person 1 | Name of person 2 | Relationship |
| 1b. Name of person 1 | Name of person 2 | Relationship |
| 1c. Name of person 1 | Name of person 2 | Relationship |

**2. Indicate whether any persons or entities listed, or any secured creditors of the provider entity, have ever been sanctioned 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 | NPI or Provider ID | Date of sanction |
| Type of sanction | Date sanction ended (please attach supporting documentation) | |
| 2b. Name | NPI or Provider ID | Date of sanction |
| Type of sanction | Date sanction ended (please attach supporting documentation) | |
| 2c. Name | NPI or Provider ID | Date of sanction |
| Type of sanction | Date sanction ended (please attach supporting documentation) | |

**3. Indicate if any persons or entities listed, or any secured creditors of the provider entity, have ever been placed on prepayment review.**

| | |
|---|---|
| 3a. Name | NPI or Provider ID |
| 3b. Name | NPI or Provider ID |
| 3c. Name | NPI or Provider ID |

**4. Indicate if any persons or entities listed have an ownership or controlling interest in any other current or prospective IHCP provider.**

| | |
|---|---|
| 4a. Name | NPI or Provider ID |
| 4b. Name | NPI or Provider ID |
| 4c. Name | NPI or Provider ID |

**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.**

| | | |
|---|---|---|
| 5a. Name of person 1 | Name of person 2 | Relationship |
| 5b. Name of person 1 | Name of person 2 | Relationship |
| 5c. Name of person 1 | Name of person 2 | Relationship |

## Final Adverse Legal Actions/Convictions

Please provide information on final adverse legal actions against the OPR provider or any disclosed individual for an OPR organization, such as convictions, exclusions, revocations, and suspensions within the last 10 years preceding enrollment or revalidation of enrollment. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

**Convictions**

- Any conviction of a federal or State felony offense that the Centers for Medicare & Medicaid Services (CMS) has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under *Section 1128(a)* of the *Social Security Act*.
- Any misdemeanor conviction, under federal or State law, related to: (a) the delivery of an item or service under Medicare or a State healthcare program, or (b) the abuse or neglect of a patient in connection with the delivery of a healthcare item or service.
- Any misdemeanor conviction, under federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a healthcare item or service.
- Any felony or misdemeanor conviction, under federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations *42 CFR Section 1001.101* or *1001.201*.
- Any felony or misdemeanor conviction, under federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

**Exclusions, Revocations, or Suspensions**

- Any revocation or suspension of a license to provide healthcare by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Any revocation or suspension of accreditation.
- Any suspension or exclusion from participation in, or any sanction imposed by, a federal or State healthcare program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Any current Medicare/Medicaid payment suspension under any Medicare/Medicaid identification number.
- Any Medicare/Medicaid revocation of any Medicare/Medicaid identification number.

**43. Have you or any disclosed individual, under any current or former name or business identity, ever had a final adverse legal action, listed previously, imposed against you?**

☐ **No** ☐ **Yes**

- If no, skip to the *Provider Signature/Attestation* section.
- If yes, complete fields 44a through 44d to report each final adverse legal action, when it occurred, the federal or State agency or the court/administrative body that imposed the action, and the resolution. If you need more room, attach a separate sheet.
- If yes, attach a copy of the final adverse legal action documentation.

| 44a. Briefly describe adverse legal action | 44b. Date | 44c. Taken by | 44d. Resolution |
|---|---|---|---|
| | | | |

## Provider Signature/Attestation

By execution of this Attestation, the undersigned individual ("Provider") agrees to participate as a provider in the Indiana Health Coverage Programs (IHCP) for the sole purpose of ordering, prescribing, or referring (OPR) services to IHCP members. The undersigned authorized individual attests that the information provided is true and accurate to the best of his or her knowledge.

| 45. Legal name of provider (please print) | |
|---|---|
| 46. Provider signature | 47. Date |