# IHCP Provider Specialty Maintenance Form

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Enrolled Indiana Health Coverage Program (IHCP) providers use this form to make changes to a provider's current specialty profile.

All providers – Use Schedule A to make specialty code changes to one or all currently enrolled service locations. Specialty code changes can be reported for no more than one service location per form unless **all** provider service locations are making the identical change.

Group and clinic providers – Use Schedule B to make specialty code changes for a rendering provider linked to your group or clinic. Specialty code changes applicable to each service location linkage must be listed unless all the rendering provider's linkages are making the identical specialty change.

**Note:** If you are a qualified provider (QP) for Presumptive Eligibility (PE), terminating any specialties that qualified you as a QP may result in termination of your QP PE status.

**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 |
|---|---|
| | All providers must complete all fields in Schedule A and the Contact Information and Signature Authorization for Profile Maintenance sections. |
| | Groups and clinics must complete all fields in Schedule A and the Contact Name and the Signature Authorization for Profile Maintenance sections. If the group or clinic is changing rendering provider specialties, all fields in Schedule B must also be completed. |
| | Include copies of required licenses or certificates related to the provider specialty change. See the *IHCP Provider Type and Specialty Matrix* for details about required documentation. |
| | If you are a qualified provider (QP) for Presumptive Eligibility (PE), terminating any specialties that qualified you as a QP may result in termination of your QP PE status. |

2. Make a copy of the maintenance form and other documentation for your records.
3. If you need additional maintenance forms, return to indianamedicaid.com and select another form.
4. Mail the maintenance forms and other required documentation to Hewlett Packard Enterprise (HPE) at the following address:

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

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| Provider Information | | |
|---|---|---|
| 1. Legacy Provider Identifier (LPI) | 2. Taxpayer Identification Number (TIN) | 3. Requested effective date |
| 4. National Provider Identifier (NPI) | 5. ZIP + 4 | 6. Taxonomy |

7. Apply the specialty change to all service locations? If yes, skip fields 8 through 13 and go to field 14. If no, continue with field 8.

Yes No

| Service Location Name and Address | | |
|---|---|---|
| 8. Doing business as (DBA) name | | 9. Service location alpha suffix |
| 10. Service location street address | | |
| 11. City | 12. State | 13. ZIP + 4 **(Nine digits required)** |

## Provider Specialty Information

See the *IHCP Provider Type and Specialty Matrix* at indianamedicaid.com to determine the specialty codes for your provider type. (You cannot use this form to change your provider type. A change in provider type is considered a new enrollment.) Include copies of required licenses or certificates related to the provider specialty change.

| 14. Current provider type (two-digit code) | 15. Change the primary specialty code to (three-digit code) |
|---|---|

16. Add specialty codes (three-digit codes)

17. Remove specialty codes (three-digit codes)

18. Is provider a current managed care PMP? If yes, contact the appropriate managed care entity regarding this change.

Yes No

19. Is the provider a qualified provider for Presumptive Eligibility?

Yes No

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## Rendering Provider's Group or Clinic Information

| 1. Group or clinic LPI | 2. Group or clinic TIN | |
|---|---|---|
| 3. Group or clinic provider legal name | | |
| 4. Mailing address | | |
| 5. City | 6. State | 7. ZIP + 4 **(Nine digits required)** |

## Rendering Provider Information

| 8. Provider's name (please print) | 9. Social Security number | 10. Date of birth |
|---|---|---|
| 11. Provider's LPI | 12. Provider's NPI | 13. Provider type (two-digit code) |

14. Does the specialty code change listed in the following table apply to all service location linkages associated with the rendering provider? If yes, the specialty code change need only be listed once. Write "All" in field 15a. If no, list each service location separately where a specialty code change is being reported.

Yes No

## Group Service Location Specialty Information

| 15a. Group service location alpha suffix | 15b. Group service location NPI | 15c. Requested start date | 15d. Requested end date | 15e. New primary specialty code | 15f. Add specialty code | 15g. Remove specialty code |
|---|---|---|---|---|---|---|
| Example: | | | | | | |
| **B** | **1001001001** | **6/1/2005** | **06/02/2006** | **344** | **315** | **328** |
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## Managed Care Information

16. Is the provider a current managed care PMP? If yes, contact the appropriate managed care entity regarding this change.

Yes No

**Please copy this form for additional rendering providers.**

## Contact Information

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

| 1. Contact name | 2. Telephone |
|---|---|
| | |

3. Contact email

## Signature Authorization for Profile Maintenance

An authorized official with the group or clinic must complete this section to authorize the request to make changes to a currently enrolled rendering provider's profile.

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

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

**The form will be returned if the appropriate signatures are not submitted.**

| 4. Legal name of provider's business (please print) | 5. TIN |
|---|---|
| | |
| 6. Authorized official's name (please print) | 7. Title |
| | |
| 8. Authorized official's signature | 9. Date |
| | |