Who Uses This Packet

You should use this packet if you are a provider type 12 – School Corporation.

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.
- **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

Providers that use Web interChange and have appropriate administrative privileges can update their profile information via Web interChange. To avoid delay when updating the provider profile, use Web interChange at indianamedicaid.com, rather than sending a paper form. Using Web interChange, you can:

- Change mail-to and pay-to addresses
- Add additional specialties to an existing profile (cannot change primary specialty)
- Enroll in electronic funds transfer (EFT) or change existing EFT information
- Enroll in Indiana Medicaid programs such as Medical Review Team (MRT) and the 590 Program

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 copy of a certification), the required documentation must be included as an attachment to the packet.
- If the packet needs correcting or is missing required documentation, the Hewlett Packard Enterprise (HPE) 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, the entire packet will be returned to the provider with a letter indicating what needs to be corrected or attached. Providers MUST return the entire packet, as well as a copy of the provider letter that explained the errors or omissions, when submitting the correction or missing information.
- All packet documents are interactive PDF files, allowing users to enter information into the fields directly from the computer screen. 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 and does not have to be returned for corrections.

Provider Use Only	Quality Checklist
☐	If you are updating your 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, 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.
☐	Make sure you have attached the CURRENT W-9 (or most current year if there is no update for the year in which the application is being submitted) from the Internal Revenue Service (IRS) website. Failure to attach the current year's W-9 may result in the application being returned to the provider.
☐	Double-check that the Service Location name, or DBA name, in the **Service Location Name and Address** section of Schedule A matches **exactly** the business name on the **Federal W-9 form**.
☐	Double-check that the name and address in the **Legal Name and Home Office Address** section of Schedule A matches **exactly** the information on the **Federal W-9 form**.
☐	Double-check that the **Provider Agreement** has been signed by an authorized official who is listed on Schedule C. (The Provider Agreement must not be signed by a delegated administrator.)
☐	Double-check that the required addenda, as applicable, are completed and included with the packet. ☐ IHCP Provider Application Fee Addendum (all) ☐ IHCP Provider Screening Addendum (as applicable) ☐ Delegated Administrator Addendum/Maintenance Form (as applicable) ☐ Electronic Funds Transfer Addendum/Maintenance Form (as applicable) ☐ Current version of the Federal W-9 Form (all) ☐ Signature Authorization Addendum (all) ☐ Provider Agreement (all)
☐	If you are required to remit an application fee to the IHCP, include the electronic payment confirmation number on the IHCP Provider Application Fee Addendum.
☐	Double-check that all required supporting documentation, including copies of applicable professional and operating licenses, is included as an attachment to the packet. Required documentation is listed on the *IHCP Provider Enrollment Type and Specialty Matrix* at indianamedicaid.com.
☐	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 Electronic Funds Transfer Addendum/Maintenance Form**, include a voided check OR a signed letter from your bank that lists the account holder's name, TIN, and the appropriate account and routing numbers as an attachment to the packet. A deposit slip will not be accepted. In lieu of completing this form, you may submit your EFT information electronically using Web interChange after your enrollment is complete. This eliminates the need for a voided check or letter from your bank.

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 HPE at the following address:

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

5. You will be notified via regular mail after your application has been approved. Please allow 20 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.
- ☐ **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

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

2. National Provider Identifier (NPI):	3. ZIP + 4: **(Nine digits required)**	4. Taxonomy code:

5a. Are you currently enrolled as an IHCP provider?	5b. If yes, what is your Legacy Provider Identifier (LPI):
☐ Yes ☐ No	

6a. Were you previously enrolled as an IHCP provider?	6b. If yes, what was your previous LPI:
☐ Yes ☐ No	

Contact Information

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

7. Contact name:	8. Telephone:

9. Contact email address:

10. Email address for provider publications:

Service Location Name and Address

- **The service location address must be a physical location. A post office box is not a valid service location address.**
- The service location is 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.
- If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State or your county recorder's office showing the business name or DBA (*405 IAC 1-19.1b*) has been registered. This document must be attached to the packet.
- If you are using this packet to change your business name, you must include a revised W-9 form as an attachment to the packet. You must also submit registration documentation from the Secretary of State 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 legal name change is required.
- If your legal name and business name changes are the same, one set of attached documents will support both changes.
- Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their service location address.

11. Service location (DBA) name:		
12. Indiana county (Indiana providers):		13. Telephone:
14. Service location street address:		
15. City:	16. State:	17. ZIP + 4: **(Nine digits required)**:
18. Is claim documentation kept at this location? ☐ Yes ☐ No	19. Are services provided in Indiana? ☐ Yes ☐ No	

Legal Name and Home Office Address

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

20. Legal name:		
21. Business name (DBA):		
22. Home office street address:		
23. City:	24. State:	25. ZIP + 4: **(Nine digits required)**

26. Telephone:	27. Current TIN:	28. Former TIN (required only for reporting a 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.

29. Addressee:		30. Telephone:
31. Mailing street address:		
32. City:	33. State:	34. ZIP + 4: **(Nine digits required)**

Pay-To Name and Address

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

35. Pay-to name:		
36. Billing agent name (if applicable):		37. Pay-to telephone:
38. Pay-to street address:		
39. City:	40. State:	41. ZIP + 4: **(Nine digits required)**

Provider Specialty Information

- See the *IHCP Provider Enrollment Type and Specialty Matrix* at indianamedicaid.com to determine the appropriate supporting documentation requirements for enrollment.
- The School Corporation provider type is 12 and the specialty is 120.
- A **taxonomy code** identifies a healthcare provider type and specialty; it is not a UPIN, Medicare provider number, or an IHCP provider number. The full provider taxonomy code set can be found at wpc-edi.com under References. You may enter up to 15 taxonomies; enter only those that apply to this service location.

42. Provider type (two-digit code):	43. Primary specialty (three-digit code):
12	**120**

44. Taxonomy codes associated with this specialty and used for billing:

Organizational Structure

- If your business is chain-affiliated, the information about the company or organization must be included in the disclosure information in Schedule C.
- If your business is operated by a management 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.
- See the IRS website for instructions about reporting disregarded entity status.

1. Provider entity legally organized and structured as (check only one) (this must match the information provided on the attached W-9):

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

2. Registered with Secretary of State (Entities doing business in Indiana, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to www.in.gov/sos/ to find out how to complete the registration process.):
☐ Yes ☐ No

3. Date business started:	4. Entity incorporated: ☐ 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	

8. Are you a charter school:
☐ Yes ☐ No

Other IHCP Program Participation

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

- The **590 Program** is a State medical assistance program providing reimbursement for medically necessary covered medical services provided at off-site facilities to individuals who reside in State institutions. The following provider types cannot be 590 providers: transportation, hospice, home health, DME, and long-term care facilities. Out-of-state providers cannot enroll as 590 providers.
- The **Medical Review Program** provides information to help determine an applicant's eligibility for Medicaid under the disability category. A provider enrolled in the Medical Review Program is authorized to complete a medical assessment of an applicant and submits the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT issues favorable or unfavorable eligibility decisions, based on medical evidence that supports whether the applicant has a significant impairment. Once the documentation has been filed, the provider may submit claims for payment of certain examinations and reports. Services should not be performed unless the applicant has presented the pre-Medicaid eligibility form. There are three options for participation in the Medical Review Program:
  - **Medical Review Program/IHCP** – Providers who elect to enroll in the IHCP and choose to provide MRT assessment services
  - **Medical Review Program Only** – Providers who do not elect to enroll in the IHCP but choose to provide MRT assessment services only
  - **Medical Review Program** – **Medical Records Only** – Providers who have been requested to supply MRT medical records only and want to bill for only those services

9. Participate in the 590 Program:	10. Medical Review Program participation:
☐ Yes ☐ No	☐ Medical Review Program/IHCP ☐ Medical Review Program Only ☐ Medical Review Program – Medical Records Only ☐ None

IHCP Provider Schedule C – Disclosure Information

indianamedicaid.com

Overview

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

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

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

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 Control Interest in the Applicant

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

Please list **all** individuals with an ownership or control interest in the applicant. Include each person's name, address, the individual's date of birth (DOB), and Social Security number (SSN). Also indicate the title (e.g., 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 "persons 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	4a. % of ownership (if applicable)	5b. Social Security number	6b. Date of birth
1c. Name of individual			
2c. Address			
3c. Title	4a. % of ownership (if applicable)	5c. Social Security number	6c. Date of birth
1d. Name of individual			
2d. Address			
3d. Title	4a. % of ownership (if applicable)	5d. Social Security number	6d. Date of birth
1e. Name of individual			
2e. Address			
3e. Title	4a. % of ownership (if applicable)	5e. Social Security number	6e. Date of birth
1f. Name of individual			
2f. Address			
3f. Title	4a. % of ownership (if applicable)	5f. Social Security number	6f. Date of birth

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

If a corporation, please list **all** corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, 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. Primary business address	4a. TIN
5a. Every business location	6a. P.O. Box address(es)

1b. Name of corporation	2b. % of ownership
3b. Primary business address	4b. TIN
5b. Every business location	6b. P.O. Box address(es)

1c. Name of corporation	2c. % of ownership
3c. Primary business address	4c. TIN
5c. Every business location	6c. P.O. Box address(es)

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

If a corporation, please list **all** corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, 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. Primary business address	4d. TIN
5d. Every business location	6d. P.O. Box address(es)

1e. Name of corporation	2e. % of ownership
3e. Primary business address	4e. TIN
5e. Every business location	6e. P.O. Box address(es)

1f. Name of corporation	2f. % of ownership
3f. Primary business address	4f. TIN
5f. Every business location	6f. 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 control interest. Include any subcontractor and their address and Tax 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 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 a person who has the word director in his or her job title, such as director of operations or departmental director.
- A managing employee is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of the provider entity.

1a. 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 control 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 control 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 control 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 control 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**

| Addendum

IHCP Provider Signature Authorization

indianamedicaid.com

Signature Authorization	
The owner or an authorized official of the business entity, directly or ultimately responsible for operating the business, is the authorized signatory of this form. A delegated administrator may sign this form if it has been expressly indicated on an IHCP Delegated Administrator Addendum/Maintenance Form, on file or attached. *The undersigned, being the provider or having the specific authority to bind the provider to the terms of the provider agreement, does hereby agree to abide by and comply with all the stipulations, conditions, and terms set forth therein. The undersigned acknowledges that the commission of any Medicaid or Children's Health Insurance Program (CHIP)-related offense, as set out in* 42 USC 1320a-7b, *may be punishable by a fine of up to $25,000 or imprisonment of up to five years or both.*	
1. Legal Name of Provider's Business (please print):	2. Taxpayer Identification Number (TIN):
3. Authorized Official's Name (please print):	4. Title:
5. Authorized Official's Signature:	6. Date:

IHCP Provider Agreement

indianamedicaid.com

IHCP Provider Agreement Overview

You must provide a completed and signed Provider Agreement in the following instances:

- If you are enrolling for the first time in the Indiana Health Coverage Programs (IHCP);
- If you are enrolling a new service location;
- If you are revalidating your enrollment with the IHCP;
- If you are reporting a change of ownership; or
- If you are changing your primary provider type.

In each of the above instances, a full enrollment packet, including a newly signed Provider Agreement must be submitted for processing. An owner or authorized official with your business must sign the *IHCP Provider Agreement*. An original signature is required. A delegated administrator must not sign this form. A new IHCP number is assigned to each Provider Type enrolled in the IHCP.

The Provider Agreement details the requirements for participation in the IHCP. Included are provider responsibilities regarding updating provider information, protecting patient health information, and requirements for claims processing, overpayments, and record retention. In addition, the Agreement details obligations regarding the appeals process, regulatory compliance, utilization controls, ownership and control, and disclosure rules. The entire Agreement must be read, signed, and returned with the packet. A signed copy must be retained by the provider.

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 provider in the Indiana Health Coverage Programs ("IHCP"). 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 provide covered services and/or supplies for which federal financial participation is available for members pursuant to all applicable federal and state statutes and regulations.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide services covered by the IHCP pursuant to this Agreement.
11. To abide by the state's *Medical Policy Manual* and *IHCP Provider Reference Modules* as amended from time to time, as well as all provider bulletins, banner pages, and notices. Any amendments to the policy manual or reference modules, including provider bulletins, banner pages, and notices, will be communicated on the official state Medicaid website and shall be binding upon publication.
12. To update and maintain a current service location address as required.
13. 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.

14. 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.
15. The Provider understands that the standard paper claim form may include a signature line. The Provider understands that all the stipulations, conditions, and terms of the provider agreement apply in the event that the Provider fails, for any reason, to sign the paper claim, even if the claim is approved for payment. The Provider agrees that payment of a paper claim that does not contain the Provider's signature in no way absolves the Provider of the terms stated in the provider agreement.
16. 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.
17. To submit claim(s) for IHCP reimbursement utilizing the appropriate claim forms specified in the policy manual, reference modules, bulletins, banner pages, and notices.
18. 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.
19. 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.
20. To refund duplicate or erroneous payments to FSSA or its fiscal agent within fifteen (15) days of receipt.
21. 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.
22. 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*.
23. 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.
24. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
25. 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.

26. To cease any conduct that FSSA or its representative deems to be abusive of the IHCP.
27. To promptly correct deficiencies in Provider's operations upon request by FSSA or its fiscal agent.
28. To make a good faith effort to provide and maintain a drug-free workplace. Provider will give written notice to the State within ten (10) days after receiving actual notice that the provider or an employee of the provider has been convicted of a criminal drug violation occurring in the provider's workplace.
29. 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.
30. 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.
31. 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.
32. 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.
33. 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.
34. 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.
35. 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. If the Provider is not familiar with these ethical requirements, the Provider should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission Web site at http://www.in.gov/ethics/. If the Provider or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Agreement immediately upon notice to the Provider. In addition, the Provider may be subject to penalties under *IC § 4-2-6, IC 4-2-7, IC 35-44-1-3*, and under any other applicable laws.
36. 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*. Long term care providers must comply with additional requirements found in *405 IAC 1-20*. 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.
37. To submit within 35 days of the date of request by the federal or state agency full and complete information about:
    a. ownership of subcontractors with whom the provider has had more than $25,000 in a twelve month hearing period;
    b. any significant business transactions between the provider and any wholly owned supplier; and
    c. any significant business transactions between the provider and any subcontractor, during five-year period ending with the date of request.
38. 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.
39. 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 40 below.

40. 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.
41. For long term care providers involved in a change of ownership, this agreement acts as an amendment to the transferor's agreement with IHCP to bind the transferee to the terms of the previous agreement; and any existing plan of correction and pending audit findings in accordance with *405 IAC 1-20*.
42. New owners of nursing facilities or intermediate care facilities for the intellectually disabled, must accept the assignment of the provider agreement executed by the previous owner(s) as required by *42 CFR 442.14*.
43. For any entity that receives or makes annual payments totaling at least $5,000,000 annually as described in *42 U.S.C. 1396a(a)(68)*, shall add written policies to their employee handbook that provide detailed information about federal and state False Claims Acts, whistleblower protections, and entity policies and procedures for preventing and detecting fraud and abuse. In any inspection, review, or audit of the entity by FSSA or its contractors, the entity shall provide copies of the entity's written policies regarding fraud, waste, and abuse upon request. Entity shall submit to FSSA a corrective action plan within 60 days if the entity is found not to be in compliance with any part of the requirements stated in this paragraph.
44. 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.
45. To allow FSSA and its representatives to perform safety inspections of motor vehicles used for transportation services of Medicaid recipients. The Provider shall require all of its contractors and subcontractors to agree to the same.
46. To receive email updates and communication from IHCP at the email address(es) provided on its enrollment application. Providers may opt-out of receiving these email communications by clicking the link found at the bottom of each email following the message prompts. Opting out does not affect the provider's obligation to stay abreast of IHCP updates and communications as required by this agreement.

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:

| Addendum

IHCP Provider Federal *W-9* Addendum

indianamedicaid.com

W-9 Form

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

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

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

| Addendum

IHCP Provider Application Fee Addendum

indianamedicaid.com

Overview

Federal and state laws require certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidation, and change of ownership, as required, and is assessed in full for each service location enrolled in the Indiana Health Coverage Programs (IHCP). See the *Provider Enrollment Application Fee* web page at indianamedicaid.com for more information and payment options.

To determine whether you must pay a fee, see the IHCP Provider Enrollment Risk Category and Application Fee Matrix.

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

On this form, please list your payment confirmation number and amount paid or reason for exemption. Submit this form with your IHCP provider packet.

1. Legal name	2. Does the application fee apply to your provider type? Use the matrix linked above to verify whether you are required to pay a fee. If **No**, skip the rest of this form. Yes ☐ No ☐

3. Is the service location enrolled in Medicare?

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

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

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

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

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

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

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

7. If you answered **Yes** to question 2 and **No** to questions 3, 4, 5, and 6, you are required to remit an application fee to the IHCP. Payments can be made online or by telephone using a credit card, debit card, or electronic funds transfer from your checking account. Paper forms of payment are not accepted. See the *Provider Enrollment Application Fee* page at indianamedicaid.com for more detailed instructions about the payment process.

   Indicate the electronic payment confirmation number:

8. Indicate the amount paid electronically:

| Addendum

IHCP Provider Screening Addendum

indianamedicaid.com

Overview

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

Federal and state laws require that providers in the high-risk category submit to fingerprinting and criminal background checks. You can determine the risk category of your provider type/provider specialty at enrollment and at revalidation by referencing the 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 State, 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. 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. Business legal 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 | indianamedicaid.com

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 signature and attachment are included.

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

It takes approximately 18 days for the bank to process and completely establish your EFT account. If you bill claims 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	
Provider Name	Enter the legal name of institution, corporate entity, practice, or individual provider.
Street	Enter the street address of the provider's home office.
City	Enter the city associated with provider's home office address.
State/Province	Enter the two-character state code associated with the provider's home office address.
ZIP Code/Postal Code	Enter the U.S. postal-zone code (ZIP + 4) associated with the provider home office.
Provider taxpayer identification number (TIN) or Federal Employer Identification Number (FEIN)	Enter the taxpayer identification number (TIN), also known as the Federal Employer Identification Number (FEIN), used to identify the business entity.
National Provider Identifier (NPI)	The NPI is a unique identification number for registered healthcare providers; enter the provider's NPI.
Assigning Authority	Enter the provider's IHCP Provider ID (formerly Legacy Provider Identifier/LPI)
Provider Contact Name	Enter the name of a contact in the provider's office who handles EFT issues.
Telephone Number	Enter the telephone number associated with the EFT contact person.
Email Address	Enter the electronic mail address associated with the EFT contact person.
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.
Provider Agent Name	Enter the name of provider's authorized provider or billing agent.
Street	Enter the street address for the provider's billing agent.
City	Enter the city associated with the street address for the provider's billing agent.
State/Province	Enter the two-character code for the state associated with the provider's billing agent.
ZIP Code/Postal Code	Enter the U.S. postal-zone code (ZIP + 4) associated with the provider's billing agent.
Provider Agent Contact Name	Enter the name of a contact in the provider's billing agent office who handles EFT issues.
Title	Enter the title of the contact in the provider's billing agent office.
Telephone Number	Enter the telephone number associated with the contact in the provider's billing agent office.
Email Address	Enter the electronic mail address associated with the contact in the provider's billing agent office.
Financial Institution Name	Enter the official name of the financial institution where the provider maintains an account where payments are to be deposited.
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.
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.
Type of Account at Financial Institution	Enter the type of account the provider will use to receive EFT payments; for example, checking or savings.
Provider's Account Number with Financial Institution	Enter the account number at the financial institution where EFT payments are to be deposited.
Account Number Linkage to Provider Identifier-Provider Tax Identification Number (TIN)	Enter the nine-digit tax identification number that ties the provider to his or her EFT account where payments are to be deposited.
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 Person Submitting Enrollment: This signature must be an authorized official or owner of the provider, per the instructions outlined in the *Authorized Signature Section* of the form.
Authorized Signature	Printed Name of Person Submitting Enrollment: Enter the printed name of the person signing the form.
Authorized Signature	Printed Title of Person Submitting Enrollment: 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 form, and follow attachment instructions below. Confirm financial institution routing number.

1. Provider name		2. Street address	3. City
4. State/Province	5. Zip Code/postal code	6. Provider tax identification number (TIN) or Federal Employer Identification Number (FEIN)	7. National Provider Identifier (NPI)
8. Assigning authority	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 taxpayer identification number (TIN)	28. Reason for submission ◯ New enrollment ◯ Change enrollment ◯ Cancel enrollment

Attachment (Required)

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

Authorized Signature Section

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 person submitting enrollment	_____ Printed title of person submitting enrollment
_____ Printed name of person submitting enrollment	Submission date _____

| Addendum/Maintenance Form

IHCP Provider Delegated Administrator Addendum/Maintenance Form

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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
☐	Double-check that only those items that the delegate is authorized to perform are checked.
☐	In fields 1 – 6, clearly identify the provider.
☐	In fields 7 – 10, print the authorized official's name and title, and obtain his or her original signature and the signature date.
☐	In fields 11 – 13, print the delegated administrator's name and title, and obtain his or her original signature and 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:

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

| Addendum/Maintenance Form

IHCP Provider Delegated Administrator Addendum/Maintenance Form

indianamedicaid.com

Overview

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

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

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

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

- Sign the IHCP provider enrollment and maintenance packet
- Make changes or updates to the organization's status in the IHCP
- Accept payment for services
- Submit claims for payment on behalf of the enrolled entity
- Commit the organization to the laws and regulations of the IHCP

1. Type of request

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

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

☐ **Revoke a delegated administrator's authority** – An individual has been previously set up as a delegated administrator and you are cancelling all signature authority.

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

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

☐ Change mail-to (non-check-related info) address

☐ Change home office address

☐ Submit name change

☐ Change tax ID, submit *W-9*

☐ Submit provider specialty change

☐ Add, change, or stop EFT

☐ Submit the *IHCP Provider Signature Authorization*

☐ Change pay-to (checks and RAs) address

☐ Change service location (cert code letters) address

☐ Submit license or certification updates

☐ Submit updates to rendering provider information

☐ Submit the *IHCP Outpatient Mental Health Addendum*

☐ Submit the *IHCP Provider Disenrollment Form* for specific service location or to disenroll rendering provider linkages from a provider group only

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

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

Contact Information

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

4. Contact name	5. Telephone
6. Contact email address	

Authorized Signature Section

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

7. Provider or business entity legal name		8. Taxpayer identification number (TIN)	
9. IHCP Provider ID	10. National Provider Identifier (NPI)	11. Taxonomy	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.