IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 01 – Hospital                     | 010 – Acute Care                     | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:  
  ○ Provider Agreement           | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:  
  ○ Provider Agreement           |
|                                  |                                      | ○ Federal W-9 form                                                                                         | ○ Federal W-9 form                                                                                            |
|                                  |                                      | • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable                              | • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable                                |
|                                  |                                      | • Proof of Medicare participation required                                                                | • Copy of license from appropriate state                                                                        |
|                                  |                                      | • Proof of Indiana State Department of Health (ISDH) Certification                                          | • Proof of Medicare participation required                                                                      |
|                                  |                                      | • Application fee required ¹                                                                               | • Proof of participation in own state’s Medicaid program, if enrolled                                          |
| 01 – Hospital                     | 011 – Psychiatric Facility Institutions for Mental Diseases (IMDs) that are freestanding or have independent organizational structure | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:  
  ○ Provider Agreement           | • Copy of Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:  
  ○ Provider Agreement           |
|                                  |                                      | ○ Federal W-9 form                                                                                         | ○ Federal W-9 form                                                                                            |
|                                  |                                      | • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable                              | • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable                                |
|                                  |                                      | • Proof of Medicare participation required                                                                | • 16 Bed or Less Addendum, if applicable                                                                       |
|                                  |                                      | • Copy of Division of Mental Health and Addiction (DMHA) Private Mental Health Facility license or certification | • Copy of appropriate license from appropriate state                                                          |
|                                  |                                      | • 16 Bed or Less Addendum, if applicable                                                                   | • Proof of Medicare participation, if enrolled in Medicare                                                    |
|                                  |                                      | • Application fee required ¹                                                                               | • Proof of participation in own state’s Medicaid program, if enrolled                                          |
|                                  |                                      |                                                                                                          | • Application fee required ¹                                                                                  |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 01 – Hospital                    | 012 – Rehabilitation (distinct part or unit) | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:
  ○ Provider Agreement
  ○ Federal W-9 form
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  • Proof of Medicare participation required
  • Proof of Indiana State Department of Health (ISDH) Certification
  • Application fee required |
|                                 |                                       | • Copy of Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:
  ○ Provider Agreement
  ○ Federal W-9 form
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  • Copy of license from appropriate state
  • Proof of Medicare participation, if enrolled in Medicare
  • Proof of participation in own state’s Medicaid program, if enrolled
  • Application fee required |
| 01 – Hospital                    | 013 – Long Term Acute Care (LTAC)     | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form (indicate update to a current provider number), which includes:
  ○ Provider Agreement
  ○ Federal W-9 form
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  • Proof of Medicare participation required
  • Copy of Indiana State Department of Health (ISDH) license complying with IC 16-21 for LTAC
  • Copy of Centers for Medicare & Medicaid Services (CMS) LTAC approval letter
  • Application fee required |
|                                 |                                       | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 – Ambulatory Surgical Center</td>
<td>020 – Ambulatory Surgical Center (ASC)</td>
<td>• Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes: 1 ○ Provider Agreement  ○ Federal W-9 form  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  • Proof of Medicare participation, if enrolled in Medicare  • Copy of Indiana State Department of Health (ISDH) Certification  • Application fee required 1</td>
<td>• Copy of Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes: 1 ○ Provider Agreement  ○ Federal W-9 form  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  • Copy of license from appropriate state  • Proof of Medicare participation, if enrolled in Medicare  • Proof of participation in own state’s Medicaid program, if enrolled  • Application fee required 1</td>
</tr>
<tr>
<td>03 – Extended Care Facility</td>
<td>030 – Nursing Facility 031 – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) 032 – Pediatric Nursing Facility 033 – Residential Care Facility</td>
<td>• Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes: 1 ○ Provider Agreement  ○ Federal W-9 form  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  • Proof of Medicare participation, if enrolled in Medicare  • Copy of Indiana State Department of Health (ISDH) Certification  • Application fee required 1</td>
<td>Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 03 – Extended Care Facility      | 034 – Psychiatric Residential Treatment Facility (PRTF) | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Indiana Family and Social Services Administration (FSSA) residential child care license for a private, secure care facility 470 IAC 3-13  
  • Copy of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Council on Accreditation (COA) credentials  
  • Attestation letter for facility compliance  
  • Application fee required | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 04 – Rehabilitation Facility     | 040 – Rehabilitation Facility        | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:
○ Provider Agreement
○ Federal W-9 form
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
• Proof of Medicare participation, if enrolled in Medicare
• Proof of Indiana State Department of Health (ISDH) Certification
• Application fee required ¹ | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
# IHCP Provider Enrollment

## Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 04 – Rehabilitation Facility     | 041 – Comprehensive Outpatient Rehabilitation Facility | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Enrollment and Maintenance Packet, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Proof of Medicare participation  
  • Proof of Indiana State Department of Health (ISDH) Certification  
  • Application fee required  
  • Per CMS requirements – Facility must have on staff: physician and HSPP mental health provider and physical therapist  
  • A copy of license from the Indiana Professional License Agency (IPLA) for rendering providers | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

---

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment
### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>05 – Home Health Agency</td>
<td>050 – Home Health Agency</td>
<td>• Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Proof of Medicare participation, if enrolled in Medicare ○ Proof of Indiana State Department of Health (ISDH) License ○ Application fee required ¹ ○ Fingerprinting and background check required ²</td>
<td>Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
<tr>
<td>06 – Hospice</td>
<td>060 – Hospice</td>
<td>• Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Proof of Medicare participation ○ Proof of hospice license ○ Application fee required ¹</td>
<td>Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 – Clinic</td>
<td>080 – Federally Qualified Health Center (FQHC)</td>
<td>• Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Approval letter from CMS (Department of Health and Human Services) for each location • Medicare number for each service location if enrolled in Medicare • A copy of license from the Indiana Professional License Agency (IPLA) for rendering providers • Application fee required</td>
<td>Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 – Clinic</td>
<td>081 – Rural Health Clinic (RHC)</td>
<td>• Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ CMS Medicare approval letter for each location ○ A copy of license from the Indiana Professional License Agency (IPLA) for rendering providers ○ Application fee required</td>
<td>Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
<tr>
<td>08 – Clinic</td>
<td>082 – Medical Clinic</td>
<td>• Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Proof of Medicare participation, if enrolled in Medicare ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ A copy of license from the Indiana Professional License Agency (IPLA) for rendering providers</td>
<td>• Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Proof of Medicare participation, if enrolled in Medicare ○ Proof of participation in own state’s Medicaid program, if enrolled ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Payment of proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>08 – Clinic</td>
<td>083 – Family Planning Clinic</td>
<td>• Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Proof of Medicare participation, if enrolled in Medicare ○ A copy of license from the Indiana Professional License Agency (IPLA) for rendering providers</td>
<td>• Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Copy of license from appropriate state ○ Proof of Medicare participation, if enrolled in Medicare ○ Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
# IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 08 – Clinic                      | 084 – Nurse Practitioner Clinic       | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Proof of Medicare participation, if enrolled in Medicare  
• A copy of license from the Indiana Professional License Agency (IPLA) for rendering providers | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Copy of license from appropriate state  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled |

---

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment Provider Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 08 – Clinic                      | 086 – Dental Clinic                    | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Proof of Medicare participation, if enrolled in Medicare  
• A dental practice must be owned by a dentist  
• For a sole proprietorship, a partnership, or professional services corporation, the owners listed on Schedule C must have dental licenses | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled |
| 08 – Clinic                      | 087 – Therapy Clinic                   | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Proof of Medicare participation, if enrolled in Medicare  
• Per CMS – Clinic must have two enrolled physicians plus one or more therapists  
• Application fee required 1 | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Per CMS – Clinic must have two enrolled physicians plus one or more therapists  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Application fee required 1 |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
# IHCP Provider Enrollment
## Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 08 – Clinic                      | 088 – Birthing Center               | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Per CMS requirements – Clinic must have a physician and/or midwife on staff | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Per CMS requirements – Clinic must have a physician and/or midwife on staff  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled | |
| 09 – Advanced Practice Registered Nurse | 090 – Pediatric Nurse Practitioner  
  091 – Obstetric Nurse Practitioner  
  092 – Family Nurse Practitioner  
  093 – Nurse Practitioner (other, for example, clinical nurse specialist)  
  094 – Certified Registered Nurse Anesthetist (CRNA)  
  095 – Certified Nurse Midwife | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Copy of current license from Indiana Professional License Agency (IPLA) – Includes rendering providers in a group and sole practitioners  
  • Copy of the Nurse Practitioner (NP) certification from accredited NP certifying organization | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from the appropriate state  
  • Copy of NP certification from accredited NP certifying organization  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled | |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 – Physician Assistant</td>
<td>100 – Physician Assistant</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: o Provider Agreement o Federal W-9 form • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Proof of Medicare participation, if enrolled in Medicare • Copy of current license from Indiana Professional License Agency (IPLA)</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: o Provider Agreement o Federal W-9 form • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Copy of license from the appropriate state • Proof of Medicare participation, if enrolled in Medicare • Outpatient Mental Health Addendum</td>
</tr>
<tr>
<td>11 – Mental Health Providers</td>
<td>110 – Outpatient Mental Health Clinic</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: o Provider Agreement o Federal W-9 form • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Proof of Medicare participation, if enrolled in Medicare • Outpatient Mental Health Addendum</td>
<td>Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 11 – Mental Health Provider      | 111 – Community Mental Health Center (CMHC) | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Outpatient Mental Health Addendum  
  • Certification from FSSA’s Division of Mental Health and Addiction (DMHA)  
  • Application fee required 1 | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
**IHCP Provider Enrollment**  
**Type and Specialty Matrix**

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 11 – Mental Health Provider       | 114 – Health Service Provider in Psychology (HSPP) | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of current license from Indiana Professional License Agency (IPLA)  
  • Proof of Medicare participation, if enrolled in Medicare | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license from appropriate state  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled |
|                                   | 115 – Adult Mental Health and Habilitation (AMHH) Service Provider | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Outpatient Mental Health Addendum  
  • Certification from FSSA’s Division of Mental Health and Addiction (DMHA)  
  • Application fee required ¹ | • Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 – Mental Health Provider</td>
<td>611 – Children’s Mental Health Wraparound (CMHW)</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  ○ Provider Agreement  ○ Federal W-9 form  ○ Proof of Medicare participation, if enrolled in Medicare  ○ Outpatient Mental Health Addendum  ○ Certification from FSSA’s Division of Mental Health and Addiction (DMHA)  ○ Application fee required 1</td>
<td>• Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
<tr>
<td>11 – Mental Health Provider</td>
<td>612 – Behavioral and Primary Healthcare Coordination (BPHC)</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification to update specialty  ○ Certification from FSSA’s Division of Mental Health and Addiction (DMHA)  ○ Not a stand-alone specialty; specialty can only be added to an enrolled community mental health center (CMHC)</td>
<td>• Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
<tr>
<td>11 – Mental Health Provider</td>
<td>613 – MRO Clubhouse</td>
<td>• Not a stand-alone specialty; specialty can only be added as a rendering provider contracted with an IHCP-enrolled community mental health center (CMHC)  ○ IHCP Rendering Provider Enrollment and Profile Maintenance Form – To enroll as a rendering provider of psychosocial rehabilitation services  ○ Certification from the FSSA’s Division of Mental Health and Addiction (DMHA)  ○ IHCP MRO Clubhouse Provider Enrollment Addendum</td>
<td>• Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment

### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 – Mental Health</td>
<td>615 – Applied Behavior Analysis (ABA) Therapist</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Proof of Medicare participation, if enrolled in Medicare ○ Copy of current, valid Behavior Analyst Certification Board (BACB) certification as a Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst-Doctoral (BCBA-D).</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
</tbody>
</table>

| 12 – School Corporation          | 120 – School Corporation             | • Indiana Health Coverage Programs (IHCP) School Corporation Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Must be listed on the approved Indiana Department of Education’s school corporation list and charter school list | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
# IHCP Provider Enrollment

## Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 13 – Public Health Agency        | 130 – County Health Department       | - Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Application fee required ¹ | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |
| 14 – Podiatrist                  | 140 – Podiatrist                     | - Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Copy of current license from Indiana Professional License Agency (IPLA) | - Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from appropriate state  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
# IHCP Provider Enrollment
## Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 15 – Chiropractor                | 150 – Chiropractor                  | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Proof of Medicare participation, if enrolled in Medicare  
• Copy of current license from Indiana Professional License Agency (IPLA) | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of license from appropriate state  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled |
| 17 – Therapist                   | 170 – Physical Therapist            | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Proof of Medicare participation, if enrolled in Medicare  
• Copy of current license from Indiana Professional License Agency (IPLA)  
• Application fee required if enrolling as a group | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of license from appropriate state  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Application fee required if enrolling as a group |
|                                  | 171 – Occupational Therapist        |                                        |                                                  |
|                                  | 173 – Speech/Hearing Therapist      |                                        |                                                  |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – Optometrist</td>
<td>180 – Optometrist</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form • Proof of Medicare participation, if enrolled in Medicare • Copy of current license from Indiana Professional License Agency (IPLA)</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form • Copy of license from appropriate state • Proof of Medicare participation, if enrolled in Medicare • Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
<tr>
<td>19 – Optician</td>
<td>190 – Optician</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form • Proof of Medicare participation, if enrolled in Medicare • Copy of retail merchant’s certificate (providers that have nonprofit status are exempt from this requirement) • Proof of nonprofit status, if applicable</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form • Copy of retail merchant’s certificate (providers that have nonprofit status are exempt from this requirement) • Proof of nonprofit status, if applicable • Copy of license from appropriate state, if that state licenses opticians • Proof of Medicare participation, if enrolled in Medicare • Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 20 – Audiologist                 | 200 – Audiologist                   | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Proof of Medicare participation, if enrolled in Medicare  
• Copy of current license from Indiana Professional License Agency (IPLA) | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of license from appropriate state, if that state licenses opticians  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled |
| 22 – Hearing Aid Dealer          | 220 – Hearing Aid Dealer            | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Proof of Medicare participation, if enrolled in Medicare  
• Copy of state’s Hearing Aid Dealer’s License  
• Application fee required  
• Fingerprint and background check required | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of appropriate state’s Hearing Aid Dealer’s License  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Application fee required  
• Fingerprint and background check required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 – Pharmacy</td>
<td>240 – Pharmacy</td>
<td>• Indiana Health Coverage Programs (IHCP) Pharmacy Provider Application and Maintenance Form, which includes:  ○ Provider Agreement  ○ Federal W-9 form  • Copy of Indiana Pharmacy License and HME license, if applicable  • Proof of Medicare participation, if enrolled in Medicare  • Application fee required 1  • If DME 250 – Fingerprint and background check required 2  • If HME 251 – Fingerprint and background check required 2</td>
<td>• Indiana Health Coverage Programs (IHCP) Pharmacy Provider Application and Maintenance Form, which includes:  ○ Provider Agreement  ○ Federal W-9 form  • Copy of license or permit from appropriate state  • Proof of Medicare participation, if enrolled in Medicare  • Proof of participation in own state’s Medicaid program, if enrolled  • If supplying to residents of Indiana via mail or other delivery services, you must have an Indiana nonresident pharmacy license  • Application fee required 1  • If DME 250 – Fingerprint and background check required 2  • If HME 251 – Fingerprint and background check required 2</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment
### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 25 – DME/Medical Supply Dealer    | 250 – DME/Medical Supply Dealer       | • Indiana Health Coverage Programs (IHCP) Durable Medical Equipment Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Medicare assignment letter, if enrolled  
  • Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy; required only if a DME provider also dispenses HME  
  • Copy of retail merchant’s certificate (providers that are nonprofit are exempt from this requirement)  
  • Proof of nonprofit status, if applicable  
  • Application fee required  
  • Fingerprint and background check required | • Indiana Health Coverage Programs (IHCP) Durable Medical Equipment Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Medicare assignment letter, if enrolled  
  • Copy of retail merchant’s certificate (providers that are nonprofit are exempt from this requirement)  
  • Copy of license if state licenses DME providers  
  • Proof of nonprofit status, if applicable  
  • Proof of Medicare participation, if enrolled in Medicare  
  • If not Medicare enrolled, proof of participation in own state’s Medicaid program  
  • Prior authorization (PA) for services required  
  • Application fee required  
  • Fingerprint and background check required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 25 – DME/Medical Supply Dealer   | 251 – HME/Home Medical Equipment Supply Dealer | • Indiana Health Coverage Programs (IHCP) Durable Medical Equipment Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of current license from Indiana Professional License Agency (IPLA)  
• Medicare assignment letter, if enrolled  
• Copy of retail merchant’s certificate (providers that are nonprofit are exempt from this requirement)  
• Proof of nonprofit status, if applicable  
• Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy  
• Application fee required ¹  
• Fingerprint and background check required ² | • Indiana Health Coverage Programs (IHCP) Durable Medical Equipment Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Medicare assignment letter, if enrolled  
• Copy of retail merchant’s certificate (providers that are nonprofit are exempt from this requirement)  
• Proof of nonprofit status, if applicable  
• Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy (physical service location does not have to be in the state of Indiana, but you must obtain an Indiana HME license to provide services to Indiana residents)  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Prior authorization (PA) for services required  
• Application fee required ¹  
• Fingerprint and background check required ² |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 26 – Transportation              | 260 – Ambulance                      | • Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Emergency Medical Services (EMS) commission certification  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Application fee required  
  1                                                                                        | • Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of appropriate state’s EMS commission certification  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled  
  • Application fee required  
  1                                                                                        |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
**IHCP Provider Enrollment Type and Specialty Matrix**

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 – Transportation</td>
<td>261 – Air Ambulance</td>
<td>• Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ EMS Commission Air Ambulance certification ○ Proof of Medicare participation, if enrolled in Medicare ○ Application fee required ¹</td>
<td>• Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Copy of appropriate state’s emergency medical services (EMS) commission certification ○ Proof of Medicare participation, if enrolled in Medicare ○ Proof of participation in own state’s Medicaid program, if enrolled ○ Application fee required ¹</td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
**IHCP Provider Enrollment**

**Type and Specialty Matrix**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 26 – Transportation    | 262 – Bus                             | • Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Motor Carrier Services (MCS) certificate from the Indiana Department of Revenue  
  • Proof of insurance coverage as required by the Indiana motor carrier authority  
  • Copy of driver’s license for all drivers  
  • Application fee required  
  • Fingerprint and background check required  | • Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of appropriate state’s certification for buses  
  • Motor carrier safety (MCS) certificate showing interstate authority, if the provider crosses state lines  
  • Proof of insurance, as indicated by local ordinances  
  • Copy of driver’s license for all drivers  
  • Application fee required  
  • Fingerprint and background check required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 26 – Transportation              | 263 – Taxi                           | • Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of driver’s license for all drivers  
  • Document showing operating authority from the local governing body (city taxi or livery license)  
  • Copy of retail merchant’s certificate (providers that have nonprofit status are exempt from this requirement)  
  • Proof of nonprofit status, if applicable  
  • Proof of insurance, as indicated by local ordinances (if unspecified by local ordinance, a minimum of $25,000/$50,000 public livery insurance covering all vehicles used in the business)  
  • Application fee required ¹  
  • Fingerprint and background check required ²  
  • Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years | • Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of retail merchant’s certificate (providers that have nonprofit status are exempt from this requirement)  
  • Proof of nonprofit status, if applicable  
  • Copy of driver’s license for all drivers  
  • Proof of insurance as indicated by local ordinances (if unspecified by local ordinance, a minimum of $25,000/$50,000 public livery insurance covering all vehicles used in the business)  
  • Document showing taxi operating authority from the local governing body as a common carrier  
  • Application fee required ¹  
  • Fingerprint and background check required ²  
  • Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 26 – Transportation              | 264 – Common Carrier (Ambulatory)     | • Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes:  
  - Provider Agreement  
  - Federal W-9 form  
  - Copy of MCS certificate form the Indiana Department of Revenue (for-profit providers only)  
  - Copy of driver’s license for all drivers  
  - Interstate carriers must submit their U.S. Department of Transportation (USDOT) number for verification  
  - Proof of nonprofit status, if applicable  
  - Proof of insurance  
  - Application fee required  
  - Fingerprint and background check required  
  - Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years (for-profit providers only) | • Indiana Health Coverage Programs (IHCP) Transportation Provider Application and Maintenance Form, which includes:  
  - Provider Agreement  
  - Federal W-9 form  
  - For interstate carriers, submission of the USDOT number for verification  
  - Copy of driver’s license for all drivers  
  - Copy of appropriate state’s certification for common carriers  
  - MCS certificate showing interstate authority, if the provider crosses state lines (for-profit providers only)  
  - Proof of nonprofit status, if applicable  
  - Proof of insurance  
  - Application fee required  
  - Fingerprint and background check required  
  - Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years (for-profit ambulatory and for-profit non-ambulatory only) |
| 26 – Common Carrier (Non-Ambulatory) | 265 – Common Carrier (Non-Ambulatory) | • Ambulatory means the clients are able to walk to and from or transfer into or out of the transporting vehicle.  
• Non-ambulatory means the clients need to remain in a wheelchair while being transported. | |

---

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment

### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 26 – Transportation               | 266 – Family Member                   | • Indiana Health Coverage Programs (IHCP) Family Member/Associate Transportation Provider Enrollment and Maintenance Packet, which includes:  
  ○ IHCP Family Member/Associate Transportation Provider Agreement  
  ○ Federal W-9 form  
• Medicaid Family Member or Associate Transportation Services Form  
• Copy of current driver’s license  
• Copy of current auto insurance for the vehicle being used  
• Copy of current auto registration for the vehicle being used | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment
### Type and Specialty Matrix

1. Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2. Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>27 – Dentist</td>
<td>270 – Endodontist</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Proof of Medicare participation, if enrolled in Medicare • Copy of current license from Indiana Professional License Agency (IPLA) • A dental practice must be owned by a dentist • The owners as listed on Schedule C for a sole proprietorship, a partnership, or a professional services corporation (&quot;P.S.C.&quot;) must have dental licenses</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Proof of Medicare participation, if enrolled in Medicare • Proof of participation in own state’s Medicaid program, if enrolled • Copy of license from state where services are performed</td>
</tr>
</tbody>
</table>
## IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 27 – Dentist                     | 276 – Mobile Dental Van              | • Indiana Health Coverage Programs (IHCP) Group and Clinic Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Copy of current registration from Indiana Professional License Agency (IPLA)  
  • Copy of current license from Indiana Professional License Agency (IPLA) for rendering providers  
  • Copy of valid Indiana driver’s license for all drivers | • Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

| 28 – Laboratory                  | 280 – Independent Lab               | • Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate required  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Application fee required ¹ | • Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate required  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled  
  • Application fee required ¹ |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 28 – Laboratory                   | 281 – Mobile Lab                    | • Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate required  
• Proof of Medicare participation, if enrolled in Medicare  
• Copy of valid driver’s license for all drivers  
• Application fee required | • Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate required  
• Proof of Medicare participation, if enrolled in Medicare  
• Copy of valid driver’s license for all drivers  
• Application fee required |
| 28 – Laboratory                   | 282 – Independent Diagnostic Testing Facility (IDTF) | • Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Proof of Medicare participation, if enrolled in Medicare  
• Application fee required  
• Per CMS requirements – Must have a physician on staff | • Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Copy of valid driver’s license for all drivers  
• Application fee required  
• Per CMS requirements – Must have a physician on staff |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 – Laboratory</td>
<td>283 – Mobile Independent Diagnostic Testing Facility (IDTF)</td>
<td>• Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Proof of Medicare participation, if enrolled in Medicare ○ Copy of valid driver’s license for all drivers ○ Per CMS requirements – Must have a physician on staff ○ Application fee required 1</td>
<td>• Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Per CMS requirements, must have a physician on staff ○ Proof of Medicare participation, if enrolled in Medicare ○ Proof of participation in own state’s Medicaid program, if enrolled ○ Copy of appropriate state’s valid driver’s license for all drivers ○ Application fee required 1</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 – Radiology</td>
<td>290 – Freestanding X-Ray Clinic</td>
<td>• Indiana Health Coverage Programs (IHCP) Radiology Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Proof of Medicare participation, if enrolled in Medicare ○ Registration certificate ○ Notice of Indiana State Department of Health (ISDH) compliance ○ Operator certificates for all employee operators, except positron emission tomography – computed tomography (PET CT) scanner operators ○ PET and magnetic resonance imaging (MRI) services do not require certification or notice of compliance ○ Copy of valid driver’s license for all drivers, if applicable ○ Application fee required ¹</td>
<td>• Indiana Health Coverage Programs (IHCP) Radiology Provider Application and Maintenance Form, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Registration certificate ○ Operator certificates for all employee operators, except PET CT scanner operators ○ PET and magnetic resonance imaging (MRI) services do not require certification or notice of compliance ○ Copy of license from appropriate state ○ Proof of Medicare participation, if enrolled in Medicare ○ Proof of participation in own state’s Medicaid program, if enrolled ○ Copy of valid driver’s license for all drivers, if applicable ○ Application fee required ¹</td>
</tr>
<tr>
<td>291 – Mobile X-Ray Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 30 – End-Stage Renal Disease (ESRD) Clinic | 300 – Freestanding Renal Dialysis Clinic | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Application and Maintenance Form, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate required  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of Indiana State Department of Health (ISDH) certification  
• Application fee required ¹ | Out-of-state (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment
### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 – Physician</td>
<td>310 – Allergist</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ⚫ Provider Agreement ⚫ Federal W-9 form • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Proof of Medicare participation, if enrolled in Medicare • Copy of license from the Indiana Professional License Agency (IPLA) • Copy of board certification for specialty requested, if applicable</td>
<td>• Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes: ⚫ Provider Agreement ⚫ Federal W-9 form • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable • Copy of license from appropriate state • Copy of board certification for specialty requested, if applicable • Proof of Medicare participation, if enrolled in Medicare • Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
<tr>
<td></td>
<td>311 – Anesthesiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>312 – Cardiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>313 – Cardiovascular Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>314 – Dermatologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>315 – Emergency Medicine Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>316 – Family Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>317 – Gastroenterologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>318 – General Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>319 – General Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>320 – Geriatric Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>321 – Hand Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>323 – Neonatologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>324 – Nephrologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>325 – Neurological Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>326 – Neurologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>327 – Nuclear Medicine Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>328 – Obstetrician/Gynecologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>329 – Oncologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>330 – Ophthalmologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>331 – Orthopedic Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>332 – Otolist, Laryngologist, Rhinologist</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
## IHCP Provider Enrollment
### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>333 – Pathologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>334 – Pediatric Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>336 – Physical Medicine and Rehabilitation Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>337 – Plastic Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>338 – Proctologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>339 – Psychiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>340 – Pulmonary Disease Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>341 – Radiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>342 – Thoracic Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>343 – Urologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>344 – General Internist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>345 – General Pediatrician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>346 – Dispensing Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

32 – Waiver Provider – see pages 41-47

34 – MRT Copy Center 366 – MRT Copy Center

- Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes:
  - Provider Agreement
  - Federal W-9 form

- Indiana Health Coverage Programs (IHCP) Billing Provider Application and Maintenance Form, which includes:
  - Provider Agreement
  - Federal W-9 form
  - Proof of participation in own state’s Medicaid program, if enrolled

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
| 35 – Addiction Services           | 835 – Opioid Treatment Program       | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Proof of Medicare participation, if enrolled in Medicare  
• Copy of current Drug Enforcement Agency (DEA) registration certificate  
• Copy of Division of Mental Health and Addiction (DMHA) Opioid Treatment Program certification | • Out-of-State (OOS) providers are ineligible for Indiana Health Coverage Programs (IHCP) provider enrollment |

| 35 – Addiction Services           | 836 – Substance Use Disorder (SUD) Residential Addiction Treatment Facility | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Provider Enrollment and Maintenance Packet, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Proof of Medicare participation, if enrolled in Medicare  
• Provider must provide proof of one of the following:  
○ Copy of a Division of Mental Health and Addiction (DMHA) certification as a Sub-Acute Facility that includes an American Society of Addiction Medicine (ASAM) designation of offering either Level 3.1 or Level 3.5 residential services | • Indiana Health Coverage Programs (IHCP) Hospital and Facility Provider Enrollment and Maintenance Packet, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Proof of Medicare participation, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Provider must provide proof of one of the following:  
○ Copy of a Division of Mental Health and Addiction (DMHA) certification as a Sub-Acute Facility that includes an American Society of Addiction Medicine |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State (OOS) Provider Document Requirements</th>
</tr>
</thead>
</table>
|                                  |                                      | ○ Department of Child Services (DCS) licensing as a child care institution or private secure-care institution with a DMHA Addiction Services Provider Regular Certification that includes an ASAM designation of offering either Level 3.1 or Level 3.5 residential services.  
   • Facilities that have designations to offer both ASAM Level 3.1 and Level 3.5 services within the facility must include proof of both designations with their enrollment application.  
   • Copy of current Drug Enforcement Agency (DEA) registration certificate (optional)  
   • Application fee required | ○ Department of Child Services (DCS) licensing as a child care institution or private secure-care institution with a DMHA Addiction Services Provider Regular Certification that includes an ASAM designation of offering either Level 3.1 or Level 3.5 residential services.  
   • Facilities that have designations to offer both ASAM Level 3.1 and Level 3.5 services within the facility must include proof of both designations with their enrollment application.  
   • Copy of current Drug Enforcement Agency (DEA) registration certificate (optional)  
   • Application fee required |
| 36 – Genetic Counselor           | 800 – Genetic Counselor              | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Copy of current license from Indiana Professional License Agency (IPLA) | • Indiana Health Coverage Programs (IHCP) Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from the appropriate state  
  • Proof of Medicare participation, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>32 – Waiver</td>
<td>350 – Aged and Disabled (AD) Waiver</td>
<td>• A00 – Adult Day Services (Level 1)&lt;br&gt;• A01 – Adult Day Services (Level 2)&lt;br&gt;• A02 – Adult Day Services (Level 3)&lt;br&gt;• A03 – Adult Foster Care ¹&lt;br&gt;• A04 – Assisted Living&lt;br&gt;• A05 – Attendant Care ²&lt;br&gt;• A06 – Case Management&lt;br&gt;• A07 – Community Transition Services&lt;br&gt;• A08 – Environmental Modifications&lt;br&gt;• A09 – Healthcare Coordination&lt;br&gt;• A10 – Home-Delivered Meals&lt;br&gt;• A11 – Homemaker&lt;br&gt;• A12 – Nutritional Supplements&lt;br&gt;• A13 – Pest Control&lt;br&gt;• A14 – Respite&lt;br&gt;• A15 – Self-Directed Attendant Care&lt;br&gt;• A16 – Specialized Medical Equipment Supplies ¹, ²&lt;br&gt;• A17 – Transportation ¹&lt;br&gt;• A18 – Vehicle Modifications&lt;br&gt;• A19 – Personal Emergency Response Systems&lt;br&gt;• A20 – Environmental Modifications Assessment&lt;br&gt;• A21 – Structured Family Caregiving</td>
<td>• Indiana Health Coverage Programs (IHCP) Waiver Provider Application and Maintenance Form for your classification, which includes:&lt;br&gt;○ Provider Agreement&lt;br&gt;○ Federal W-9 form&lt;br&gt;• Certification letter from the appropriate waiver administering division&lt;br&gt;• A03 – Application fee required ¹&lt;br&gt;• A05 – Fingerprint and background check required ²&lt;br&gt;• A16 – Application fee, fingerprint, and background check required ¹, ²&lt;br&gt;• A17 – Application fee required ¹</td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.

³ Out-of-state providers must contact the appropriate waiver division for requirements.
### IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements³</th>
</tr>
</thead>
</table>
| 32 – Waiver        | 356 – Traumatic Brain Injury (TBI) Waiver | • B00 – Adult Day Services (Level 1)  
• B01 – Adult Day Services (Level 2)  
• B02 – Adult Day Services (Level 3)  
• B03 – Adult Foster Care ¹  
• B04 – Attendant Care ²  
• B05 – Behavior Management/Behavior Program & Counseling  
• B06 – Case Management  
• B07 – Community Transition Services  
• B08 – Environmental Modifications  
• B09 – Healthcare Coordination  
• B10 – Home-Delivered Meals  
• B11 – Homemaker  
• B12 – Nutritional Supplements  
• B14 – Personal Emergency Response Systems  
• B15 – Pest Control  
• B17 – Residential Habilitation and Support  
• B18 – Respite  
• B19 – Specialized Medical Equipment & Supplies  
• B21 – Structured Day Program  
• B22 – Supported Employment Follow Along  
• B23 – Transportation ¹  
• B24 – Vehicle Modifications  
• B25 – TBI Assisted Living | • Indiana Health Coverage Programs (IHCP) Waiver Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Certification letter from the appropriate waiver administering division  
• B03 – Application fee required ¹  
• B04 – Fingerprint and background check required ²  
• B19 – Application fee, fingerprint, and background check required ¹, ²  
• B23 – Application fee required ¹ |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.

³ Out-of-state providers must contact the appropriate waiver division for requirements.
## IHCP Provider Enrollment

### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Specialty</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 32 – Waiver   | 359 – Community Integration and Habilitation Waiver | • C00 – Adult Day Services (Level 1, 2, 3)  
• C01 – Adult Foster Care 1  
• C02 – Behavior Management/Behavior Program & Counseling  
• C03 – Community-Based Habilitation – Group  
• C04 – Community-Based Habilitation – Individual  
• C05 – Community Transition Services  
• C06 – Electronic Monitoring  
• C07 – Environmental Modifications  
• C08 – Facility-Based Habilitation – Group  
• C09 – Facility-Based Habilitation – Individual  
• C10 – Facility-Based Support Services  
• C11 – Family and Caregiver Training  
• C12 – Intensive Behavioral Intervention  
• C13 – Music Therapy 1  
• C14 – Occupational Therapy  
• C15 – Personal Emergency Response Systems  
• C16 – Physical Therapy 1  
• C17 – Prevocational Services  
• C18 – Psychological Therapy  
• C19 – Recreational Therapy 1  
• C20 – Rent/Food for Unrelated Live-In Caregiver  
• C21 – Residential Habilitation and Support  
• C22 – Respite  
• C23 – Specialized Medical Equipment & Supplies 1, 2  
• C24 – Speech/Language Therapy 1  
• C25 – Extended Services |

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Notes</th>
</tr>
</thead>
</table>
| • Indiana Health Coverage Programs (IHCP) Waiver Provider Application and Maintenance Form for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
• Certification letter from the appropriate waiver administering division  
• C01 – Application fee required 1  
• C13 – Application fee required, if group 1  
• C14 – Application fee required, if group 1  
• C16 – Application fee required, if group 1  
• C19 – Application fee required, if group 1  
• C23 – Application fee, fingerprint, and background check required 1, 2  
• C24 – Application fee required, if group 1  
• C26 – Application fee required 1  
• C29 – Application fee required 1  
• C30 – Application fee required 1 |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.

3 Out-of-state providers must contact the appropriate waiver division for requirements.
## IHCP Provider Enrollment
### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• C26 – Transportation Level 1 ¹</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• C27 – Workplace Assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• C28 – Case Management</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• C29 – Transportation Level 2 ¹</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• C30 – Transportation Level 3 ¹</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• C31 – Wellness Coordination</td>
<td></td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.

³ Out-of-state providers must contact the appropriate waiver division for requirements.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Code</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements[^3]</th>
</tr>
</thead>
</table>
| 32 – Waiver        | 360 – Family Supports Waiver | • D00 – Adult Day Services (Level 1, 2, 3)  
• D01 – Behavior Management/Behavior Program & Counseling  
• D02 – Community-Based Habilitation – Group  
• D03 – Community-Based Habilitation – Individual  
• D04 – Facility-Based Habilitation – Group  
• D05 – Facility-Based Habilitation – Individual  
• D06 – Facility-Based Support Services  
• D07 – Family and Caregiver Training  
• D08 – Intensive Behavioral Intervention  
• D09 – Music Therapy ^1  
• D10 – Occupational Therapy ^1  
• D11 – Personal Emergency Response Systems  
• D12 – Speech/Language Therapy ^1  
• D13 – Physical Therapy ^1  
• D14 – Prevocational Services  
• D15 – Psychological Therapy  
• D16 – Recreational Therapy ^1  
• D17 – Respite  
• D18 – Specialized Medical Equipment & Supplies ^1,^2  
• D19 – Extended Services  
• D20 – Transportation ^1  
• D21 – Workplace Assistance  
• D22 – Case Management  
• D23 – Participant Assistance and Care | • Indiana Health Coverage Programs (IHCP) Waiver Provider Application and Maintenance Form for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Certification letter from the appropriate waiver administering division  
• D09 – Application fee required, if group ^1  
• D10 – Application fee required, if group ^1  
• D12 – Application fee required, if group ^1  
• D13 – Application fee required, if group ^1  
• D16 – Application fee required, if group ^1  
• D18 – Application fee, fingerprint, and background check required ^1,^2  
• D20 – Application fee required ^1 |

[^1]: Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

[^2]: Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.

[^3]: Out-of-state providers must contact the appropriate waiver division for requirements.
| 32 – Waiver | 363 – Money Follows the Person (MFP) Demonstration Grant | 365 – Indiana Health Coverage Programs (IHCP) Waiver Provider Application and Maintenance Form for your classification, which includes:  
- Provider Agreement  
- Federal W-9 form  
- Certification letter from the appropriate waiver administering division  
- F03 – Application fee required  
- F05 – Fingerprint and background check required  
- F21 – Application fee required, if group  
- F23 – Application fee required, if group  
- F26 – Application fee required, if group  
- F29 – Application fee required, if group  
- F34 – Application fee, fingerprint, and background check required  
- F35 – Application fee required, if group  
- F38 – Application fee required  |
| --- | --- | --- |
| | | 1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.  
2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.  
3 Out-of-state providers must contact the appropriate waiver division for requirements. |
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements³</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• F38 – Transportation ¹</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F39 – Vehicle Modifications</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F40 – Workplace Assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F41 – Environmental Modifications Assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F42 – Structured Family Caregiving</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F43 – Wellness Coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F44 – Extended Services</td>
<td></td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required.

³ Out-of-state providers must contact the appropriate waiver division for requirements.