



### Before You Begin!

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

For additional help using the Portal, online web-based training for the new Provider Healthcare Portal is available on the [Provider Healthcare Portal Training](#) page on this site.

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

## Who Uses This Packet

Use this packet if you are a new or existing group or clinic to link practitioners, or rendering providers, to your business. Group or clinic providers complete and submit this enrollment packet on behalf of rendering providers associated with the group or clinic. The following provider types may be enrolled as rendering providers linked to groups or clinics.

- 09 – Advanced Practice Nurse
- 10 – Physician Assistant
- 11 – Mental Health Provider (specialties 114 and 613)
- 14 – Podiatrist
- 15 – Chiropractor
- 17 – Therapist
- 18 – Optometrist
- 19 – Optician (with optometry groups only)
- 20 – Audiologist
- 27 – Dentist
- 31 – Physician
- 36 – Genetic Counselor

## General Instructions

This enrollment and maintenance packet can be used to do the following:

- **Establish an initial linkage between your business and a rendering provider** – Complete all fields in each section unless a section is optional and does not apply to you.
- **Update the information about a rendering provider** (also known as a Provider Profile) already linked to your business, including changing service locations, terminating linkages, and so on. Only the following sections are required when using the packet to update a rendering provider's profile:
  - Schedule A – Type of request
  - Schedule A – Group or clinic information
  - Schedule A – In the *Rendering Provider Information* section, the rendering provider's current name and rendering provider's IHCP Provider ID (formerly Legacy Provider Identifier/LPI) fields
  - Schedule A – Any other field where the information has changed; if the information in a field has not changed, leave the field blank. For example, if the rendering provider's name has not changed, leave the *Rendering provider's former name* field blank.
  - Schedule B – All fields

- Enroll in Indiana Medicaid programs such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)/HealthWatch, Medical Review Team (MRT), and the 590 Program.

## Tips for Completing this Packet

- Read the instructions in each section of the packet carefully.
- Where sections of the packet request supporting documentation (such as a copy of a certification), the required documentation must be included as an attachment to the packet.

## Next Steps

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

Provider Use Only	Quality Checklist
	If you are enrolling multiple rendering providers, double-check that a rendering packet for each has been included with your enrollment application.
	<p>When updating a rendering provider's profile, complete only the following sections:</p> <ul style="list-style-type: none"> <li>Schedule A – Type of request</li> <li>Schedule A – Group or clinic information</li> <li>Schedule A – In the <i>Rendering Provider Information</i> section, the rendering provider's current name and rendering provider's IHCP Provider ID fields</li> <li>Schedule A – Any other field where the information has changed; if the information in a field has not changed, leave the field blank. For example, if the rendering provider's name has not changed, leave the <i>Rendering provider's former name</i> field blank.</li> <li>Schedule B – All fields</li> </ul>
	Double-check that required supporting documentation for each rendering provider is included as an attachment to his or her packet. Required documentation for rendering provider types is listed on the <a href="#">IHCP Provider Enrollment Type and Specialty Matrix</a> at indianamedicaid.com.
	Double-check that the authorized signatures section of this packet has been completed and signed by both an authorized official and the rendering provider.
	Double-check that the <b>Rendering Provider Agreement</b> has been signed by an authorized official who is listed on Schedule C for the group/clinic provider <b>and</b> by the rendering provider. (The Rendering Provider Agreement must not be signed by a delegated administrator.)

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

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

5. If the packet needs correcting or is missing required documentation, the IHCP Provider Enrollment Unit will contact you by telephone, email, fax, or mail. This contact is intended to communicate what needs to be corrected, completed, and submitted before the IHCP can process your enrollment transaction. If an application is rejected for missing or incomplete information, a letter will be sent, indicating what needs to be corrected or attached. When submitting the correction or missing information, providers **MUST** return the entire packet, along with a copy of the letter explaining the errors or omissions as a cover sheet.
6. You will be notified via regular mail after your application has been approved. Please allow 15 business days plus mailing time before inquiring about the status of your application.
7. After you are enrolled as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's managed care programs, you must apply directly with one or more of the managed care entities (MCEs). Please see the [Managed Care](#) page at indianamedicaid.com for information about the programs and the MCEs with which the State contracts for each.



| Schedule A

IHCP Rendering Provider Enrollment and Profile Maintenance Packet

indianamedicaid.com

**To enroll multiple rendering providers, complete a separate *IHCP Rendering Provider Enrollment and Profile Maintenance Packet* for each.**

### Type of Request

1. Type of request:

- This form can be used for multiple purposes; select the purpose that applies:
  - New enrollment** – You are enrolling the rendering provider for the first time.
  - Profile update** – The rendering provider is already enrolled and you need to change the provider’s profile information.
  - Terminate linkage** – The rendering provider is already enrolled and you need to terminate the provider’s linkage to a service location.
- Only groups and clinics have rendering providers. The group or clinic’s service location must be enrolled before the rendering provider can be linked to the service location.
- Groups and clinics do not need to submit rendering provider packets during revalidation. See the revalidation instructions in the *IHCP Group and Clinic Provider Enrollment and Profile Maintenance Packet*.

### Group or Clinic Service Location Information

2. Group or clinic’s service location name:		3. Group or clinic’s taxpayer identification number (TIN):		
4. Service location address:	5. City:	6. State:	7. ZIP + 4 ( <b>Nine digits required</b> ):	
8. Group or clinic’s IHCP Provider ID (if currently enrolled):		9. Group or clinic’s Medicare number:		
10. Group or clinic’s National Provider Identifier (NPI):	11. Taxonomy codes:			

### Rendering Provider Information

- See the [IHCP Provider Enrollment Type and Specialty Matrix](#) at indianamedicaid.com to determine the appropriate provider type, specialty codes, and enrollment requirements for this packet.
- Only one provider type code is permitted per packet. Only one **primary** specialty code is permitted per packet. Submit a separate packet for each additional provider type or primary specialty.
- A **taxonomy code** identifies a healthcare provider type and specialty; it is not a universal physician identification number (UPIN), Medicare provider number, or IHCP provider number. The full provider taxonomy code set can be found at [wpc-edi.com](#) under Reference. You may enter up to three taxonomies per form.
- By entering the rendering provider’s Social Security number, you are providing consent to the Indiana Family and Social Services Administration and its contractors to use the Social Security number for the sole purpose of verifying initial and continuing eligibility to participate in the Medicaid program with the Office of the Inspector General, the Centers for Medicare & Medicaid Services, licensing bodies, and other appropriate state and federal agencies.
- If the rendering provider’s name has changed, submit documentation showing proof of the name change. A provider’s updated license or appropriate certification may be presented as proof of a name change. If a provider license does not show the new name, an official document showing the legal name change is required. Rendering provider name changes do not require a new W-9.
- If the rendering provider is a qualified provider (QP) for presumptive eligibility (PE), terminating any specialties that qualified the provider may result in termination of QP PE status.
- If the rendering provider is a mental health provider with a provider specialty **613 – MRO Clubhouse**, complete the *IHCP MRO Clubhouse Provider Enrollment Addendum*.

12. Rendering provider’s current name (please print):		13. Rendering provider’s former name (required only for name changes):		
14. Rendering provider’s IHCP Provider ID (if currently enrolled):	15. Social Security number (enter N/A if an organization):	16. Date of birth (enter N/A if an organization):		
17. Rendering provider’s NPI:	18. Rendering provider’s taxonomy codes:			
19. Provider type (two-digit code):	20. Primary specialty code (three-digit code):	21. Additional specialty codes (three-digit codes):		

### Group Service Location Linkage Information

**A rendering provider may be linked to more than one service location.** Also, because rendering providers can perform services across state lines for groups that are in multiple states, the license number for each service location is required. If all the service locations are in the same state, fill in the license number one time and indicate "same" for the remaining linkage lines. When requesting a retroactive start date, you must submit proof to support the retroactive date requested.

22a. Group service location NPI/Provider ID	22b. ZIP + 4 for service location (nine digits required)	22c. Requested start date at service location	22d. Termination date at service location	22e. Rendering provider Medicare # for service location	22f. Rendering provider license # for service location	22g. Issuing state of license at service location

### Licensure/Certification

The licensing or certification requirements for all rendering provider types are listed in the [IHCP Provider Enrollment Type and Specialty Matrix](#) at indianamedicaid.com. A copy of the license or certificate from the appropriate board or authority must be included as an attachment to the packet.

### Additional Programs Requested

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

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

23. 590 Program participation:

Yes          No

24. Participate in the Medical Review Program:

Medical Review Program/IHCP  
 Medical Review Program Only  
 None

### Managed Care Information

After you are enrolled as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's managed care programs, you must apply directly with one or more of the managed care entities (MCEs). Please see the [Managed Care](#) page at indianamedicaid.com for information about the programs and the MCEs with which the State contracts for each.



**To enroll multiple rendering providers, complete a separate *IHCP Rendering Provider Enrollment and Profile Maintenance Packet* for each.**

### Contact Information

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

1. Contact name:

2. Telephone:

3. Contact email address:

4. Email address for provider publications:

### IHCP Provider Signature Authorization

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

**The owner or an authorized official of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. Both the authorized official and the rendering provider must sign this section. A delegated administrator may sign this form as the authorized official if it has been expressly indicated on an *IHCP Delegated Administrator Addendum/Maintenance Form*, on file or attached. The IHCP can process provider maintenance requests only when the appropriate signature is present. **The form will be returned if the appropriate signatures are not submitted.****

5. Group or clinic's business name (please print):

6. Tax ID:

7. Authorized official's name (please print):

8. Title:

9. Authorized official's signature:

10. Date:

11. Rendering provider's name (please print):

12. Tax ID:

13. Rendering provider's signature:

14. Date:



## IHCP MRO Clubhouse Provider Enrollment Addendum

Version 2.0, August 2017

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### Overview

This addendum must be completed by mental health providers with a provider specialty **613 – MRO Clubhouse**.

The purpose of this addendum is to provide the Indiana Health Coverage Programs (IHCP) with information about the rendering clubhouse provider that will be providing psychosocial rehabilitation services. The rendering clubhouse provider must:

- Be certified by the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DHMA).
- Be enrolled as an IHCP rendering provider linked to a DMHA-approved IHCP-enrolled Medicaid Rehabilitation Option (MRO) provider.

A copy of the DMHA certification must be attached to this addendum and included with the enrollment packet.

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

#### Disclosure Information

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

#### Disclosure of Social Security Numbers

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

#### Consent to Release Social Security Numbers

Submission of information on this schedule indicates that consent has been given to the Indiana FSSA and its contractors to use the information, including the Social Security number, for the sole purpose of verifying eligibility to participate in the Medicaid program through the Office of the Inspector General, the Centers for Medicare & Medicaid Services, relevant licensing bodies, and other appropriate state and federal agencies. It is further understood that the FSSA and its contractors may use a Social Security number so the office may determine eligibility for continued participation in the Medicaid program.

This addendum must be submitted with your *IHCP Rendering Provider Enrollment and Profile Maintenance Packet*.

### General Information

1. Legal name of community mental health center	2. Taxpayer identification number (TIN)
3. Legal name of the contracting clubhouse provider	4. Taxpayer identification number (TIN)

### Signature

**I certify the information stated on this addendum is correct and complete to the best of my knowledge. I further certify that I am an authorized official of the MRO Clubhouse provider and have authority to provide and attest to the information listed on this addendum.**

5. Authorized official's name (please print)	6. Title
7. Authorized official's signature	8. Date

**Individuals with an Ownership or Control Interest and Managing Individuals**

Please list **all** individuals with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers must also list their managing individuals: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of the provider entity.

Include each person's name, address, date of birth (DOB), and Social Security number (SSN). Also indicate the title (for example, chief executive officer, owner, board member) and, if an owner, the percent of ownership. Attach additional pages as needed.

1a. Name of individual

2a. Address

3a. Title

4a. % of ownership (if applicable)

5a. Social Security number

6a. Date of birth

1b. Name of individual

2b. Address

3b. Title

4b. % of ownership (if applicable)

5b. Social Security number

6b. Date of birth

1c. Name of individual

2c. Address

3c. Title

4c. % of ownership (if applicable)

5c. Social Security number

6c. Date of birth

1d. Name of individual

2d. Address

3d. Title

4d. % of ownership (if applicable)

5d. Social Security number

6d. Date of birth

1e. Name of individual

2e. Address

3e. Title

4e. % of ownership (if applicable)

5e. Social Security number

6e. Date of birth

1f. Name of individual

2f. Address

3f. Title

4f. % of ownership (if applicable)

5f. Social Security number

6f. Date of birth

1g. Name of individual

2g. Address

3g. Title

4g. % of ownership (if applicable)

5g. Social Security number

6g. Date of birth

**Relationships and Background Information**

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

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

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

**2. Indicate whether any persons or entities listed, or any secured creditors of the provider entity, have ever been sanctioned through criminal conviction or exclusion from participation in any program under Medicare, Medicaid, or Title XX services since the inception of the programs.**

2a. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction	Date sanction ended (please attach supporting documentation)	
2b. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction	Date sanction ended (please attach supporting documentation)	
2c. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction	Date sanction ended (please attach supporting documentation)	

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

3a. Name	NPI or IHCP Provider ID
3b. Name	NPI or IHCP Provider ID
3c. Name	NPI or IHCP Provider ID

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

4a. Name	NPI or IHCP Provider ID
4b. Name	NPI or IHCP Provider ID
4c. Name	NPI or IHCP Provider ID

**5. Indicate any former agent, officer, director, partner, or managing employee who has transferred ownership to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion.**

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





## | Rendering Provider Agreement

IHCP Rendering Provider Enrollment and Profile Maintenance Packet

[indianamedicaid.com](http://indianamedicaid.com)

**To enroll multiple rendering providers, complete a separate *IHCP Rendering Provider Enrollment and Profile Maintenance Packet* for each.**

### Overview

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

## Rendering Provider Agreement

Version 6.4, July 2017

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

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs ("IHCP"). As an enrolled provider in the IHCP, the undersigned entity agrees to provide covered services and/or supplies to Indiana Health Coverage Program members ("members"). As a condition of enrollment, this agreement cannot be altered and the Provider agrees to all of the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("FSSA").
2. To comply with all federal and state statutes and regulations pertaining to the IHCP, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.
4. To notify FSSA or its agent within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.
5. To provide covered services and/or supplies for which federal financial participation is available for members pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about members including at a minimum:
  - a. members' name, address, and social and economic circumstances;
  - b. medical services provided to members;
  - c. members' medical data, including diagnosis and past history of disease or disability;
  - d. any information received for verifying members' income eligibility and amount of medical assistance payments;
  - e. any information received in connection with the identification of legally liable third party resources.
7. To release information about members only to the FSSA or its agent and only when in connection with:
  - a. providing services for members; and
  - b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of IHCP covered services.
8. To maintain a written contract with all subcontractors, which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.
9. To notify the IHCP in writing of the name, address, and phone number of any entity acting on Provider's behalf for electronic submission of Provider's claims. Provider understands that the State requires 30 days prior written notice of any changes concerning Provider's use of entities acting on Provider's behalf for electronic submission of Provider's claims and that such notice shall be provided to the IHCP.
10. To submit claims, using only the billing number assigned to it by FSSA or its fiscal agent, for services rendered by the Provider or employees of the Provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital, ICF-IID, or nursing home), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide services covered by the IHCP pursuant to this Agreement.
11. To abide by the state's *Medical Policy Manual* and *IHCP Provider Reference Modules* as amended from time to time, as well as all provider bulletins, banner pages, and notices. Any amendments to the policy manual or reference modules, including provider bulletins, banner pages, and notices, will be communicated on the official state Medicaid website and shall be binding upon publication.
12. To update and maintain a current service location address as required.
13. To submit timely billing on IHCP-approved electronic or paper claims, as outlined in the policy manual, reference modules, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

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14. To certify that any and all information contained on any IHCP billings submitted on the Provider's behalf by electronic, telephonic, mechanical, or standard paper means of submission shall be true, accurate, and complete. The Provider accepts total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (whether by the Provider, the Provider's employees, agents, or a third party acting on the Provider's behalf, such as a service bureau). The Provider fully recognizes that any billing intermediary or service bureau that submits billings to the FSSA or its fiscal agent contractor is acting as the Provider's representative and not that of the FSSA or its fiscal agent contractor. The Provider further acknowledges that any third party that submits billings on the Provider's behalf shall be deemed to be the Provider's agent for the purposes of submission of the IHCP claims. The Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable federal and state laws.
15. The Provider understands that the standard paper claim form may include a signature line. The Provider understands that all the stipulations, conditions, and terms of the provider agreement apply in the event that the Provider fails, for any reason, to sign the paper claim, even if the claim is approved for payment. The Provider agrees that payment of a paper claim that does not contain the Provider's signature in no way absolves the Provider of the terms stated in the provider agreement.
16. To submit claim(s) for IHCP reimbursement only after first exhausting all other sources of reimbursement as required by the policy manual, reference modules, bulletins, and banner pages.
17. To submit claim(s) for IHCP reimbursement utilizing the appropriate claim forms specified in the policy manual, reference modules, bulletins, banner pages, and notices.
18. To submit claims that can be documented by Provider as being strictly for:
  - a. medically necessary medical assistance services;
  - b. medical assistance services actually provided to the person in whose name the claim is being made; and
  - c. compensation that Provider is legally entitled to receive.
19. To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for IHCP covered services provided to members. Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for IHCP covered services, excluding any co-payment permitted by law.
20. To refund duplicate or erroneous payments to FSSA or its fiscal agent within fifteen (15) days of receipt.
21. To make repayments to FSSA or its fiscal agent, or arrange to have future payments from the IHCP withheld, within sixty (60) days of receipt of notice from FSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. Outstanding overpayments made under prior provider agreements will remain collectable under this provider agreement.
22. To pay interest on overpayments in accordance with *Indiana Code (IC) 12-15-13-3, IC 12-15-21-3, and IC 12-15-23-3*.
23. To make full reimbursement to FSSA or its fiscal agent of any federal disallowance incurred by FSSA when such disallowance relates to payments previously made to Provider under the IHCP.
24. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
25. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of IHCP payments made to Provider, to assure the proper administration of the IHCP and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 Indiana Administrative Code (IAC) 1-5* and in the policy manual, reference modules, bulletins, and banner pages, and shall include, without being limited to, the following:
  - a. medical records as specified by *42 United States Code (USC) 1396(a)(27)*, and any amendments thereto;
  - b. records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs, or services;

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- c. any records determined by FSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the IHCP;
  - d. documentation in each patient's record that will enable the FSSA or its agent to verify that each charge is due and proper;
  - e. financial records maintained in the standard, specified form;
  - f. all other records as may be found necessary by the FSSA or its agent in determining compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the FSSA; and
  - g. any other information regarding payments claimed by the provider for furnishing services to the plan.
26. To cease any conduct that FSSA or its representative deems to be abusive of the IHCP.
  27. To promptly correct deficiencies in Provider's operations upon request by FSSA or its fiscal agent.
  28. To make a good faith effort to provide and maintain a drug-free workplace. Provider will give written notice to the State within ten (10) days after receiving actual notice that the provider or an employee of the provider has been convicted of a criminal drug violation occurring in the provider's workplace.
  29. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
    - a. the petitioner is the person to whom the order is specifically directed;
    - b. the petitioner is aggrieved or adversely affected by the order; or
    - c. the petitioner is entitled to review under the law.
  30. Provider must file a statement of issues within the time limits listed below, setting out in detail:
    - a. the specific findings, actions, or determinations of FSSA from which the Provider is appealing; and
    - b. with respect to each finding, action, or determination, all statutes or rules supporting the Provider's contentions of error and why the Provider believes that the office's determination was in error.
  31. Time limits for filing an appeal and the statement of issues are as follows:
    - a. A provider must file an appeal of any of the following actions within sixty days of receipt of FSSA's determination:
      - (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
      - (2) A notice of overpayment.The statement of issues must be filed with the request for appeal.
    - b. All appeals of actions not described in (a) must be filed within 15 days of receipt of FSSA's determination. The statement of issues must be filed within 45 days of receipt of FSSA's determination.
  32. To cooperate with FSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.
  33. To comply with the advance directives requirements as specified in *42 Code of Federal Regulations (CFR) Part 489, Subpart I*, and *42 CFR 417.436(d)*, as applicable.
  34. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of an IHCP covered service.
  35. The Provider and its agents shall abide by all ethical requirements that apply to persons who have a business relationship with the State, as set forth in *IC § 4-2-6 et seq.*, *IC § 4-2-7, et seq.*, the regulations promulgated thereunder, and *Executive Order 04-08*, dated April 27, 2004. If the Provider is not familiar with these ethical requirements, the Provider should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission Web site at <http://www.in.gov/ethics/>. If the Provider or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Agreement immediately upon notice to the Provider. In addition, the Provider may be subject to penalties under *IC § 4-2-6*, *IC 4-2-7*, *IC 35-44-1-3*, and under any other applicable laws.

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36. To disclose information on ownership and control, information related to business transactions, information on change of ownership, and information on persons convicted of crimes in accordance with 42 CFR, Part 455, Subpart B, and 405 IAC 1-19. Long term care providers must comply with additional requirements found in 405 IAC 1-20. Pursuant to 42 Code of Federal Regulations, part 455.104(c), OMPP shall terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
37. To submit within 35 days of the date of request by the federal or state agency full and complete information about:
  - a. ownership of subcontractors with whom the provider has had more than \$25,000 in a twelve month hearing period;
  - b. any significant business transactions between the provider and any wholly owned supplier; and
  - c. any significant business transactions between the provider and any subcontractor, during five-year period ending with the date of request.
38. To furnish to FSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in the IHCP Provider Application and maintenance forms, which are incorporated here by reference, and to update this information as it may be necessary.
39. The effective date of this Agreement will be the date set out in the provider enrollment notification letter. This Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider. This Agreement shall remain in effect until terminated in accordance with item 40 below.
40. That this Agreement may be terminated as follows:
  - a. By FSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by FSSA pursuant to 405 IAC 1-1-6; or
  - b. By FSSA or its fiscal agent, or by Provider, without cause upon 60 days' written notice.
41. For long term care providers involved in a change of ownership, this agreement acts as an amendment to the transferor's agreement with IHCP to bind the transferee to the terms of the previous agreement; and any existing plan of correction and pending audit findings in accordance with 405 IAC 1-20.
42. New owners of nursing facilities or intermediate care facilities for the intellectually disabled, must accept the assignment of the provider agreement executed by the previous owner(s) as required by 42 CFR 442.14.
43. For any entity that receives or makes annual payments totaling at least \$5,000,000 annually as described in 42 U.S.C. 1396a(a)(68), shall add written policies to their employee handbook that provide detailed information about federal and state False Claims Acts, whistleblower protections, and entity policies and procedures for preventing and detecting fraud and abuse. In any inspection, review, or audit of the entity by FSSA or its contractors, the entity shall provide copies of the entity's written policies regarding fraud, waste, and abuse upon request. Entity shall submit to FSSA a corrective action plan within 60 days if the entity is found not to be in compliance with any part of the requirements stated in this paragraph.
44. To verify and maintain proof of verification that no employee or contractor is an excluded individual or entity with the Health and Human Services (HHS) Office of the Inspector General (OIG). Providers shall review the HHS-OIG List of Excluded Individuals/Entities (LEIE) database for excluded parties. This LEIE database is accessible to the general public at <http://www.oig.hhs.gov/fraud/exclusions.asp>.
45. To allow FSSA and its representatives to perform safety inspections of motor vehicles used for transportation services of Medicaid recipients. The Provider shall require all of its contractors and subcontractors to agree to the same.
46. To receive email updates and communication from IHCP at the email address(es) provided on its enrollment application. Providers may opt-out of receiving these email communications by clicking the link found at the bottom of each email following the message prompts. Opting out does not affect the provider's obligation to stay abreast of IHCP updates and communications as required by this agreement.

AS A CONDITION OF PAYMENT AND CONTINUED ENROLLMENT IN THE IHCP THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN. THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY INDIANA HEALTH COVERAGE PROGRAM RELATED OFFENSE AS SET OUT IN 42 USC 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO \$25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

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### Rendering Provider Agreement Authorized Signature – All Schedules and Addenda as applicable

**The owner or an authorized representative of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. This Agreement must be signed by both the authorized representative of the business entity and the rendering provider. A delegated administrator may not sign this form.**

Group or clinic's business name (please print):	Tax ID:
Authorized official's name (please print):	Title:
Authorized official's signature:	Date:
Rendering provider's name (please print):	Tax ID:
Rendering provider's signature:	Date: