Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

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To: All Indiana Health Coverage Programs Providers

Subject: Changes to Billing and Rendering Provider Files

Overview

The purpose of this bulletin is to define the difference between rendering providers and billing providers, and to provide education about the correct use of rendering provider numbers and billing provider numbers when completing a HCFA-1500 claim form. The bulletin also highlights system changes that will benefit the provider community by preventing misdirected and/or inappropriate claims payment, and preventing misdirected and/or redundant correspondence. The following topics are addressed in this bulletin:

- Definitions of rendering, billing, and group providers
- Correct billing procedures for the HCFA-1500 claim form
- System modifications that prevent incorrect billing and inappropriate mailings
- Ways to adjust HCFA-1500 claims submitted prior to May 31, 2001
- Updated provider enrollment application forms
- New provider file update forms
- Reporting provider file changes to EDS

Definitions of Rendering, Billing, and Group Providers

There are four categories of providers. These categories are:

- Sole proprietor – A sole practitioner operating under a unique taxpayer ID (TIN). The TIN may be the practitioner's Social Security number (SSN) or Federal Employer Identification Number (EIN), **but a sole proprietor's TIN may not be shared or used by any other practitioner, group, or facility**.
- Group – Any practice with two or more practitioners sharing a common taxpayer identification number (TIN). A group may be a corporation or partnership. The

business itself must be enrolled as a billing provider and each of the group member practitioners must be enrolled as rendering providers.

- Rendering provider – The licensed individual practitioner who actually performs or renders services. May be a sole proprietor, group member, or employee.
- Organization – A hospital, long-term care facility, or other business entity (for example, transportation provider, medical equipment supplier). Organizations bill for services performed by employees who may or may not be allowed to enroll as rendering practitioners.

Sole proprietors, groups, and organizations are billing providers and submit claims using their IHCP billing provider numbers. The billing provider number identifies the provider who should receive payment from the IHCP. These providers bill the IHCP directly for services and receive payment directly from the IHCP through check or electronic funds transfer.

Rendering providers who are performing services as either employees or group members must not bill the IHCP directly for services and should not receive payments from the IHCP. The practitioner who performs the service is identified as a rendering provider on the HCFA-1500 claim form.

Correct Billing Procedures on the HCFA-1500

Understanding and following correct billing procedures helps ensure that providers are paid appropriately and timely. By following appropriate billing procedures, providers can ensure that the correct billing provider number and service location gets paid in the most timely manner possible. When the procedures outlined below are not followed, the result can be misdirected or delayed claims payments or denied claims.

- Enter the nine-digit *billing provider number* with the appropriate service location alphabetic suffix in Field 33 of the HCFA-1500 claim form. The provider number listed in Field 33 of the HCFA-1500 indicates to whom payment will be issued, under what tax identification number the payment will be reported to the IRS, and to what address the payment will be mailed.
- Enter the *rendering* practitioner's provider number in Field 24 K. The rendering provider number indicates the practitioner who *performed* the service.
- **Do not enter the rendering provider number in Field 33 or put more than one number in Field 33.**

> *Note: There are two spaces in Field 33:* PIN *and* Group Number. *EDS recommends placing the billing number in the* Group Number *section of Field 33.*

- If a practitioner is a sole proprietor who also practices as a member of a group (known as a dual-status provider), ensure that the correct IHCP billing provider

number and service location is used in Field 33 on the HCFA-1500. When a practitioner renders a service as a sole proprietor, the same provider number is entered in both Field 24K and Field 33. If the same practitioner renders a service as a group member at a different service location, the service is billed with the group's billing provider number and service location in Field 33.

- The practitioner's rendering provider number is always entered in Field 24K, regardless of where the service is rendered. There is no service location code associated with a rendering provider number, thus only the nine-digit number is entered in Field 24K. However, the alphabetic location code must be entered after the nine-digit billing provider number in Field 33.
- An organization billing for a service which was not rendered by an individual practitioner enters the organization's provider number in both Field 24K and Field 33. For example, transportation providers and medical equipment suppliers (who have no employees with individual rendering provider numbers) would enter the billing provider number in both fields. The alphabetic location code is not required after the nine-digit number in Field 24K, but is required in Field 33.
- While an entry in Field 25 of the HCFA-1500 is not currently required, the Billing Provider Number entered in Field 33 must link to the billing provider's Taxpayer ID Number (TIN) on the W-9 form submitted to EDS. If it does not, incorrect information will be reported to the IRS.
- Consult the *IHCP Provider Manual, Chapter 8,* for detailed instructions on completing the HCFA-1500 claim form.

System Modifications for Rendering and Billing Providers

A number of system enhancements are being made to help ensure that billing providers are paid appropriately and timely. The enhancements also will help ensure that correspondence is mailed only to active, billing providers at active service locations. These modifications will reduce misdirected payment and misdirected and/or redundant correspondence. The following system enhancements will be effective May 31, 2001:

- Rendering providers and billing providers will be differentiated in the system. A provider is identified as rendering-only if the provider's tax ID matches the tax ID of the group to which it is linked. Rendering-only providers are not allowed to submit claims. Claims can be submitted only by the billing group or employer of a rendering practitioner.
- A claim submitted with the rendering-only provider number in Field 33 of the HCFA-1500 will be denied for edit 1001, *Billing provider and service location not enrolled in program billed. Please verify provider number and service location and resubmit*.

- If the billing provider on the claim is not identified as a billing provider in the system, the claim will be denied for edit 1001, *Billing provider and service location not enrolled in program billed. Please verify provider number and service location and resubmit.*
- If the rendering provider on the claim is not the same as the billing provider, the billing provider must be a group provider and the rendering provider must be a member of that group; otherwise, the claim will be denied for edit 1010, *Rendering provider is not an eligible member of the billing group or the billing provider is not equal to the rendering provider. Please verify provider number and resubmit.*
- The billing provider must be eligible at both the program level and at the service location level for the service location billed on the claim. If the billing provider is not eligible in both situations, the claim will be denied for edit 1001, *Billing provider and service location not enrolled in program billed. Please verify provider number and service location and resubmit*, and/or Edit 1003, *Billing provider and service location not enrolled in the program billed for the dates of service. Please verify provider number and service location and resubmit*.

  Note: For all other claim types (in addition to the HCFA-1500), the system also will check billing and service location eligibility.

- The rendering provider must be eligible at both the program level and the group membership level for the billing provider at the service location billed on the claim. If the rendering provider is not eligible in both situations, the claim will be denied for edit 1002, *Rendering provider not enrolled in the program billed. Please verify provider number and resubmit*, and/or Edit 1004, *Rendering provider not enrolled in the program billed for the dates of service. Please verify provider number and resubmit*, and/or edit 1010, *Rendering provider is not an eligible member of the billing group or the billing provider is not equal to the rendering provider. Please verify provider number and resubmit*.
- Provider bulletins will no longer be mailed to rendering-only providers; provider enrollment confirmation and update letters will be mailed to the appropriate Mail To address of the group(s) to which the rendering provider is linked. Groups are responsible for ensuring that information is shared with their group members.
- For billing providers, including sole proprietors, provider enrollment confirmation and update letters will be mailed to the Mail To address for the group number and each enrolled service location.
- **With the exception of dental providers, public health agencies, and school corporations, EDS will identify providers who were enrolled as of January 1, 2000, but who have had no claim activity (paid, denied, or suspended) since January 1, 2000 (as either a rendering or billing provider). EDS will end-date the IHCP enrollment of these providers, effective May 30, 2001. This is a one-time clean-up action to remove inactive provider numbers, and ensure that providers are correctly identified as billing or rendering providers. This**

action will reduce the opportunity for Medicaid fraud and prevent the mailing of correspondence to inactive providers. Any provider who has not billed a claim since January 1, 2000, and wishes to have IHCP eligibility reinstated should submit a reinstatement request to EDS Provider Enrollment within six months of termination. The provider must submit the request on the billing provider update form, noting on the form that the request is to reactivate the provider file.

- For provider type 03, extended care facility, and specialties 030, 031, 032, and 033, EDS will identify facilities that have had multiple service locations due to change of ownership and end-date all but the newest service location effective May 30, 2001. This change prevents payment of claims to the wrong location or previous owner. The system will still allow adjustments of claims involving billing providers with closed service locations. All adjustments are based on the date of service for the claim.
- When a provider's service location eligibility is closed, the Electronic Funds Transfer (EFT) segment will be closed with the same date. However, this will not prevent the provider from receiving payment by check. EFT segments cannot extend past the service location's end date.
- Any service location that is end-dated will no longer receive mail at the Mail To location. If you have a service location that should be end-dated, contact the EDS Provider Enrollment Unit and submit an enrollment update form. Claims for dates of service prior to the service location end date will continue to pay to the Pay To address.

How to Adjust HCFA-1500 Claims Submitted Prior to May 31, 2001

Beginning May 31, 2001, if a provider needs to adjust a claim that was submitted *incorrectly* (for example, claims with the wrong provider numbers in Field 24K and 33) prior to May 31, 2001, the provider should file an adjustment to cancel the original claim that already has been adjudicated and paid. When this type of claim has been denied, the provider should resubmit the claim with the rendering provider number in Field 24K and the billing number and Service Location in Field 33.

Beginning May 31, 2001, claims that were submitted *correctly* prior to May 31, 2001 (claims with rendering provider number in Field 24K and billing provider number and Service Location in Field 33), can be adjusted normally.

Provider Enrollment Applications, New Update Forms, and Reporting Provider File Changes to EDS

Timely and appropriate updates from providers are critical to enabling EDS to accurately process IHCP claims and direct correspondence to the correct address. If EDS is not notified of changes in provider information, misdirected payments and unnecessary claim denials may occur.

Billing providers are responsible for notifying EDS of any group member additions or changes. A sole proprietor must enroll as a group if the proprietor wants to add practitioners to the practice. Group and facility providers also are responsible for ensuring that the rendering provider numbers for each of their group members are linked to all group Service Locations where the rendering practitioner performs services.

> *Note: If a practitioner is enrolled as a managed care primary medical provider (PMP), the PMP (or PMP's group if a group member) must notify both EDS and the managed care network (PrimeStep or the managed care organization) about any enrollment changes.*

Revised provider enrollment applications to incorporate changes for rendering providers and billing providers will be available on the Indiana Medicaid Web site at www.indianamedicaid.com on May 31, 2001. These applications can be downloaded and used by providers.

The revised provider enrollment applications will be mandatory for use beginning May 31, 2001. EDS will send the new forms to providers who request enrollment applications on or after May 31, 2001. Providers who request an enrollment application prior to May 31, 2001, will receive and may submit the current application.

> *Note: Provider applications printed from the Web site, and not sent to the provider by EDS, will not be assigned an enrollment tracking number (ETN) until EDS receives the completed application from the provider. Therefore, EDS Customer Assistance will not be able to provide status information about the application until EDS receives and tracks it in its enrollment tracking system.*

To maintain the accuracy of the provider enrollment file, EDS must be notified within 10 days if there are any changes in the following information:

- Provider address, including changes to a Mail To, Pay To, Service Location, or Home Office
- Licensure or certification
- Medicare provider number

- Addition or removal of a group member (group providers must submit a group member application when linking additional members to a practice)
- Taxpayer identification number (TIN) (providers must submit a new W-9 for any tax ID changes)
- Clinical Laboratory Improvement Amendments certification
- Change of legal or DBA name, with or without change of ownership
- Change of ownership (providers must submit a new enrollment application when there is a change of ownership)

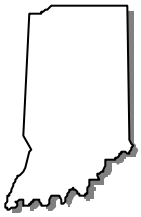
New provider update forms can be used effective immediately. Copies of these forms are included with this bulletin. These forms will be mandatory for use beginning May 31, 2001, and are now available on the www.indianamedicaid.com Web site. Updates or changes submitted to EDS without the update form attached will not be accepted after May 31, 2001.

Billing providers and rendering providers have different update forms. Please read the instructions on the forms to ensure the appropriate form is used for each type of update. When submitting these forms, an authorized officer of the company must sign the forms. EDS will no longer accept changes submitted on provider letterhead beginning May 31, 2001.

Please mail all provider enrollment forms, including updates and applications, to the following address:

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

Note: Faxed enrollment applications and provider file updates cannot be accepted. Due to the large volume of faxes EDS receives daily, faxes can be lost and pages can be missing. Providers also should not send documents to EDS by overnight express unless requested by the Provider Enrollment Unit.



GROUP MEMBER UPDATE FORM INSTRUCTIONS

When should the Group Member Update Form be used?

The Group Member Update Form should be used when:

- Adding a previously enrolled Indiana Health Coverage Programs (IHCP) provider to a group location
- End-dating a current group member's link to a group location
- Recertifying a current group member
- Updating a current group member's information

Completing the form:

Please carefully read the instructions prior to completing the Group Member Update Form. The instructions are numbered to correspond with the field number on the form. Please complete the **entire** form and enclose **all requested attachments** before sending the form to IHCP Provider Enrollment.

Group (Billing) Provider:

If you have a change to the group's information, please complete a Billing Provider Update Form

1. Enter the group's IHCP provider number. If the group has not yet applied for a Billing Provider Number, this form can be used to add currently enrolled rendering providers to the new group. Please attach this form to the new group application. Provider Enrollment will assign the new group billing provider number and process any other updates requested for the group member.

   NOTE: If you are waiting for confirmation of enrollment for a billing application previously sent to Provider Enrollment, please hold the Group Member Update Form until you have received your confirmation letter and provider number.

2. Enter the Federal Employer Taxpayer Identification Number used for tax reporting by the group. A completed W-9 form signed by the group member must be attached to the form.
3. Enter the name of the group in the Provider Name field.

Group Member (Rendering Provider)

4. Enter the Provider Number of the group member (practitioner).
5. Enter the first name of the group member.

6. Enter the middle initial of the group member.
7. Enter the last name of the group member.
8. Enter the Universal Provider Identification Number (UPIN) for the group member if applicable. If not applicable, please write N/A in this field.
9. Enter the Federal Drug Enforcement Agency Certificate number for the group member. A copy of the certificate must be attached to the form.
10. Please enter the date of expiration on the DEA certificate.

Service Location Links

11. Please enter the transaction code that best describes the activity being requested in this field. Each transaction code will trigger Provider Enrollment to perform a specific function. Each transaction code is listed in the table below with the use for the code.

Transaction Code	Use	Group Membership Completion Requirements
A	This transaction code is used when adding a group member with a current provider number to a group location.	• *Complete fields 11 – 17* • *Attach a copy of all licenses* • *Attach a copy of W-9 Tax Form* • *Attach a DEA certificate as applicable* • *Attach a copy of the Medicare Number assignment letters*
E	This transaction code is used when end-dating a group member's link to a group location.	• *Complete fields 11, 12, and 13*
U	This transaction code is used when updating a group member's information such as licensing recertification, primary specialty, and Medicare Numbers	• *Complete fields 11, 12, 13, and the appropriate field to be updated* • *Attach a copy of the license for recertification updates* • *For Medicare Number updates, attach a copy of the Medicare Number assignment letter or an Explanation of Medicare Benefits (EOMB) that has your current Medicare provider number.*

12. Enter the alpha suffix for the group service location(s) that is being updated. The alpha suffix is the alpha character that follows the nine-digit billing provider number that should be used in field 33 on the HCFA-1500 form. For example, if you place 303030330B in field 33 of the HCFA-1500 form, then 303030330 is the billing provider number and **B** is the service location alpha suffix. Please verify that both the provider number and service location being used are the **group's** billing provider number and service location.
13. Enter the effective date of the information being submitted. The effective date for transaction code "A" generally will be the date a practitioner started working for the group. The effective date for transaction code "E" generally will be the separation date for a practitioner. The effective date for

transaction code "U" should be the date that the update is to take effect. This date will vary depending upon the information being updated. For instance, if a doctor changes his or her primary specialty from family practice to cardiovascular, the effective date would be the date that the change in primary specialty occurred.

14. Enter the expiration date of the applicable license or certificate. This field is primarily used for licensing certification. If the certification does not have an end date, enter NA in this field.
15. Please refer to the Rendering Provider Specialty List and list the primary specialty of the group member as applicable. This field is generally completed when adding a group member and updating the primary specialty.
16. Enter the Medicare number for the group member that corresponds to the Medicare number for the group. This number should be a six-digit number that matches the group's Medicare number followed by one or more alpha characters. Please attach the Medicare number assignment letter or a recent EOMB for the group.
17. Please enter the valid state license number for the group member to practice in the state where the group location is located. Please attach a copy of the license.
18. The group member must sign the form certifying that the group has the right to bill for the services rendered by the group member.
19. Please enter the date the group member signs the form in this field.
20. Please print the name of the authorized officer of the group certifying the relationship between the group and the group member.
21. Please print the title of the authorized officer listed in field 20.
22. The officer listed in field 20 must sign the form to certify the relationship between the group and the group member.
23. Enter the date the form is signed by the officer listed in field 20

Mailing Instructions

Once you have fully completed the form and enclosed copies of all required licenses, forms, and certifications, please send the entire packet to:

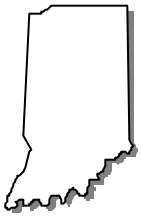
EDS – Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

Once your enrollment update has been reviewed, you will be notified by EDS of the status of your enrollment in writing. Please allow 15 business days for mailing and processing time.

Questions

Please visit our Web site at www.indianamedicaid.com or contact Customer Assistance at 1-800-577-1278, option 3, or locally at (317) 655-3240, option 3, with any questions regarding this form.

Indiana Health Coverage Programs



GROUP MEMBER UPDATE FORM

Billing Provider:

1. Provider Number: _____ 2. Taxpayer Identification Number: _____

3. Provider Name: _____

Please update the following Indiana Health Coverage Programs (IHCP) enrolled physician's participation information for our group.

Rendering Provider:

4. Provider Number: _____

5. First Name: _____ 6. MI: _____ 7. Last Name: _____

8. Universal Provider Identification Number (UPIN): _____

9. Federal DEA Permit Number: _____ 10. DEA Expiration: _____

Please make the following updates for this rendering provider at our group locations.

Service Location Links

Transaction Types:
A = Add practitioner to service location
E = End-date practitioner from service location
U = Update information for practitioner at service location

11. Transaction Code	12. Service Location	13. Effective Date	14. Expiration Date	15. Primary Specialty	16. Individual Medicare Number	17. License Number

I certify, under penalty of law, that the information stated in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Indiana Health Coverage Program (IHCP) and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institution, medical/license board, or organization to provide all information that may be sought in connection with my participation in the Indiana Medicaid Programs, Children's Health Insurance Programs, and Indiana Health Coverage Programs.

18. Group Member's Signature: _____ 19. Date: _____

20. Group Provider Officer's Printed Name: _____

21. Officer's Title: _____

22. Officer's Signature: _____ 23. Date: _____

BILLING PROVIDER UPDATE FORM INSTRUCTIONS

General Instructions

Please read carefully

This form is to be used for updating Provider Enrollment records on a billing service location. Please do not use this form for new enrollments, group member updates, or changes of ownership.

- If you are enrolling a new service location, please contact EDS Customer Assistance at 1-800-577-1278, option 3, or locally at 317-655-3240, option 3, for a Billing Provider Enrollment Application.
- If you are adding, updating, or ending a **currently enrolled** group member's relationship with your group, please use the Group Member Update Form.
- If you are adding a **non-enrolled** group member, please contact EDS Customer Assistance at 1-800-577-1278, option 3, or locally at 317-655-3240, option 3, for a Provider Enrollment Application.
- If you have undergone or are undergoing a change of ownership, please contact EDS Customer Assistance at 1-800-577-1278, option 3, or locally at 317-655-3240, option 3, for a Billing Provider Enrollment Application and a Change of Ownership Addendum.

Please complete only the sections that pertain to updated information for the Provider Number and Service Location listed. Each section includes some instructions on proper completion. Please read the instructions carefully. Many of the updates require attached documentation, so please be sure to include a copy of the necessary documents with the form.

Mailing Instructions

Once you have fully completed the form and enclosed copies of all required licenses, forms, and certifications, please send the entire packet to:

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

Once your service location update has been reviewed, you will be notified in writing by EDS of the status of your update. Please allow 15 business days for mailing and processing time.

Questions

Please visit our Web site at www.indianamedicaid.com or contact Customer Assistance at 1-800-577-1278, option 3, or locally at (317) 655-3240, option 3, with any questions regarding this form.

Indiana Health Coverage Programs

B I L L I N G P R O V I D E R U P D A T E F O R M

Provider Information

Provider Number: _____ Service Location (Alpha Suffix): _____

Provider Name: _____

Taxpayer Identification Number: _____

Address Information

1. Service Location Name and Address

Please complete the Name, Telephone Number, Street Address, City, State, and ZIP Code for the actual site where services will be performed. The address must be a physical location. A post office box is not a valid service location address. The Service Location name is the Doing Business As (DBA) name at each location.

DBA Name _____ Telephone _____

Street Address _____

City _____ State _____ ZIP _____

2. Legal Name and Home Office Address

Please complete the contact information for the home office of the legal entity maintaining ownership of this service location. The legal name must be the current name registered with the Secretary of State, on corporation, tax, and other legal documents. If there is more than one legal name currently used by this business entity, attach an explanation listing each name. The address must be a physical location. A post office box is not a valid home office address.

Legal Name _____ Telephone _____

Street Address _____

City _____ State _____ ZIP _____

3. Mailing Name and Address

Please complete the contact information for the addressing of bulletins, provider manual updates, and general correspondence. A post office box is acceptable for a mailing address.

Name _____ Telephone _____

Street Address _____

City _____ State _____ ZIP _____

4. Pay To Name and Address

Please complete the contact information for the addressing of checks, remittance advices, and general claims payment information. If this is a billing agent's address, please provide the name, address, and phone number of the billing agent. A post office box is acceptable for this address.

Name _____ Telephone _____

Street Address _____

City _____ State _____ ZIP _____

Billing Agent? ☐ Yes ☐ No

Certification Information

Note: Sections 5-9 require copies of the following documents for verification as applicable.

- *Completed Federal W-9 Form*
- *Practitioner License from Licensing Board*
- *Clinical Laboratory Improvement Amendment (CLIA) Certificate*
- *Federal Drug Enforcement Administration (DEA) Certificate*
- *Medicare Provider Number Assignment Letter*

5. Federal Tax Information

Please complete this field with your Federal Taxpayer Identification Number (TIN).

NOTE: A copy of a completed Federal W-9 Form must be attached with this form. Failure to attach this form will result in EDS returning this form for incomplete information.

Taxpayer Identification Number _____

6. Provider Licensing Information

Please complete the information about your licensure by the official licensing board for your provider type and specialty. Please refer to the Billing Provider Specialty List to determine the specialty numbers for your primary and secondary specialty. Primary and secondary specialties must be from the same provider type.

NOTE: A copy of the license from the appropriate licensing board must be attached with this form. Failure to attach a copy of the license will result in EDS returning this form for incomplete information.

Primary Specialty _____ Secondary Specialty _____

License Number _____ Licensing Board _____

License Effective Date _____ License Expiration Date _____

7. CLIA Certification

Please complete this section with the information from your Clinical Laboratory Improvement Amendment (CLIA) Certificate.

NOTE: A copy of the certificate must be attached with this form. Failure to attach a copy of the certificate will result in denied claims for laboratory services.

CLIA Number _____ Certification Type _____

Effective Date _____ Expiration Date _____

8. Federal DEA Certification

Please complete this section with the information from your Federal Drug Enforcement Administration (DEA) Certificate.

NOTE: A copy of the certificate must be attached with this form. Failure to attach a copy of the certificate will result in denied claims for prescriptions you prescribe.

DEA Number _____

Effective Date _____ Expiration Date _____

9. Medicare Participation

Please complete the appropriate Federal identification numbers.

NOTE: A copy of the assignment letter must be attached with this form. Failure to attach a copy of the letter may result in Medicare Crossover claims not crossing over to the IHCP.

Medicare Number _____ DME Supplier Number _____

Universal Provider Identification Number (UPIN) _____

10. Provider-Authorized Signature

I certify, under penalty of law, that the information stated on this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make all necessary verifications concerning me and my practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my participation in the Indiana Medicaid Programs, Children's Health Insurance Programs, and Indiana Health Coverage Programs.

Signature _____ Date _____

Name _____

Title _____