



PROVIDER ENROLLMENT INSTRUCTIONS

Dear Prospective Provider,

On behalf of EDS and the Office of Medicaid Policy and Planning (OMPP), thank you for your interest in becoming a provider in the Indiana Health Coverage Programs (IHCP).

THE APPLICATION PROCESS

Step 1:

To enroll in the IHCP please refer to the **“TYPE and SPECIALTY MATRIX”** to determine what best fits the profile of your business service. You will need the assigned type and specialty code for your service location to complete *Schedule A - Provider Information* of this packet. *If a provider performs more than one type of service, additional applications may be required. Please see the Type and Specialty Matrix for the list of specialties that can be linked to a group type and listed on one application.*

Step 2:

To properly enroll in the IHCP it is important to compare the structure of your business to the different location types described below, taking into consideration how payment for services is reported to the federal Internal Revenue Service (IRS).

- **Billing Providers**

The billing provider is an entity that submits claims for services to the IHCP by any submission means, including paper, electronic, or the Web interChange for reimbursement. The billing provider may be a sole proprietor, a facility, or a group organization.

- **Enrolling a “sole proprietorship” service location.** A sole proprietorship is defined as a provider who owns or leases a service location where he or she is the sole practitioner performing services. An example of this type of provider may be a hearing aid dealer, or a transportation provider. If this practitioner seeks to provide services at additional sites as the sole practitioner, an application must be submitted for each additional service location. A federal tax identification number is assigned to the sole proprietor and payments made to the sole proprietor are reported on a 1099 to the federal IRS.
- **Enrolling a “facility” service location.** A facility location is defined as a large business entity which considers itself to be an organization (which may have branch locations) or a parent company such as a hospital, surgery center, long term care facility, or pharmacy. A separate application must be completed for the parent service location as well as applications for each service location to capture pertinent information regarding each branch, off site, or satellite location.
- **Enrolling a “group” service location.** A group location is defined as a business in which the provider entity submits claims seeking repayment for services, however has not itself performed the service. A group location is defined as a provider entity that owns or leases one or more service locations where multiple practitioners may be employed or contracted to perform professional services. Payments for rendering provider’s services are made to the group and reported on the group or corporation’s 1099 to the federal IRS. Physicians’ groups and clinics are examples of this type of provider. A separate application must be submitted for each service location where services are provided.

- **Rendering Providers**

The rendering providers are those persons who actually perform services at a group location. Each rendering provider must be enrolled in the IHCP with a signed *Provider Agreement*. In addition, the rendering provider must be associated with a group service location, and must sign an acknowledgment of “linkage” to the group location by completing *Schedule G – Rendering Providers Linkage Assignment*.

- **Dual Providers**

In some instances, persons may act as a billing provider at one location, and as a rendering provider at another location. These providers are designated as dual providers and must have a provider enrollment application as a billing provider on file, in addition to a signed *Schedule G – Group Member Linkage Assignment* form associating the provider with a group provider.

- **Medical Review Program Providers**

Providers can elect to participate in IHCP for the Medical Review Program only. To indicate MRT participation only, providers will need to check the Medical Review Program Only box in Schedule A-4. Providers should complete all portions of the application.

- **MRT Medical Record Providers**

During the Medicaid disability determination process, providers may be requested to provide medical records. In order to bill and receive reimbursement for the service of providing medical records, it will be necessary for the entity to complete the following: Schedule A-1: Application Completion Date, Enrollment Effective Date, 3, 4, 5, 6, 8-Utilize Provider Type 08 and Specialty Code 082, Schedule B, Signed Provider Agreement, W-9 Form, Addendum – Claim Certification Statement for Signature on File.

Step 3:

Complete the following sections, leaving blank only those sections that are specifically titled for a provider type that is not yours. The *IHCP Provider Enrollment Application Packet* is divided into the following sections:

- **Schedule A – Provider Information**
 - This section collects all pertinent information related to the prospective provider including name, location, provider type, and address information. All information boxes **must** be completed.
- **Schedule B – Organization Structure**
 - This section collects information about the business structure of the prospective provider including information about the ownership and officers of the business.
- **Schedule C – Disclosure Information**
 - This section collects information required by federal regulation that details information of those individuals with five percent direct or indirect ownership in the prospective provider's business, as well as the degree of relationship for each individual. Any changes in disclosure information due to change of ownership or reorganization must be reported on this schedule. The disclosure of social security numbers under this schedule is voluntary. The number will be used only for the purposes of checking the owner's identity with a list of persons who are disqualified by federal law from having an ownership interest in providers. Refusal to provide a social security number will lead to the rejection of this application.
- **Schedule D – Change of Ownership**
 - This section **must** be completed by prospective providers that have had or anticipate a change in ownership.
- **Schedule E – Institutional Providers**
 - This section **must** be completed by prospective providers that are considered institutional facilities; otherwise, the information may remain blank.
- **Schedule F – Transportation Providers**
 - This section **must** be completed by transportation providers; otherwise, the information may remain blank.
- **Schedule G – Group Member Linkage**
 - This section **must** be completed to link **enrolled** rendering providers (those who actually perform the service) to a prospective or current group provider. The disclosure of social security numbers under this schedule is voluntary. The number will be used only for the purpose of checking the provider's identity with a list of persons who are disqualified by federal law from providing services. Refusal to provide a social security number will lead to rejection of this application.
- **Schedule H – Authorized Signatures Form**
 - This section defines an authorized official and delegated administrator for signature purposes and provides a form for submitting a delegated administrator for authorized signatures. As the authorized official of your business, you may delegate an administrator to make changes you specify to your enrollment information.
- **Schedule I – Electronic Funds Transfer (EFT) Form**
 - EFT accounts are required to receive payment of funds. This form must be completed upon enrollment or the enrollment will be returned as incomplete.
- **Schedule J – Waiver Providers**
 - This section **must** be completed by waiver providers; otherwise, the information may remain blank.

- **Provider Agreement**
 - The Agreement details the requirements of participation in the IHCP. Included are provider responsibilities regarding updating provider information, protecting patient health information, requirements for claims processing, overpayments, and record retention. In addition, the Agreement details obligations regarding the appeals process, civil rights regulation compliance, utilization, control, and disclosure rules. This Agreement must be read, signed, and returned with the application. A signed copy must be retained by the provider.
- **Enrollment Application Checklist**
 - This checklist reviews the required documentation necessary for enrollment in the IHCP. Please follow this checklist to ensure that all licensure, certification, tax information, and any other required enrollment documents are included with this application for accurate processing.

Step 4 – Addenda

The following addenda are required for specific type specialties indicated, before enrollment is finalized:

- **Certification Statement for Signature on File Addendum**
 - This must be signed by the provider, authorized official, or delegated official. Signing this form exempts the billing provider from Edit 228 –*No signature on file*.
- **Outpatient Mental Health Addendum (Type 11, Specialties 110, 111, and 119)**
 - This must be signed by practitioners who are providing outpatient mental health services. This addendum briefly outlines the IHCP requirements regarding certification of diagnosis, supervision of a patient's plan of treatment, and documentation of these services.
- **Request for designation as a psychiatric hospital with 16 beds or less Addendum (Type 11, Specialty 011)**
 - To determine if your psychiatric hospital qualifies for the designation of a 16 bed or less facility, you must complete this addendum.
- **Psychiatric Residential Treatment Facility (PRTF) Attestation Letter (Type 03, Specialty 034)**
 - This must be completed by practitioners who are providing PRTF health services certifying the facility meets restraint and seclusion regulations and agrees to validation procedures.

To avoid having an application returned for incomplete or missing information, each section required for the specified provider type must be thoroughly completed, and must contain original, authorized official or delegated administrator signatures on all documents requiring signatures. Authorized official and delegated administrator signatures are defined on *Schedule H*. Please retain a copy of the completed application packet for your records. Enclose the signed *Provider Agreement* and copies of all required documentation as listed on the provider enrollment application checklist, and mail the entire packet to the address below.

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

When the Provider Enrollment Unit receives, reviews, and processes the provider enrollment application, notification is sent in writing with the status of the enrollment. If there is missing information or the required supporting documentation is incomplete, the entire application packet will be returned with a response letter stating the reason or reasons the enrollment request could not be completed. If the application is denied, notification is also sent explaining the denial reason. Please allow at least 30 business days for mailing and processing time before checking the status of the provider enrollment application submission.

Please refer to the IHCP Web site at www.indianamedicaid.com for additional information and telephone contact numbers for assistance in completing IHCP provider enrollment applications.

PROVIDER ENROLLMENT APPLICATION

Schedule A.1- Provider Information

Application Completion Date: _____ **Enrollment Effective Date:** _____

1. If this is a Change of Ownership application, enter current IHCP Provider Number: _____

2. Which of the following best describes this provider location? (see definitions on the Instructions page)

Please check the box that best describes the provider location being enrolled. Only one box may be checked.

- Group Practice Facility or Organization Sole Proprietor
 Please check here if this application is for an additional service location and enter Billing Provider Number: _____
 Prospective Managed Care PMP Service Location **Please contact your Managed Care Plan for completion of the PMP enrollment process.**

3. Service Location Name and Address

Generally, the service location name and address is for the site where members go to obtain services from the perspective provider. A service location maintains the supporting documentation related to the claim submitted for a service. The service location name must be the Doing Business As (DBA) name registered with the Secretary of State, except for sole proprietors or business owners who must register their Assumed Business Name with their county recorder. Anesthesiologists who provide services at multiple locations, should enter their home office as their service location. **The address must be a physical location. A post office box is not a valid service location address.**

Provider Name: _____ Indiana County: _____

DBA Name: _____ Telephone: _____

Street Address: _____

City: _____ State: _____ ZIP + 4: _____ - _____

Is claim documentation kept at this location? Yes No If this is not an Indiana address, are services provided in Indiana? Yes No

4. Legal Name and Home Office Address

Please complete the contact information for the home office of the legal entity maintaining ownership of the above service location. The legal name must be the current name on tax, corporation, and other legal documents, and currently registered with the Secretary of State, or filed with the County Recorder as the Assumed Business Name. **The address must be a physical location. A post office box is not a valid home office address.**

Legal Name: _____

DBA Name: _____ Telephone: _____

Street Address: _____

City: _____ State: _____ ZIP +4: _____ - _____

*Tax ID Number: _____ **The Legal Name and Business Name on the W-9 must match.**

Schedule A.2– Provider Information Continued

5. Mailing Name and Address

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

Name: _____ Telephone: _____
 Address: _____
 City: _____ State: _____ ZIP + 4: _____ - _____

6. Pay To Name and Address

Please complete the 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. The name listed below as the Payee Name will appear as the payee on all checks. A post office box is acceptable for this address. **Billing agents must furnish proof of authorization to be the billing agent for provider.**

Payee Name: _____
 Billing Agent Name: _____ Telephone: _____
 Address: _____
 City: _____ State: _____ ZIP + 4: _____ - _____

7. Contact Person

Please complete the information below for a contact person who can answer questions about the information provided in this application. If this information is not completed, questions will be referred to the authorized official or delegated administrator listed on *Schedule H*.

Contact Name: _____ Telephone: _____
 Contact Person’s E-mail Address: _____

8. Provider Specialty and Licensing Information

Please complete the information about your licensure as determined and maintained by the official licensing board for your provider type and specialty. Refer to the ***Provider Type and Specialty Matrix*** to determine the provider type and specialty codes and the enrollment requirements for the provider type and specialties selected. **Only type and specialty codes listed on the *Provider Type and Specialty Matrix* will be accepted.**

Provider Type	Primary Specialty	Additional	_____
Code (two digits) _____	Code (three digits) _____	Specialty Codes	_____
		(three digits)	_____

For Provider Type 31, Specialties 322 and 335 only, enter Subspecialty Code (three digits) _____

NOTE: You may select only one provider type code for this application. If you want to enroll more than one provider type, a separate application must be completed for each provider type. Primary and additional specialties must be associated with the same provider type. See *Provider Type and Specialty Matrix* for codes.

License Number: _____
 Effective Date: _____ Expiration Date: _____
 *Licensing State: _____ *The licensing state must match the service location state.

NOTE: A copy of the license from the appropriate licensing board must be submitted with this application. Failure to attach a copy of the license will result in EDS returning the entire application as incomplete.

Schedule A.3 – Provider Information Continued

9. CLIA Certification

Please complete this section with the information from your Clinical Laboratory Improvement Amendment (CLIA) Certificate. CLIA numbers are assigned to one specific service location unless CMS exemption status has been met.

CLIA Number: _____ Certification Type: _____

Effective Date: _____ Expiration Date: _____

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

10. Medicare Participation

Please complete the appropriate Medicare identification numbers.

Medicare Number: _____ Issuing State: _____

UPIN: _____ DMERC: _____

Service Address where Medicare Number is Assigned: _____

NOTE: A copy of the Medicare number assignment letter (or Medicare RA with correct Medicare number) is recommended to ensure accuracy of Medicare number assignment. If there are any questions with this number, the assignment letter will be requested to verify.

11. Are you certified or licensed by the Indiana State Department of Health (ISDH)?

Enrollment of institutional providers surveyed and licensed by the ISDH is dependent upon EDS receiving a completed CMS-1539, Certification and Transmittal Form (C&T) from the ISDH. The ISDH must survey each institutional provider to determine whether federal and state qualifications to participate in the IHCP are met.

Have you completed the ISDH survey process? Yes No

If you answered No, you must contact ISDH to complete the survey process prior to enrolling in the IHCP.

12. Are you currently, or have you ever been enrolled as an IHCP provider?

If you are currently, or have ever been enrolled as an IHCP provider, please check the box labeled yes and list the provider number(s) you were assigned.

Yes No

Provider Number(s): _____

Schedule A.4 – Provider Information Continued**13. Do you wish to participate in the Health Watch program?**

HealthWatch is a preventative health care program offered to Medicaid eligible members younger than 21 years of age. Physicians or nurse practitioners who are enrolled as Medicaid providers are qualified to perform HealthWatch screenings. Reimbursement for HealthWatch services is higher than equivalent services billed using standard CPT codes. HealthWatch screenings must be completed in accordance with recommendations set forth in the *HealthWatch Provider Manual Periodicity Schedule*. Check the box labeled yes to receive the *HealthWatch Provider Manual*.

Yes No

14. Do you wish to participate in the 590 program?

The 590 Program is a State medical assistance program providing reimbursement for medically necessary covered medical services provided off site to individuals who reside in State institutions. If a 590 member receives services that have a total billed amount per claim of less than \$150 for one services instance; the State owned facility where the member resides is responsible for payment of the services. If the total billed amount of the claim is \$150 or more, the claim is submitted to the IFSSA's fiscal agent for processing and payment. Services may not span several days of service and be lumped together on one claim to exceed \$150. Prior authorization is required for all services provided to 590 members when an amount greater than \$500 per procedure is billed. Check the box labeled yes to participate in this program. The following provider types cannot be 590 providers: transportation, hospice, home health, DME, and long term care facilities. There are no out-of-state 590 providers.

Yes No

15. Do you wish to participate in the Medical Review Program?

The Medical Review Program provides determination of an applicant's eligibility for Medicaid under the disability category. The provider completes a medical assessment of an applicant and submits the required forms to the Office of Family Resources. The MRT issues a favorable or unfavorable eligibility decisions based on medical evidence that supports whether the applicant has a significant impairment. Once the documentation has been filed, the provider may submit claims to EDS for payment of certain examination and reports. Services should not be performed unless the applicant has presented the pre-Medicaid eligibility form. Providers who wish to participate in the Medical Review Program in addition to other IHCP programs, should check the Yes box. To participate solely in the Medical Review Program, the provider should check the Medical Review Program ONLY. Providers that choose not to participate in the IHCP Programs and have been requested to submit medical records, should check MRT Medical Records.

Yes No Medical Review Program ONLY MRT Medical Records

16. Do you wish to participate in the Pre-Admission Screening and Resident Review (PASRR) Level II ?

All Diagnostic and Evaluation Teams must be contracted and approved by the Division of Disability, Rehabilitative Services (DDRS, formerly the Division of Disability, Aging and Rehabilitative Services (DDARS)) and Bureau of Developmental Disability Services (BDDS). Community Mental Health Centers must be contracted and approved by the Division of Mental Health and Addiction (DMHA).

Yes No

17. What percentage of your total patient or client population is Medicaid enrolled? Please fill in the appropriate boxes below.

Percent Medicaid Percent Self Pay Percent Medicare Percent TPL

Schedule B – Organizational Structure

1. How is this provider entity legally organized and structured?

Check the entity type that best describes the structure of the enrolling provider entity. Please check **only one** box.

- | | | |
|---|---|--|
| <input type="checkbox"/> For Profit Corp | <input type="checkbox"/> Partnership | <input type="checkbox"/> Sole Proprietorship (Individual) |
| <input type="checkbox"/> Not-for-Profit Corp | <input type="checkbox"/> Government Owned | <input type="checkbox"/> Limited Liability Partnership (LLP) |
| <input type="checkbox"/> Limited Liability Co (LLC) | <input type="checkbox"/> Other (Please Specify) _____ | |

2. Is the provider entity registered with the Secretary of State?

- Yes No

If yes, please submit a copy of the state registration papers (*405 IAC 1-19.1b*). If no, please submit a copy of the Assumed Business Name form on file with the county recorder’s office.

3. Date Business Started: _____

4. Is this entity incorporated?

- Yes No If yes, enter the Incorporation Date: _____

5. Is this entity chain affiliated?

If yes, the information about the company or organization must be included in the disclosure information.

- Yes No

6. Is the provider entity operated by a management company, or leased in whole or in part by another organization?

If yes, the information about the company or organization must be included in the disclosure information.

- Yes No

Schedule C.1 – Disclosure Information

Disclosure of Ownership and Control – List below the Name, Title, Federal Employer Identification Number (FEIN), and Business Address of any PERSON OR ENTITY that has an ownership or controlling interest in the prospective provider entity.

This includes any person or entity that has a direct or indirect ownership interest equal to five percent or more of the value of the provider entity; or owns an interest of five percent or more in any mortgage, deed of trust, note or other obligation secured by the provider entity if that interest equals five percent of the value of the property of assets of the provider entity. Copy this page to list additional names.

Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	

Disclosure of Ownership and Control – List below the Name, Title, FEIN, and Business Address of any PERSON OR ENTITY that has an ownership or controlling interest in any subcontractor in which the provider entity has direct or indirect ownership of five percent or more. Copy this page to list additional names.

Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	

Schedule C.2 – Disclosure Information Continued

Managing Individuals – List below the Name, Title, FEIN, and Business Address of ALL agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Any individual who has operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the provider entity should be included. This may include such individuals as a general manager, business manager, administrator, or director. Copy this page to list additional names.

Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	
Legal Name	FEIN	Business Address
Title	Social Security #	

Schedule C.3 -Disclosure Information Continued

1. Indicate below if any of the individuals listed in *Schedule C.1 or C.2* above, are related through blood or marriage, either as spouse, parent, child, or sibling. List their names and degree of relationship. Copy this page if additional space is required.

Name	Name	Degree of Relationship

2. Indicate below if any of the PERSONS OR ENTITIES listed in *Schedule C.1 or C.2* above, or any secured creditor(s) of the provider entity, have ever been sanctioned either through criminal conviction, or exclusion from participation in any program under Medicare, Medicaid, or the Title XX services since the inception of the programs.

Name	Type of Sanction	Date of Sanction

3. Indicate below if any of the PERSONS OR ENTITIES listed in *Schedule C.1 or C.2* above, or any secured creditor(s) of the provider entity, have ever been placed on prepayment review.

Name	Provider Number

4. Indicate below if any of the PERSONS or ENTITIES listed in *Schedule C.1 or C.2* above, has an ownership or controlling interest in any other current or prospective provider.

Name	Provider Number

5. Indicate below any former agent, officer, director, partner, or managing employee from the lists in this schedule, who has transferred ownership to a family member related through blood or marriage, either as spouse, parent, child, or sibling, in anticipation of or following a conviction, or imposition of an exclusion.

Name	Name	Degree of Relationship

Schedule D – Change of Ownership

1. Long Term Care Providers Transfer or Change of Ownership Information – Complete this section, or send in a notification letter within 45 days of the contemplated transfer date. A pay hold will be initiated on the expected date of transfer to ensure appropriate payee information for claim payments.

2. Long Term Care Providers' Change of Ownership Types (405 IAC 1-20-3)

A change of ownership occurs, but is not limited to, any of the following circumstances:

- **For a sole proprietorship** – if a provider of services is an entity owned by a single individual, a transfer of title and property to the enterprise to another person or firm, whether or not including a transfer of title to the real estate or if the former sole proprietorship becomes one of the members of a business entity succeeding him or her as the new owner.
- **For a partnership** – a new partnership, or the removal, addition, or substitution of an individual partner in an existing partnership, in the absence of an express statement to the contrary in the partnership agreement that dissolves the old partnership and creates a new partnership.
- **For a corporation** – a new corporation, the merger of the applicant or provider corporation into another corporation, or the consolidation of two or more corporations, or any change resulting in the creation of a new corporation. In an incorporated provider entity, the corporation is the owner. The governing body of the corporation is the group having direct legal responsibility under state law for operation of the corporation's entity, whether that body is: a board of trustees; a board of directors; the entire membership of the corporation; or known by some other name.

3. Has there been a change in ownership or control, or is a change of ownership or control anticipated?

Yes No

Actual Date of Transfer or Ownership Change: _____

Expected Date of Transfer or Ownership Change: _____

If the provider is sanctioned by the Indiana State Department of Health (ISDH), the effective date of the change of ownership will be determined by the date indicated on the ISDH's certificate and transmittal and amended by the ISDH, if necessary, to correspond with the transferor/transferee agreement of sale or transfer.

IHCP Provider Name of Alpha Suffix Changing Ownership: _____

Previous Owner's Provider Name: _____

Familial Relationship to Previous Owner, if any: _____

4. Record retention (405 IAC 1-20-5)

Authority: *IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3*

Affected: *IC 12-13-7-3; IC 12-15*

A transferee shall take possession of the Medicaid records of the transferor and safeguard them for no less than three years from the date of the last claim reimbursed by the office or until any pending administrative or judicial appeal is closed, whichever is longer. (Office of the Secretary of Family and Social Services; 405 IAC 1-20-5)

1. Non-Long Term Care Providers' Change of Ownership – Complete this section if there has been a change in ownership or control. You must submit a copy of the purchase agreement, bill of sale, or transfer of ownership paperwork or other documentation to verify change of ownership information.

IHCP Provider Name of Alpha Suffix Changing Ownership _____

Previous Owner's Provider Name _____

Familial Relationship to Previous Owner, if any _____

Actual or Expected Date of Transfer or Ownership Change _____

Schedule E – Institutional Providers

Section 1 – Hospitals

1. If the provider is a hospital, are the requirements of 42 USC Section 1395ww (d) (5)(D)(iii) met for the hospital to qualify as a sole community hospital?

If you satisfy the requirements of 42 USC Section 1395ww(d)(5)(D)(iii) to qualify as a sole community hospital, please check Yes. Otherwise, please check No.

Yes No

2. Do you qualify as a teaching hospital for rate setting purposes? Yes No

Section 2 – Psychiatric Hospitals

1. If the provider is a psychiatric hospital, how many beds does the facility have?

Enter Bed Count: _____

A copy of the Private Mental Health Institution license from the Division of Mental Health and Addiction must be included with the application. If the facility's bed count is 16 bed or less, you must complete Addendum to be designated a 16 bed or less psychiatric facility.

Section 3 – Long Term Care Facilities

1. Are you enrolling in Medicaid solely to be reimbursed for services provided to Qualified Medicare Beneficiaries (QMB) in long term care facilities?

Yes No

Section 4 – Psychiatric Residential Treatment Facilities (PRTF)

1. To be eligible for enrollment as a PRTF, the facility must be licensed under 470 IAC 3-13 as a private, secure, child-caring institution, and must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Council On Accreditation (COA), or the Council on Accreditation of Rehabilitation Facilities (CARF). All enrolled facilities must comply with the requirements in 42 CFR 482, Subpart G governing the use of restraint and seclusion, and submit an attestation letter to the enrollment broker.

- Copy of the Attestation Letter submitted with application.
- Copy of the license for secure facility submitted with application.
- Copy of the credentialing verification from approved accrediting entity.

Please indicate below whether you are currently affiliated with a psychiatric hospital, mental health facility, or acute care hospital:

Psychiatric Hospital Mental Health Facility Acute Care Hospital No – Freestanding facility

Schedule F – Transportation Providers

1. Type of Service (indicate all that apply)

Please check all of the services provided by this location. You may select more than one box.

- | | |
|---|---|
| <input type="checkbox"/> Common Carrier Ambulatory (for profit) | <input type="checkbox"/> Common Carrier Ambulatory (not-for-profit) |
| <input type="checkbox"/> Common Carrier Non-Ambulatory (for profit) | <input type="checkbox"/> Common Carrier Non-Ambulatory (not-for-profit) |
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Air Ambulance |
| <input type="checkbox"/> Taxicab | <input type="checkbox"/> Bus |
| <input type="checkbox"/> Family Member Transportation | |

2. Please Attach All That Apply

For each box checked on type of service above, please include all of the attachments shown below :

	Attachment included?	
	Yes	No
Ambulance or Air Ambulance:		
Emergency Medical Services Commission (EMS) Certification	<input type="checkbox"/>	<input type="checkbox"/>
Bus		
Motor Carrier Services (MCS) Certification	<input type="checkbox"/>	<input type="checkbox"/>
Common Carrier Ambulatory or Non-Ambulatory (for profit):		
MCS Certification	<input type="checkbox"/>	<input type="checkbox"/>
Common Carrier Ambulatory or Non-Ambulatory (not-for-profit):		
Certification of not-for-profit status from the IRS	<input type="checkbox"/>	<input type="checkbox"/>
Proof of insurance (\$500,000 combined single limit commercial automobile liability insurance is required)	<input type="checkbox"/>	<input type="checkbox"/>
Taxicabs:		
Operating agreement from local governing body (like a public livery license, or city taxi license)	<input type="checkbox"/>	<input type="checkbox"/>
Note: If you intend to transport outside of the jurisdiction designated by your city taxi license, or across county borders, you must enroll as a common carrier. Please contact the Indiana Department of Revenue Motor Carriers Division for MCS certification.		
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)	<input type="checkbox"/>	<input type="checkbox"/>
Family Member/Volunteer Transportation:		
Proof of insurance as specified by Indiana state law	<input type="checkbox"/>	<input type="checkbox"/>
Appropriate and valid driver’s licenses as specified by Indiana state law	<input type="checkbox"/>	<input type="checkbox"/>
A letter of approval from the IHCP member’s County Office of Family and Children. Contact the IHCP member’s caseworker, and see 405 IAC 5-4-3 for further clarification.	<input type="checkbox"/>	<input type="checkbox"/>
Note: Failure to attach the necessary attachments will result in EDS returning this application for incomplete information.		

Schedule G.1 – Rendering Providers Linkage Assignment

Group Provider Number (or Name if new): _____

Service Location: _____

Note: Individual Practitioners (sole proprietorships) do not have group members, only group practices have group members. If the rendering provider is not actively enrolled, a signed provider agreement must be submitted for each new rendering provider you are enrolling. Group member’s (rendering providers) must authorize enrollment information submitted by a group. Please have group member sign this form to authorize the linkage request. *You must submit a separate application with assignment for each additional service location.*

The signature below authorizes the billing of claims through any method, paper or electronic, submitted on my behalf by the group provider.

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate Linkage Effective _____				

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate linkage effective _____				

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate Linkage Effective _____				

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate Linkage Effective _____				

Schedule G.2 – Rendering Providers Linkage Assignment

Group Provider Name: _____

Group Provider Number (include alpha service location): _____

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate Linkage Effective _____				

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate linkage effective _____				

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate Linkage Effective _____				

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate Linkage Effective _____				

Rendering Provider Name (Group Member)	Rendering Provider IHCP Number	Rendering Provider Specialty Code	Group Linkage Start Date	Rendering Provider Medicare Number
Rendering Provider Signature	UPIN	Social Security Number	License #	590 Program Participation <input type="checkbox"/> Yes
Action <input type="checkbox"/> New <input type="checkbox"/> Update <input type="checkbox"/> Terminate Linkage Effective _____				

Schedule H – Authorized Signature Form

Please complete this schedule if you are an authorized official and want to delegate an administrator for authorized signature purposes. As the authorized official of your business, you may delegate an administrator to make the changes you select below to your IHCP enrollment file information.

What is an authorized official? The authorized official must be a general partner, agent, officer, director, or managing employee who has expressed or implied authority to obligate or act on behalf of the provider entity. Any individual who has operational or managerial control over, or who directly or indirectly conducts the day-to-day operations for the provider entity. The authorized official includes such individuals as a general manager, business manager, administrator, or director.

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

- Enroll the organization in the Indiana Health Coverage Programs (IHCP)
- Make changes or updates to the organization's status in the IHCP
- Accept payment for services
- Submit claims for payment on behalf of the enrolled entity
- Commit the organization to the laws and regulations of the IHCP

Furthermore, as the authorized officer of the enrolling provider, I assign signature authority to the delegated administrator the following selection(s):

- | | |
|---|--|
| <input type="checkbox"/> Change Mail To (non check related info) Address
<input type="checkbox"/> Change Pay To (checks and RAs) Address
<input type="checkbox"/> Change Home Office Address
<input type="checkbox"/> Change Service Location (cert code letters) Address
<input type="checkbox"/> Submit Name Change
<input type="checkbox"/> Submit License or Certification Updates | <input type="checkbox"/> Change Tax ID, Submit W-9
<input type="checkbox"/> Group Member maintenance
<input type="checkbox"/> Submit Claims for Payment
<input type="checkbox"/> Submit Enrollment Applications
<input type="checkbox"/> Add, Change, or Stop EFT
<input type="checkbox"/> Submit Specialty changes |
|---|--|

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.

Enrolling Provider or Business Entity Name _____

Authorized Official’s Name **(please print)** _____

Authorized Official’s Signature _____ Date _____

Delegated Administrator Name **(please print)** _____

Delegated Administrator Signature _____ Date _____

*Please submit one form per **Delegated Administrator**.*

Schedule I – Electronic Funds Transfer Form	
Complete all fields on this form and attach a voided check or one of your bank deposit slips. The ABA transit routing number can be obtained from your bank.	
Does the bank account listed below belong to a billing agency? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Provider Name: _____	Provider Number: _____
Provider Tax ID: _____	ABA Transit Routing Number: _____
Bank Name: _____	
Bank Address: _____	
Bank Account Number: _____	Bank Account Name: _____
Tax ID Number of Account Holder: _____	
Bank Telephone Number: () - _____	Type of Account: <input type="checkbox"/> Savings <input type="checkbox"/> Checking
Type of Authorization: Start <input type="checkbox"/> Cancel <input type="checkbox"/> Change <input type="checkbox"/>	
Is the change due to a change of ownership? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please include one of the following documents with this form for verification of account owner and account numbers: voided check, deposit slip, or a copy of a bank statement listing the bank account number and the account holder's name.	

On behalf of the provider entity named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of claim payments received from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept, as payment in full, the amount paid by the IHCP for claims submitted with the exception of authorized cost sharing by members. I understand payment of IHCP claims is from state and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under state or federal law. I ensure that this EFT request complies with the regulation set forth in *42 CFR 447.10*, which prohibits State payments for any IHCP service to be made to anyone other than a Provider, a non-cash member, or to one of the listed exceptions. I understand that an IHCP payment may be sent via EFT to an account held by the following only: (1) to the Provider; (2) a non-cash member; (3) a government agency on reassignment by the Provider (IRS); (4) a third party by court order on reassignment by the Provider (child support); (5) a business agent (billing service, account firm) if three specific criteria are met (see page 2*); (6) the employer of the Practitioner (if a contract so requires); (7) a health care facility, or a health care delivery system (if a contract so requires) if the organization itself submits the claim directly to the IHCP.

I authorize the electronic transfer of IHCP payments (including 590, Medicaid, and Package C) made to the above provider number. I understand that I am responsible for the validity of the above information. I agree to notify EDS within ten days of any change in any of the information included on this form.

This section must be completed by an authorized officer or owner of the billing provider.

 Printed Name & Title

 Signature

 Telephone Number

 Date

Note: It will take approximately four weeks for this information to be processed by EDS and validated by your bank. Please send this form to EDS, Provider Enrollment, P.O. Box 7263, Indianapolis, IN 46207-7263.

The following section must be completed if a billing agent is receiving payment on behalf of the provider.

**The exception for a business agent is limited to agents who furnish statements and receive payments in the name of the provider, and the service provided by the agent is: (1) related to the cost of processing the bill; (2) not related to a percentage or other basis to the amount billed or collected; and (3) not dependent upon the collection of payment. Further, a payment for a provider may not be made to or through an individual or organization (collection agency or service bureau), or by power of attorney thereof, that advances money for accounts receivable that a provider has assigned, sold, or transferred to the organization for a fee or deduction of accounts receivable.*

If the EFT for the provider named on this document will be sent to a bank account belonging to a billing agent and not the bank account of the provider, you must complete the section below.

Billing Agent Name	Telephone Number	Billing Agent's Tax ID
Billing Agent Address		
Authorized Billing Agent Contact Name	Title	
Authorized Billing Agent Signature	Date	

Schedule J – Waiver Providers

Check all specialties or services provided by this location. Select all that apply.

1. Waiver Services (Specialties)

- Aged & Disabled Waiver (A&D) Assisted Living Waiver (AL) Autism Waiver
- Developmental Disabilities Waiver (DD) Medically Fragile Children's Waiver (MFC)
- Support Services Waiver (SS) Traumatic Brain Injury Waiver (TBI)

2. Division of Mental Health and Addiction (Specialties)

- Seriously Emotionally Disturbed Children’s Waiver (SED)

3. State Medicaid Services (Specialties)

- Targeted Case Management (TCM) – State Plan Services Only

4. Attachments

For each box checked above, please attach a copy of the appropriate Waiver Service Provider Certification. Mark the boxes below that correspond to the required attachments.

- Aged & Disabled Waiver (A&D) Assisted Living Waiver (AL)
- Autism Waiver Developmental Disabilities Waiver (DD)
- Medically Fragile Children's Waiver (MFC) Support Services Waiver (SS)
- Traumatic Brain Injury Waiver (TBI) Seriously Emotionally Disturbed Children’s Waiver (SED)
- Targeted Case Management (TCM) – State Plan Services Only

I H C P P R O V I D E R A G R E E M E N T

By execution of this Agreement, the undersigned entity (“Provider”) requests enrollment as a provider in the Indiana Health Coverage Programs. As an enrolled provider in the Indiana Health Coverage Programs, the undersigned entity agrees to provide covered services and/or supplies to Indiana Health Coverage Program 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 (“IFSSA”).
2. To comply with all federal and state statutes and regulations pertaining to the Indiana Health Coverage Programs, 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 IFSSA 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 Indiana Health Coverage Program members pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about Indiana Health Coverage Program 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 Indiana Health Coverage Program members only to the IFSSA 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 Indiana Health Coverage Program 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. Provider also agrees 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 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-MR, 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 Indiana Health Coverage Program covered services rendered pursuant to this Agreement.
11. To comply, if a hospital, nursing facility, provider of home health care and personal care services, hospice, or HMO; with advance directive requirements as required by *42 Code of Federal Regulations, parts 489, subpart I, and 417.436*.
12. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the provider manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its fiscal agent.
13. To submit timely billing on Indiana Health Coverage Program approved claim forms, as outlined in the *Indiana Health Coverage Programs Provider Manual*, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.
14. To be responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. 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/or state law.
15. To submit claim(s) for Indiana Health Coverage Program reimbursement only after first exhausting all other sources of reimbursement as required by the *Indiana Health Coverage Programs Provider Manual*, bulletins, and banner pages.
16. To submit claim(s) for Indiana Health Coverage Program reimbursement utilizing the appropriate claim forms and codes as specified in the provider manual, bulletins and notices.
17. 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.*
18. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for Indiana Health Coverage Program covered services provided to Indiana Health Coverage Program members (recipients). Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Indiana Health Coverage Program covered services, excluding any co-payment permitted by law.

19. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.
20. To make repayments to IFSSA or its fiscal agent, or arrange to have future payments from the Indiana Health Coverage Program withheld, within sixty (60) days of receipt of notice from IFSSA 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.
21. To pay interest on overpayments in accordance with *IC 12-15-13-3*, *IC 12-15-21-3*, and *IC 12-15-23-3*.
22. To make full reimbursement to IFSSA or its fiscal agent of any federal disallowance incurred by IFSSA when such disallowance relates to payments previously made to Provider under the Indiana Health Coverage Programs.
23. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
24. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Indiana Health Coverage Program payments made to Provider, to assure the proper administration of the Indiana Health Coverage Program and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 IAC 1-5* and in the *Indiana Health Coverage Programs Provider Manual*, and shall include, without being limited to, the following:
 - *a. medical records as specified by Section 1902(a)(27) of Title XIX of the Social Security Act, and any amendments thereto;*
 - *b. records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs or services;*
 - *c. any records determined by IFSSA 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 Indiana Health Coverage Program;*
 - *d. documentation in each patient's record that will enable the IFSSA 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 IFSSA 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 IFSSA.*
25. To cease any conduct that IFSSA or its representative deems to be abusive of the Indiana Health Coverage Program.
26. To promptly correct deficiencies in Provider's operations upon request by IFSSA or its fiscal agent.
27. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
 - *a. the petitioner is a person to whom the order is specifically directed;*
 - *b. the petitioner is aggrieved and, or adversely affected by the order;*
 - *c. the petitioner is entitled to review under the law.*
28. 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 IFSSA from which Provider is appealing;
 - b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.
29. 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 IFSSA's determination:
 - (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
 - (2) A notice of overpayment.
 - (3) 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 IFSSA's determination. The statement of issues must be filed within 45 days of receipt of IFSSA's determination.
30. To cooperate with IFSSA 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.
31. 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 a Indiana Health Coverage Program covered service.
32. 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 *Indiana Code § 4-2-6 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/>>>](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 *Indiana Code § 4-2-6-12*.
33. 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 Code of Federal Regulations, 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 must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
34. 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 must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
35. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedules A through I to this Agreement, which are incorporated here by reference, and to update this information as it may be necessary.

36. That subject to item 32, this Agreement shall be effective as of the date set out in the provider enrollment notification letter.
37. That this Agreement may be terminated as follows:
 - a. By IFSSA or its fiscal agent for Provider’s breach of any provision of this Agreement as determined by IFSSA; or
 - b. By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.
38. That this Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider.
39. 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.
40. To complete and submit the Electronic Funds Transfer (EFT) form for receipt of IHCP payments. The use of EFT as a payment vehicle allows direct deposit of IHCP payments into a provider’s designated bank account. The EFT requirement may be waived at the discretion of the IHCP for those providers that can justify in writing that the EFT requirement places a burden upon their business operations. A written letter outlining reasons for an exclusion request must be submitted with the signed Agreement.

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

Provider Agreement-Authorized Signature – All Schedules and applicable addendums	
The owner or an authorized representative of the business entity directly, or ultimately responsible for operating the business enterprise must complete this section. In addition, all rendering providers must sign this section.	
Provider Name (please print): _____	Tax ID: _____
Provider Signature: _____	Date: _____
Authorized Official’s Name (please print): _____	Title: _____
Authorized Official’s Signature: _____	Date: _____

ENROLLMENT APPLICATION CHECKLIST

To avoid return of this enrollment application, the following checklist contains the most common reasons Indiana Health Coverage Programs (IHCP) enrollment applications are returned. Please use this checklist to review the enrollment application before sending it to the IHCP.

Did you remember to...

- Include a copy of your professional license or certification
- Sign the *Provider Agreement*
- Sign the *Electronic Claim Certification (ECC) Statement* to approve claim submission without your signature.
- Include a copy of your CLIA certificate for laboratory services
- Complete all *Schedules A – I*
- Indicate *only one provider type* on *Schedule A*
- Indicate *only one primary provider specialty* and secondary specialties, as applicable
- If this is a group application, complete all information requested on *Schedule G (Rendering Provider's Linkage Assignment)*, and make sure rendering signatures are completed
- Include a copy of a current approved federal W-9 form for tax identification purposes
- Include a copy of your *Medicare Assignment Letter*
- Include all applicable addenda

Thank you for your participation in the IHCP.