



IHCP Ordering, Prescribing, or Referring Provider Enrollment and Profile Maintenance Packet

in.gov/medicaid/providers

Before You Begin!

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

For additional help using the IHCP Portal, online web-based training is available on the [IHCP Provider Healthcare Portal Training](#) page at in.gov/medicaid/providers.

If you choose not to use the IHCP Portal, you may use paper forms.

Which Providers Should Use This Packet to Enroll in the IHCP?

You should use this packet only if you wish to be an ordering, prescribing or referring (OPR) provider for Indiana Health Coverage Programs (IHCP) members, **and** you are **not** otherwise enrolled as a provider with the IHCP.

OPR providers do not bill the IHCP for services rendered to members; they only order, prescribe and/or refer services and supplies for their IHCP-eligible patients. If you are already enrolled in the IHCP as another type of provider, you do not need to complete this form.

This form should not be used to enroll as a billing, group, or rendering provider with the intent to submit claims for reimbursement. To enroll as a billing, group or rendering provider, see the [Complete an IHCP Provider Application](#) page at in.gov/medicaid/providers.

Note for organizations: Organizations cannot enroll as OPR providers. Instead, specific practitioners within the organization who might order, prescribe, or refer services or supplies for IHCP-eligible members (but not provide services for IHCP reimbursement) will need to enroll separately as individual OPR providers.

General Instructions

This enrollment and maintenance packet can be used for the following tasks:

- **Enrolling in the IHCP as an OPR provider for the first time** – Complete *all sections* of the form unless the section does not apply to you. Follow the instructions in each section carefully.
- **Converting from a rendering provider to an OPR provider** – Complete *all sections* of the form unless the section does not apply to you. Follow the instructions in each section carefully.
- **Making updates to your existing enrollment information, also known as your provider profile.** When your profile information – such as license information, contact information, name or address – changes, you are **required** to submit an update. Complete *only* the following:
 - Field 1: Type of request
 - Fields 20–24: Contact information for the transaction
 - Field 25: Provider name
 - Field 28: National Provider Identifier (NPI)
 - Any other fields with information that needs to be updated
 - Fields 40–42: Provider Signature/Attestation
- **Revalidation** – Complete *all sections* of the form unless the section does not apply to you. Follow the instructions in each section carefully. OPR providers are required to revalidate provider enrollment in the IHCP. Providers will receive notification letters when it is time to revalidate.

- **Disenrolling from the IHCP** – Complete *only* the following:
 - Field 1: Type of request
 - Field 3: Requested enrollment effective date [*Enter date for disenrollment.*]
 - Fields 20–24: Contact information for the transaction
 - Field 25: Provider name
 - Field 28: National Provider Identifier (NPI)
 - Fields 40–42: Provider Signature/Attestation

You will need the following information to complete your enrollment request:

- National Provider Identifier (NPI)
- IHCP Provider ID if updating or revalidating an existing enrollment
- Provider name and address, including nine-digit ZIP Code (postal code + 4)
- Provider taxonomy code
- Provider license number, if applicable to your provider specialty
- Provider Social Security number and date of birth

Next Steps

1. After completing this packet, double-check that all required information has been completed. This quality check helps ensure that your packet can be processed and does not have to be returned for corrections.
2. Print the completed packet.
3. Make a copy of the packet for your records.
4. Mail the packet to the IHCP at the following address:

IHCP Provider Enrollment
PO Box 50443
Indianapolis, IN 46250-0418
5. If the packet needs correcting or is missing required documentation, the IHCP Provider Enrollment Unit will contact you by telephone, email or mail. This contact is intended to communicate what needs to be corrected, completed and submitted before the IHCP can process your enrollment transaction. If an application is rejected for missing or incomplete information, a letter will be sent indicating what needs to be corrected or attached. You must include a copy of this letter as a cover sheet when you submit the missing or corrected pages.
6. You will be notified via regular mail after your application has been approved. Please allow 15 business days plus mailing time before inquiring about the status of your application.
7. After you are enrolled as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's managed care programs, you must apply directly with one or more of the managed care entities (MCEs). Please see the [Enrolling as a Managed Care Program Provider](https://in.gov/medicaid/providers) page at in.gov/medicaid/providers for information about the programs and the MCEs with which the state contracts for each.



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Type of Request

1. Type of request:

This packet is used for multiple purposes; select the purpose that applies:

- ☐ **New Enrollment** – You are enrolling in the Indiana Health Coverage Programs (IHCP) for the sole purpose of ordering, prescribing, or referring services and/or medical supplies for your Medicaid-eligible patients.
- ☐ **Conversion from rendering to OPR** – You are currently enrolled in the IHCP as a rendering provider and are applying to convert your enrollment classification to OPR provider. Upon conversion, the effective date of the OPR enrollment will be the same as the end date of the rendering enrollment, with no enrollment gap.
- ☐ **Profile Update** – You are already enrolled as an OPR provider with the IHCP and need to change your provider profile information.
- ☐ **Revalidating** – You are revalidating your OPR provider enrollment with the IHCP.
- ☐ **Disenroll** – You are disenrolling from the IHCP as an OPR provider.

Request Information

Initial Enrollment Information

2. Provider classification:

Ordering, Prescribing, Referring (OPR)

3. Requested enrollment effective date:

Provider Identification

For the taxpayer identification number (TIN), enter the provider's **Social Security number**. The TIN disclosed on this form is used to determine whether the person or entity named in this enrollment application is a federally excluded party and to verify licensure/certification. Refusal to provide a TIN will result in rejection of this enrollment packet.

5. Provider name:

6. TIN (Social Security number):

7a. Are you currently enrolled as an IHCP provider?

☐

Yes

☐

No

7b. If yes, what is your IHCP Provider ID?

8a. Were you previously enrolled as an IHCP provider?

☐

Yes

☐

No

8b. If yes, what is your previous IHCP Provider ID?

Specialties

Physician specialties: Physicians must complete fields 9 and 10.

If you are a physician, designate your specialties. **Please select all specialties that apply.** A physician must meet all federal and state requirements for the specialties selected. You must also identify which specialty is primary in field 9. Only one primary specialty is allowed.

Nonphysician specialties: Nonphysicians must complete field 11.

If you are a nonphysician provider, add the appropriate specialty. **Select only one specialty.** All nonphysician providers must meet specific licensing, certification, educational, and work experience requirements.

Physician Specialties

9. Physicians, indicate your **primary** specialty (from the following list):

10. **Physician specialties:** If you are a physician, designate your specialties. **Check all that apply:**

- | | |
|--|---|
| ☐ Addiction medicine | ☐ Medical oncology |
| ☐ Allergy/Immunology | ☐ Nephrology |
| ☐ Anesthesiology | ☐ Neurology |
| ☐ Cardiac electrophysiology | ☐ Neuropsychiatry |
| ☐ Cardiac surgery | ☐ Neurosurgery |
| ☐ Cardiovascular disease (cardiology) | ☐ Nuclear medicine |
| ☐ Colorectal surgery (proctology) | ☐ Obstetrics/Gynecology |
| ☐ Critical care (intensivists) | ☐ Ophthalmology |
| ☐ Dermatology | ☐ Oral surgery (dentist only) |
| ☐ Diagnostic radiology | ☐ Orthopedic surgery |
| ☐ Emergency medicine | ☐ Osteopathic manipulative medicine |
| ☐ Endocrinology | ☐ Otolaryngology |
| ☐ Family practice | ☐ Pain management |
| ☐ Gastroenterology | ☐ Palliative peripheral vascular disease |
| ☐ General practice | ☐ Pediatrician |
| ☐ General surgery | ☐ Physical medicine and rehabilitation |
| ☐ Geriatric medicine | ☐ Plastic and reconstructive surgery |
| ☐ Geriatric psychiatry | ☐ Podiatry |
| ☐ Gynecological oncology | ☐ Preventive medicine |
| ☐ Hand surgery | ☐ Psychiatry |
| ☐ Hematology | ☐ Pulmonary disease |
| ☐ Hematology/Oncology | ☐ Radiation oncology |
| ☐ Hospice | ☐ Rheumatology |
| ☐ Infectious disease | ☐ Sports medicine |
| ☐ Internal medicine | ☐ Surgical oncology |
| ☐ Interventional pain management | ☐ Thoracic surgery |
| ☐ Interventional radiology | ☐ Urology |
| ☐ Maxillofacial surgery | ☐ Vascular surgery |

Nonphysician Specialties

11. **Nonphysician specialties:** If you are a nonphysician provider, check the appropriate box to indicate your specialty.

Check only one of the following:

- | | |
|---|---|
| ☐ Certified nurse midwife with prescriptive authority | ☐ Genetic counselor |
| ☐ Certified nurse midwife without prescriptive authority | ☐ Mental health |
| ☐ Certified registered nurse anesthetist (CRNA) with prescriptive authority | ☐ Nurse practitioner |
| ☐ Certified registered nurse anesthetist (CRNA) without prescriptive authority | ☐ Occupational therapist |
| ☐ Clinical nurse specialist with prescriptive authority | ☐ Optometrist |
| ☐ Clinical nurse specialist without prescriptive authority | ☐ Physical therapist |
| ☐ Clinical pharmacist | ☐ Physician assistant |
| ☐ Clinical psychologist | ☐ Psychologist billing independently |
| ☐ Clinical social worker | ☐ Registered dietician |
| ☐ Dentist | ☐ School psychologist |

Addresses/Contact Information

Provider Address

Enter a mailing address for the OPR provider for correspondence related to this enrollment.

12. Street address:

13. City:

14. State:

15. ZIP Code+ 4 (nine digits required):

16. County:

17. Email address (optional):

18. Telephone number (with extension):

19. Fax number (optional):

Enrollment Transaction Contact Information

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

20. Contact name:

21. Title:

22. Contact email address:

23. Contact telephone (with extension):

24. Preferred method of communication:

☐

Email

☐

Phone

☐

Mail

Provider Identification		
Provider Name		
Please enter the provider's name and date of birth. Middle initial and title are optional. The provider name should match what is listed on the provider's license or certificate, when one is required.		
25. Provider name (last name, first name, middle initial):		
26. Title:	27. Birth date:	
National Provider Identifier		
The National Provider Identifier (NPI) is the standard, unique healthcare identifier for healthcare providers and is assigned by the National Plan and Provider Enumeration System (NPPES). As an enrolling provider, you must have obtained an NPI. Applying for the NPI is a process separate from IHCP enrollment. To obtain an NPI, you may apply online at nppes.cms.hhs.gov . For more information about NPI enumeration, visit the National Provider Identifier Standard (NPI) page at cms.gov. A healthcare practitioner enrolling as an OPR provider must enroll using a Type 1 NPI.		
28. National Provider Identifier (NPI):		
Licensure/Certification Information		
List all professional licenses (for all states) and all required certifications. At least one license must be entered. <i>Note: Drug Enforcement Administration (DEA) license should not be listed here, but instead should be listed in the next section, if applicable.</i>		
29a. License type:		
29b. License number:	29c. Issuing state:	
29d. Effective date:	29e. Expiration date:	
29f. Name as it appears on the license:		
30a. Other license/certificate type:		
30b. License/certificate number:	30c. Issuing state:	
30d. Effective date:	30e. Expiration date:	
30f. Name as it appears on the license/certificate:		
31a. Other license/certificate type:		
31b. License/certificate number:	31c. Issuing state:	
31d. Effective date:	31e. Expiration date:	
31f. Name as it appears on the license/certificate:		
Drug Enforcement Administration (DEA) License		
32. Drug Enforcement Administration (DEA) number:	33. Effective date:	34. End date:

Adverse Legal Actions

Please provide information on final adverse legal actions, such as convictions, exclusions, revocations and suspensions. All applicable final adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Convictions

- The physician or non-physician practitioner was, within the last 10 years preceding enrollment or revalidation of enrollment, convicted of a federal or state felony offense that the Centers for Medicare & Medicaid Services (CMS) has determined to be detrimental to the best interests of the program and its beneficiaries. Offenses include felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction of criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under *Section 1128(a)* of the *Social Security Act*.
- Any misdemeanor conviction, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state healthcare program, or (b) the abuse or neglect of a patient in connection with the delivery of a healthcare item or service.
- Any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a healthcare item or service.
- Any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations *42 CFR Section 1001.101* or *1001.201*.
- Any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Exclusions, Revocations, or Suspensions

- Any revocation or suspension of a license to provide healthcare by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.
- Any revocation or suspension of accreditation.
- Any suspension or exclusion from participation in, or any sanction imposed by, a federal or state healthcare program, or any debarment from participation in any federal executive branch procurement or non-procurement program.
- Any current Medicare/Medicaid payment suspension under any Medicare/Medicaid identification number.
- Any Medicare/Medicaid revocation of any Medicare/Medicaid identification number.

35. Have you, under any current or former name or business identity, ever had a final adverse legal action, listed previously, imposed against you?

☐ No ☐ Yes

- If no, skip to the *Provider Signature/Attestation* section.
- If yes, complete fields 35a through 35d to report each final adverse legal action, when it occurred, the federal or state agency or the court/administrative body that imposed the action, and the resolution. If you need more room, attach a separate sheet.
- If yes, attach a copy of the final adverse legal action documentation.

35a. Briefly describe adverse legal action:

35b. Date of adverse legal action:

35c. Taken by:

35d. Resolution:

Provider Signature/Attestation

By execution of this Attestation, the undersigned individual ("Provider") agrees to participate as a provider in the Indiana Health Coverage Programs (IHCP) for the sole purpose of ordering, prescribing, or referring (OPR) services to IHCP members. The undersigned authorized individual attests that the information provided is true and accurate to the best of their knowledge.

36. Provider name (please type or print):

37. Provider signature:

38. Date: