



IHCP Family Member/Associate Transportation Provider Enrollment and Profile Maintenance Packet

in.gov/medicaid/providers

Instructions

Note: The [IHCP Provider Healthcare Portal](https://portal.indianamedicaid.com) (portal.indianamedicaid.com) offers an online alternative to enrolling by mail using this packet.

Who Uses This Packet

You should use this packet if you are a family member or associate enrolling as a driver for a Medicaid member (Provider type 26 – *Transportation*; provider specialty 266 – *Family Member/Associate*). For more information about this specialty, see the [Family Member/Associate Transportation Providers](https://in.gov/medicaid/providers) webpage at in.gov/medicaid/providers.

General Instructions

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

- **Enrolling as a provider in the Indiana Health Coverage Programs (IHCP) for the first time** – Complete all fields in each section, unless a section or field is optional and does not apply to you.
- **Revalidating your current enrollment in the IHCP** – Complete all fields in each section, unless a section or field is optional and does not apply to you.
- **Making updates to information about your enrollment (also known as your *provider profile*)** – Do not complete the entire packet when making an update to your profile. Instead, complete and submit only the parts of the packet and the supporting documentation that apply to the update. The following sections are required with all updates to your provider profile:
 - *Type of Request* section
 - *Contact Information* section
 - *Legal Name and Address and Provider Identification* section
 - *Signature Authorization* section
 - Any section where the information has changed; if the information in a section has not changed, leave the section blank. For example, if the mailing address has changed but the pay-to address has not, complete the mailing address section and leave the pay-to address blank.

Tips for Completing This Packet

The following tips provide additional guidance for completing this packet:

- Read the instructions in each section of the packet carefully.
- Attach the [Medicaid Family Member or Associate Transportation Services Form](#) to this packet. This form must be completed and signed by the Medicaid member you will be driving.
- For sections of this packet that require supporting documents (such as a copy of a driver's license and proof of insurance), the required documents must be included as attachments to the packet.
- This packet is an interactive PDF file, allowing you to enter information into the fields directly from a computer. This information can be saved as a file and printed for mailing. Using these interactive features makes it easier to complete and review the packet.

Next Steps

After completing this packet and collecting the necessary supporting documents, use this quality checklist to make sure the packet is complete. The quality check helps to be certain that your application can be processed and does not have to be delayed for corrections.

For Your Use Only	Quality Checklist
☐	If you are enrolling for the first time or revalidating your enrollment: Double-check that <i>all sections</i> of this packet have been completed. If a question or section does not apply to you, enter N/A in that section rather than leaving it blank. If you are already enrolled and updating your provider profile: Do not complete the entire packet. Instead, double-check that the appropriate sections, and <i>only these sections</i>, have been completed and supporting documents attached: ☐ <i>Type of Request</i> section ☐ <i>Contact Information</i> section ☐ <i>Legal Name and Address and Provider Identification</i> section ☐ <i>Signature Authorization</i> section (signed) ☐ Any section where the information has changed (if the information in a section has not changed, leave the section blank) ☐ Documents supporting the update
☐	Make sure you have attached the current W-9 form from the Internal Revenue Service (IRS) website. Failure to attach the current year's W-9 may result in the application being returned for correction. Follow these steps to obtain and complete the current version of the IRS W-9: 1. Go to the irs.gov website. 2. Locate the W-9 form and click the link to open the form in your browser. 3. Complete the W-9 form, based on the instructions provided by the IRS. 4. Save (download), print and sign the completed W-9 form.
☐	Double-check that the name and address in the <i>Legal Name and Address and Provider Identification</i> section of this packet exactly match the information in lines 1, 5 and 6 of the W-9 form.
☐	Double-check that you have read and signed the <i>IHCP Family Member/Associate Transportation Provider Agreement</i>. This agreement must not be signed by anyone other than the enrolling transportation provider.
☐	If you want payments to be deposited directly into your bank account, you must complete the <i>IHCP Family Member/Associate Transportation Provider Electronic Funds Transfer Addendum/Maintenance Form</i> – and include it with this packet.
☐	Confirm that the individual you will be transporting has fully completed the <i>Medicaid Family Member or Associate Transportation Services Form</i>, and has provided you with a copy to submit with this packet.
☐	Double-check that the required documents are included with the packet: ☐ Current version of the federal W-9 Form ☐ Copy of current driver's license ☐ Copy of current auto insurance for the vehicle being used ☐ Copy of current auto registration for the vehicle being used ☐ <i>IHCP Family Member/Associate Transportation Provider Agreement</i> (signed) ☐ <i>IHCP Family Member/Associate Transportation Provider Electronic Funds Transfer Addendum/Maintenance Form</i> (if direct deposit is preferred) ☐ <i>Medicaid Family Member or Associate Transportation Services Form</i> (completed by the member)

After confirming that the packet has been completed appropriately, follow these steps:

1. Print the completed packet to mail and make a copy for your records. It is important to return all pages in the packet, in the correct page number order, with all required documents.
2. Mail the packet, including all required documents, to the IHCP at the following address:

**IHCP Provider Enrollment
PO Box 50443
Indianapolis, IN 46250-0418**

3. If the packet needs corrected or is missing required documents, the IHCP Provider Enrollment Unit will contact you by telephone, email or mail.
4. You will be notified via mail if your enrollment is approved. Please allow 15 business days plus mailing time before inquiring about the status of your application.
5. After you have successfully enrolled as a provider with the IHCP, the Medicaid member's transportation broker will contact you to finalize any paperwork needed, so you can begin scheduling trips and submitting claims for reimbursement.



IHCP Family Member/Associate Transportation Provider Enrollment and Profile Maintenance Form

in.gov/medicaid/providers

Type of Request

1. Type of request

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

- ☐ **New Enrollment** – You are enrolling for the first time.
- ☐ **Revalidate Enrollment** – You received a letter indicating you must revalidate your enrollment.
- ☐ **Profile Update** – You are already enrolled and you need to change your Provider Profile information.

2. Are you currently enrolled as an IHCP provider?

☐ Yes ☐ No

3. If yes, what is your **current** IHCP Provider ID?

4. Were you previously enrolled as an IHCP provider?

☐ Yes ☐ No

5. If yes, what was your **previous** IHCP Provider ID?

6. Requested enrollment date:

Contact Information

- Please provide the contact name, phone number and email address of the person who can answer questions about the information provided in this packet.
- Providers will be enrolled to receive emails when new information is published to in.gov/medicaid/providers. Enter the email address where these notices should be sent.
- Email addresses will be used for IHCP business only and will not be sold or shared for other purposes.

7. Contact name:

8. Contact telephone:

9. Contact email address:

10. Email address for provider publications if different than in #9:

Legal Name and Address and Provider Identification

- The name, address and Social Security number (SSN) entered in this section must **exactly match the information on the attached W-9 form**.
- The address provided must be a physical location. A post office box is not a valid legal address.
- If you are using this packet to **change** the legal name, legal address, or SSN on your provider profile, a revised W-9 tax form is required, matching the new information entered in this section.
For a personal name change, you will also need to submit documents showing proof of the name change. A provider's updated driver's license may be presented as proof of a name change. If a provider's license does not show the new name, an official document showing the legal name change is required.

11. Legal name:

12. Indiana county (Indiana providers):

13. Telephone:

14. Legal street address:

15. City:

16. State:

17. ZIP + 4 (**Nine digits required**):

18. Current Social Security number (SSN):

19. Former SSN (required only for reporting a change):

20. Date of birth:

Mail-To Name and Address		
- The mail-to address is the location where the IHCP sends general communication. A post office box is acceptable for a mailing address. - Your mail-to name, address and/or telephone number may be the same as those entered in the previous section. If ALL your mail-to information is the same as in the previous section, you can check the box below and skip to the next section; otherwise, please complete all fields in this section. ☐ Same as previous		
21. Mail-to name:	22. Mail-to telephone:	
23. Mail-to street address:		
24. City:	25. State:	26. ZIP + 4 (Nine digits required) :
Pay-To Name and Address		
- The pay-to name is the name that will appear on all checks. - The pay-to address is the location where the IHCP sends checks and payment information. A post office box is acceptable for this address. - Your pay-to name, address and/or telephone number may be the same as those entered in the previous section. If ALL your pay-to information is the same as in the previous section, you can check the box below and skip to the next section; otherwise, please complete all fields in this section. ☐ Same as previous		
27. Pay-to name:		
28. Pay-to street address:	29. Pay-to telephone:	
30. City:	31. State:	32. ZIP + 4 (Nine digits required) :
33. Direct deposit: <i>Attach a completed IHCP Family Member/Associate Transportation Provider Electronic Funds Transfer Addendum/Maintenance Form if you want payments to be deposited directly into your bank account.</i>		
Provider Type and Specialty Information		
Your IHCP provider type is 26; your IHCP specialty is 266. This information has been entered for you in boxes 34 and 35.		
34. Provider type 26 – Transportation Provider		
35. Specialty 266 – Family Member/Associate Transportation		
36. Medicaid member authorization: <i>Attach a copy of the completed and signed Medicaid Family Member or Associate Transportation Services Form from the member being transported.</i>		
37. Proof of active driver's license: <i>Attach a copy of your current driver's license.</i>		
38. Proof of auto insurance: <i>Attach a copy of the auto insurance for the vehicle to be used to transport the member.</i>		
39. Proof of auto registration: <i>Attach a copy of the auto registration for the vehicle to be used to transport the member.</i>		
Organizational Structure		
40. Your organizational structure has been entered for you as "individual/sole proprietor." This should match what is shown on your federal W-9 tax form. ☒ Individual/sole proprietor		

Disclosure Information – Relationships and Background Information

(Attach additional copies of this section if you need additional space.)

41. Does the enrolling individual have ownership or controlling interest in a business or organization that participates in a program established under the *Social Security Act* (Medicaid, Medicare, Maternal and Child Health Services Block Grants, or Block Grants to States for Social Services) that would require the business or organization to disclose ownership or controlling interest information?

☐ Yes ☐ No

42. If yes, please list the names of the businesses or organizations (disclosing entities) in which the enrolling individual has ownership or controlling interest:

Businesses or organization (disclosing entities)

43. Has the enrolling individual ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid, or Block Grants to States for Social Services programs? ☐ Yes ☐ No

44. If yes, please indicate the dates of conviction:

Date of conviction

45. Has the enrolling individual transferred ownership in a business or organization to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a healthcare-related conviction or imposition of an exclusion? ☐ Yes ☐ No

46. If yes, please indicate the person to whom ownership was transferred and his or her relationship to the enrolling individual:

Name of person**Relationship****Signature Authorization**

The enrolling individual must sign this form; no other signature will be accepted.

The undersigned, as the enrolling individual, attests that all information on this form is accurate. Further, the enrolling individual binds themselves to the terms of the provider agreement, and does hereby agree to abide by and comply with all the stipulations, conditions, and terms set forth therein. The undersigned acknowledges that the commission of any Medicaid- or Children's Health Insurance Program (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.

47. Legal name of enrolling individual (please print):

48. Social Security number:

49. Enrolling individual's signature:

50. Date:

51. Authorized agreement:

Attach a copy of a signed IHCP Family Member/Associate Transportation Provider Agreement.



| Overview

IHCP Family Member/Associate Transportation Provider Agreement

in.gov/medicaid/providers

IHCP Provider Agreement Overview

You must provide a completed and signed IHCP Family Member/Associate Transportation Provider Agreement in the following instances:

- When you are enrolling for the first time in the Indiana Health Coverage Programs (IHCP)
- When you are revalidating your enrollment with the IHCP

In each of the above instances, a full *IHCP Family Member/Associate Transportation Provider Enrollment and Profile Maintenance Packet*, including a newly signed IHCP Family Member/Associate Transportation Provider Agreement, must be submitted for processing. An original signature of the enrolling individual is required; no other signature will be accepted. The IHCP Family Member/Associate Transportation Provider Agreement details the requirements for participation in the IHCP. Included are provider responsibilities regarding updating your enrollment information, protecting member health information, and claim payments. In addition, the agreement details obligations regarding the appeals process and other requirements associated with participation in the IHCP. The entire agreement must be read, signed, and returned with the *IHCP Family Member/Associate Transportation Provider Enrollment and Profile Maintenance Packet*. You should keep a signed copy for your records.



| Provider Agreement

IHCP Family Member/Associate Transportation Provider Agreement

in.gov/medicaid/providers

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

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

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

14. To certify that any and all information contained on any IHCP billings submitted on Provider's behalf by electronic, telephonic, mechanical, or standard paper means of submission shall be true, accurate, and complete. Provider accepts total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (whether by Provider, Provider's employees, agents, or a third party acting on Provider's behalf, such as a service bureau). Provider fully recognizes that any billing intermediary or service bureau that submits billings to the FSSA or its fiscal agent contractor is acting as Provider's representative and not that of the FSSA or its fiscal agent contractor. Provider further acknowledges that any third party that submits billings on Provider's behalf shall be deemed to be Provider's agent for the purposes of submission of the IHCP claims. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable federal and state laws.

Provider understands that the standard paper claim form may include a signature line. Provider understands that all the stipulations, conditions, and terms of the provider agreement apply in the event that Provider fails, for any reason, to sign the paper claim, even if the claim is approved for payment. Provider agrees that payment of a paper claim that does not contain Provider's signature in no way absolves Provider of the terms stated in the provider agreement.

15. To submit claim(s) for IHCP reimbursement only after first exhausting all other sources of reimbursement as required by the reference modules and bulletins.
16. To submit claim(s) for IHCP reimbursement utilizing the appropriate claim forms specified in the reference modules, 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 as payment in full the amounts determined by the FSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for IHCP covered services provided to members. Provider agrees not to bill members, or anyone in the member's family, for any additional charge for IHCP covered services, excluding any copayment permitted by law.
19. To refund duplicate or erroneous payments to the FSSA or its fiscal agent within fifteen (15) days of receipt.
20. To make repayments to the FSSA or its fiscal agent, or arrange to have future payments from the IHCP withheld, within sixty (60) days of receipt of notice from the FSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. Outstanding overpayments made under prior provider agreements will remain collectable under this provider agreement.
21. To pay interest on overpayments in accordance with *Indiana Code (IC) 12-15-12.7-7(e), 12-15-13-3.5, IC 12-15-13-4, IC 12-15-21-3, and IC 12-15-23-3*.
22. To make full reimbursement to the FSSA or its fiscal agent of any federal disallowance incurred by the FSSA when such disallowance relates to payments previously made to Provider under the IHCP.
23. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits. At the discretion of the Office of Medicaid Policy and Planning (OMPP), failure to cooperate or promptly make available requested documentation can result in provider sanctions pursuant to *405 IAC 1-1.4-4*, including suspension of payments, as well as exclusion from the Indiana Medicaid program for a period of up to three years.
24. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of IHCP payments made to Provider, to assure the proper administration of the IHCP and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 Indiana Administrative Code (IAC) 1* and in the reference modules and bulletins, and shall include, without being limited to, the following:
 - a. medical records as specified by *42 United States Code (USC) 1396a(a)(27)*, and any amendments thereto;
 - b. records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs, or services;
 - c. any records determined by the FSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the IHCP;
 - d. documentation in each patient's record that will enable the FSSA or its agent to verify that each charge is due and proper;
 - e. financial records maintained in the standard, specified form;
 - f. all other records as may be found necessary by the FSSA or its agent in determining compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the FSSA; and
 - g. any other information regarding payments claimed by Provider for furnishing services to the plan.

25. To cease any conduct that the FSSA or its representative deems to be abusive of the IHCP. Abusive behavior includes but is not limited to:
 - a. misconduct unbecoming of an IHCP provider;
 - b. conduct that impacts the care provided to IHCP members; and
 - c. conduct that is aggressive or threatening towards the IHCP, its employees, or its contractors.
26. To promptly correct deficiencies in Provider's operations upon request by the FSSA or its fiscal agent.
27. To make a good faith effort to provide and maintain a drug-free workplace. Provider will give written notice to the State within ten (10) days after receiving actual notice that Provider or an employee of Provider has been convicted of a criminal drug violation occurring in Provider's workplace.
28. To comply with the following procedures and time limits when filing an appeal request and statement of issues:
 - a. Appeal requests must state facts demonstrating that:
 - (1) the petitioner is the person to whom the order is specifically directed;
 - (2) the petitioner is aggrieved or adversely affected by the order; or
 - (3) the petitioner is entitled to review under the law.
 - b. A statement of issues must be filed in conjunction with the appeal request, setting out in detail:
 - (1) the specific findings, actions, or determinations of the FSSA from which Provider is appealing; and
 - (2) with respect to each finding, action, or determination, all statutes or rules supporting Provider's contentions of error and why Provider believes that the office's determination was in error.
 - c. To appeal any of the following actions, Provider must submit the appeal request and the statement of issues within sixty days of receipt of the FSSA's determination:
 - (1) a notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement
 - (2) a notice of overpayment
 - d. All appeals of actions not described in (c) must be filed within 15 days of receipt of the FSSA's determination. The statement of issues must be filed within 45 days of receipt of the FSSA's determination.
29. To cooperate with the FSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.
30. To comply with the advance directives requirements as specified in *42 Code of Federal Regulations (CFR) Part 489, Subpart I*, and *42 CFR 417.436(d)*, as applicable.
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 an IHCP covered service.
32. To abide by (and ensure its agents abide by) by all ethical requirements that apply to persons who have a business relationship with the State, as set forth in *IC § 4-2-6 et seq.*, *IC § 4-2-7, et seq.*, the regulations promulgated thereunder, and *Executive Order 04-08*, dated April 27, 2004. If Provider is not familiar with these ethical requirements, Provider should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission webpage at <https://www.in.gov/ig/commission>. If Provider or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Agreement immediately upon notice to Provider. In addition, Provider may be subject to penalties under *IC § 4-2-6*, *IC 4-2-7*, *IC 35-44.1-1*, and under any other applicable laws.
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 CFR, Part 455, Subpart B*, and *405 IAC 1-19*. Long-term care providers must comply with additional requirements found in *405 IAC 1-20*. Pursuant to *42 CFR 455.104(c)*, OMPP shall terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
34. To immediately notify the FSSA of any felony arrest or conviction of anyone employed by or with ownership interest in the provider.
35. To submit within 35 days of the date of request by the federal or state agency full and complete information about:
 - a. ownership of subcontractors with whom Provider has had more than \$25,000 in a twelve-month hearing period;
 - b. any significant business transactions between Provider and any wholly owned supplier; and
 - c. any significant business transactions between Provider and any subcontractor, during five-year period ending with the date of request.
36. To furnish to FSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in the IHCP Provider Application and maintenance forms, which are incorporated here by reference, and to update this information as it may be necessary.

37. That this Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by Provider. The effective date of this Agreement will be the date set out in the provider enrollment notification letter. This Agreement shall remain in effect until terminated in accordance with item 38 below.
38. That this Agreement may be terminated as follows:
 - a. By the FSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by the FSSA pursuant to *405 IAC 1-1.4-4* and *IC 12-15-22*; or
 - b. By the FSSA or its fiscal agent, or by Provider, without cause upon 60 days' written notice.
39. That this Agreement may be suspended as follows:
 - a. By the FSSA or its agent pursuant to the provisions in *405 IAC 1-1.4-4*; or
 - b. By the FSSA or its agent upon notice of a pending criminal investigation of an owner or employee for a felony or healthcare related fraud.
40. For long-term care providers involved in a change of ownership, this agreement acts as an amendment to the transferor's agreement with the 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*.
41. New owners of nursing facilities or ICF/IIDs, must accept the assignment of the provider agreement executed by the previous owner(s) as required by *42 CFR 442.14*.
42. For any entity that receives or makes annual payments totaling at least \$5 million annually as described in *42 U.S.C. 1396a(a)(68)*, the entity shall add written policies to their employee handbook that provide detailed information about federal and state False Claims Acts, whistleblower protections, and entity policies and procedures for preventing and detecting fraud and abuse. In any inspection, review, or audit of the entity by the FSSA or its contractors, the entity shall provide copies of the entity's written policies regarding fraud, waste, and abuse upon request. Entity shall submit to the FSSA a corrective action plan within 60 days if the entity is found not to be in compliance with any part of the requirements stated in this paragraph.
43. To verify and maintain proof of verification that no employee or contractor is an excluded individual or entity with the Health and Human Services (HHS) Office of the Inspector General (OIG). Providers shall review the HHS-OIG List of Excluded Individuals/Entities (LEIE) database for excluded parties. This LEIE database is accessible to the general public at <https://hhs.gov/exclusions>.
44. To allow the FSSA and its representatives to perform safety inspections of motor vehicles used for transportation services of IHCP members. Provider shall require all of its contractors and subcontractors to agree to the same.
45. To receive email updates and communication from the IHCP at the email address(es) provided on its enrollment application. Providers may opt-out of receiving these email communications by clicking the link found at the bottom of each email following the message prompts. Opting out does not affect the provider's obligation to stay abreast of IHCP updates and communications as required by this agreement.

AS A CONDITION OF PAYMENT AND CONTINUED ENROLLMENT IN THE IHCP, THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN. THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY INDIANA HEALTH COVERAGE PROGRAMS (IHCP)-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.

IHCP Family Member/Associate Transportation Provider Agreement Authorized Signature – All Schedules and Applicable Addenda	
The enrolling individual must complete this section and sign the agreement. No other signature will be accepted.	
1. Enrolling individual's name (please print):	2. Social Security number:
3. Enrolling individual's signature:	4. Date:



| Addendum/Maintenance Form

**IHCP Family Member/Associate Transportation Provider
Electronic Funds Transfer Addendum/Maintenance Form**

in.gov/medicaid/providers

Complete all fields on this form. Confirm the account number and bank or financial institution routing number. The Social Security number of the enrolling individual (as shown on the W-9 tax form submitted with this application) must be connected with the account identified for direct deposit.

General Information for Enrolling Individual

1. Name		2. Street address	
3. City		4. State/Province	5. ZIP Code/postal code
6. Social Security number	7. Telephone number	8. Email address	

Bank or Financial Institution Information

9. Bank or financial institution name	10. Bank or financial institution telephone number	11. Bank or financial institution routing number	12. Type of account ☐ Checking ☐ Savings
13. Account number	14. Confirm the enrolling individual's Social Security number is connected to this account: ☐ Yes	15. Reason for submission ☐ New EFT enrollment ☐ Change EFT enrollment ☐ Cancel EFT enrollment	

Authorized Signature Section

As the enrolling individual, 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. 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 an enrolled provider, a noncash 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) an enrolled provider; (2) a noncash member; (3) a government agency on reassignment by an enrolled provider (IRS); (4) a third party by court order on reassignment by an enrolled provider (child support); (5) the employer of a practitioner (if a contract so requires); or (6) a healthcare facility, or a healthcare delivery system (if a contract so requires), if the organization itself submits the claim directly to the IHCP.

I authorize that electronic transfer of IHCP payments be made to the above account. I understand that I am responsible for the validity of the above information. I agree to notify the IHCP within 10 days of any change in any of the information included on this form.

This form must be signed by the enrolling individual; no other signature will be accepted.

Authorized signature

Written signature of person submitting enrollment

Printed name of person submitting enrollment

Submission date