| Addendum/Maintenance Form

IHCP Claim Certification Statement for Signature on File Addendum/ Maintenance Form

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IHCP Claim Certification Statement for Signature On File Overview

UB billers are required to submit the IHCP Claims Certification Statement for Signature on File

All UB billing providers that submit paper claims are required to complete this form. All other providers that submit claims electronically are not required to complete the form but should do so to cover instances in which submission of a paper claim is necessary. Rendering providers are not required to complete this form. After your request is processed, paper claims will not need a signature to be adjudicated, because the signature will be "on file." An owner, authorized official, or delegated administrator with the business must sign this form. The IHCP Delegated Administrator Addendum/Maintenance Form must be completed before a delegated administrator can sign. The delegated administrator can sign only for items expressly delegated. The IHCP can process provider maintenance requests only when the appropriate signature is present. **An original signature is required.**

IHCP Claim Certification Statement for Signature on File (please read carefully)

This is to certify that any and all information contained on any Indiana Health Coverage Programs (IHCP) billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (either by myself, my staff, and/or a third party acting on my behalf, such as a service bureau). I fully recognize that any billing intermediary or service bureau that submits billings to the Indiana Family and Social Services Administration (FSSA) or its Fiscal Agent Contractor is acting as my representative and not that of the FSSA or its Fiscal Agent Contractor. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for the purposes of submission of IHCP claims.

I understand that the standard paper claim form may include a signature line. I understand that all the stipulations, conditions, and terms of the provider agreement apply in the event that I fail, for any reason, to sign the paper claim, and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature in no way absolves me of the terms stated in the provider agreement that I have signed.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS CERTIFICATION STATEMENT, AND HAVING READ THIS CERTIFICATION STATEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL STIPULATIONS, CONDITIONS, AND TERMS SET FORTH THEREIN.

Authorized Signature Section

1. Legacy Provider Identifier (LPI):	2. Service Locations:	3. National Provider Identifier (NPI):
4. ZIP + 4: **(Nine digits required)**		5. Taxonomy:
6. Provider or Authorized Official's Name (Printed):		7. Title:
8. Provider or Authorized Official's Signature:		9. Date:

Contact Information

- The contact person is the person who answers questions about the information provided in this form.

10. Contact Name:	11. Telephone:
12. Contact Email Address:	

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