IHCP Provider Medicare Number Maintenance Form

Enrolled providers use this form to submit new or revised Medicare participation information to the Indiana Health Coverage Programs (IHCP) for crossover claims purposes.

- Billing providers may be assigned separate Medicare numbers for each of their service locations. In other instances, a single billing Medicare number may be assigned to multiple service locations.
- Medicare number changes can be reported for no more than one service location per form unless **all** provider service locations are making the identical change.
- Groups and clinics must submit updated Medicare participation information for rendering providers linked to the groups' or clinics' service locations.

Submit Medicare approval letters for all providers named on this form, including rendering providers, if applicable. The approval letters help the IHCP validate the numbers processed in the IHCP's claims processing system.

Next Steps

1. After completing this form, perform a quality check using the checklist below.

For Provider Use Only	Quality Check
	If you are a billing provider, meaning you do not have rendering providers linked to your service location, double-check that you have completed the following: • Fields 1 through 16 (do not complete field 17a through 17f) • The Contact Name section • The Authorized Signature Information section
	If you are a group or clinic provider, meaning you have rendering providers linked to your service location, double-check that you have completed the following: • All fields, including the Contact Name and Authorized Signature Information sections
	Sign the form; an original signature is required.
	Enclose Medicare approval letters for all providers, including rendering providers, if applicable, named on the form.

2. Make a copy of the maintenance form and other documentation for your records.
3. If you need additional maintenance forms, return to in.gov/medicaid/providers and select another form.
4. Place all forms and required documentation in an envelope.
5. Mail the maintenance forms and other required documentation to the following address:

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

IHCP Provider Medicare Number Maintenance Form

in.gov/medicaid/providers

- Billing providers must complete fields 1 through 16 (do not complete fields 17a through 17f), the contact section, and the signature section.
- Groups and clinics must complete all fields, including the contact section and the signature section.

Provider Information

1. Legacy Provider Identifier (LPI)	2. Taxpayer Identification Number (TIN)	3. Requested effective date
4. National Provider Identifier (NPI)	5. ZIP + 4	6. Taxonomy

7. Apply the Medicare number change to all service locations? If yes, skip fields 8 through 13 and go to field 14. If no, complete fields 8 through 13.

Yes No

Service Location Name and Address Where Submitted Medicare Number Applies

8. Doing business as (DBA) name		9. Service location alpha suffix:
10. Service location street address		
11. City	12. State	13. ZIP + 4 **(Nine digits required)**

Service Location Medicare Information

14. Medicare Number	15. Individual's Unique Physician Identification Number (UPIN)	16. DMEPOS number

Rendering Provider Medicare Information

(Providers linked to the service location presented on this form)

17a. Rendering provider LPI	**17b. Rendering provider name**	**17c. Rendering provider NPI**	**17d. UPIN**	**17e. Effective date**	**17f. Rendering provider Medicare Number**

Contact Information

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

18. Contact name	19. Telephone
20. Contact email	

Authorized Signature Information

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.*

The owner or an authorized representative of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. A delegated administrator must not sign this form. The form will be returned if the appropriate signatures are not submitted.

21. Legal name of provider's business (please print)	22. Taxpayer Identification Number (TIN)
23. Authorized official's name (please print)	24. Title
25. Authorized official's signature	26. Date