| Addendum/Maintenance Form

# IHCP Psychiatric Hospital Bed Addendum/Maintenance Form

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## Overview

A hospital is eligible for Medicaid reimbursement for psychiatric care provided to individuals 65 years and older and 21 years and younger. Pursuant to the Institution for Mental Disease (IMD) exclusion, reimbursement is not available under the Indiana Health Coverage Programs (IHCP) for psychiatric care rendered to patients between 22 years old and 64 years old if the hospital is an institution for mental disease (such as a psychiatric hospital) comprising more than 16 beds (see *42 CFR 435.1008(a)(2)*; *Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual 4390*; and *IC 12-15-2-9*). However, a psychiatric hospital that has 16 beds or less is eligible to receive reimbursement from the IHCP for services rendered to patients between 22 years old and 64 years old (see IMD Provision 4390; *405 IAC 5-20-1*).

## Provider Information

1. Provider legal name

2. IHCP Provider ID (formerly Legacy Provider Identifier/LPI)

3. National Provider Identifier (NPI)

## Determining Qualification as a 16 Bed or Less Psychiatric Facility

To determine whether your facility qualifies for reimbursement as a 16 bed or less psychiatric facility, please answer all the following questions.

1. Does the psychiatric hospital (facility) have 16 beds or less?
☐ Yes ☐ No

2. Does the facility have independent licensing?
☐ Yes ☐ No

3. Does the facility have its own Medicaid certification?
☐ Yes ☐ No

4. Does the facility have its own Medicare certification?
☐ Yes ☐ No

If you answered "no" to any of the previous questions, your facility does not qualify for this exclusion, and it is not necessary for you to complete the remaining questions.

If you answered "yes" to all the previous questions, please answer the following additional questions and provide an explanation where needed. These questions are necessary to determine whether your facility is separate from any other existing hospitals.

5. Please list the name and address of any hospital with which your facility is in any way affiliated:

6a. Is your facility geographically separated from the hospitals identified in your answer to Question 5 above?
☐ Yes ☐ No

6b. Please explain your answer and describe the facility's physical location:

7. Does your facility have separate organizational elements from the hospitals identified in your answer to Question 5 above?
☐ Yes ☐ No

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

8. Does your facility have the same owners as the hospitals identified in your answer to Question 5 above?
☐ Yes ☐ No

9. Does your facility have the same chief medical officer as the hospitals identified in your answer to Question 5 above?
☐ Yes ☐ No

10a. Is your facility's medical staff totally integrated with the medical staff of the hospitals identified in your answer to Question 5 above?
☐ Yes ☐ No

10b. Please explain:

11a. Does your facility's medical staff have privileges at the hospitals identified in your answer to Question 5 above?
☐ Yes ☐ No

11b. Please explain:

12a. Do the medical committees of the hospitals identified in your answer to Question 5 above have any responsibilities in regard to your facility?
☐ Yes ☐ No

12b. Please explain:

13. Does your facility have the same chief executive officer as the hospitals identified in your answer to Question 5 above?
☐ Yes ☐ No

## Contact Information

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

| 1. Contact name | 2. Telephone |
|---|---|
| 3. Contact email | |

## Signature

I certify that the information stated on this document is correct and complete to the best of my knowledge. I further certify that I am an authorized official of the corporation and have authority to answer the questions listed above for my corporation. A delegated administrator may not sign this form.

| 4. Authorized official's name (please print) | 5. Title |
|---|---|
| 6. Authorized official's signature | 7. Date |