IHCP Provider Enrollment Type and Specialty Matrix

All provider types and specialties listed in this document as eligible to enroll in the Indiana Health Coverage Programs (IHCP) can apply online through the Provider Healthcare Portal. Providers who choose to enroll by mail can go to the Complete an IHCP Provider Enrollment Application web page, select the applicable provider type, and download the appropriate enrollment packet. For more information about enrolling as an Indiana Medicaid provider, see the Provider Enrollment IHCP provider reference module.

All links above are accessible from the IHCP provider website at in.gov/medicaid/providers.

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 01 – Hospital                    | 010 – Acute Care                     | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement
  ○ Federal W-9 form
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  • Copy of Indiana State Department of Health (ISDH) certification
  • Medicare number required for each service location
  • Application fee required ¹ | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement
  ○ Federal W-9 form
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  • Copy of license from appropriate state
  • Medicare number required for each service location
  • Proof of participation in own state’s Medicaid program, if enrolled
  • Application fee required ¹ |

| 01 – Hospital                    | 011 – Psychiatric Facility (Freestanding or with independent organizational structure; includes institutions for mental disease [IMDs]) | • IHCP Hospital and Facility provider enrollment packet (or online application), which includes:  
  ○ Provider Agreement
  ○ Federal W-9 form
  ○ IHCP Psychiatric Hospital Bed Addendum (for facilities with 16 beds or less), if applicable
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  • Copy of Division of Mental Health and Addiction (DMHA) Private Mental Health Facility license or Indiana State Department of Health (ISDH) certification
  • Medicare number required for each service location
  • Application fee required ¹ | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement
  ○ Federal W-9 form
  ○ IHCP Psychiatric Hospital Bed Addendum (for facilities with 16 beds or less), if applicable
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  • Copy of appropriate license from appropriate state
  • Medicare number required for each service location
  • Proof of participation in own state’s Medicaid program, if enrolled
  • Application fee required ¹ |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

#### Provider Type Code & Description | Provider Specialty Code & Description | In-State Provider Document Requirements | Out-of-State Provider Document Requirements
---|---|---|---
01 – Hospital | 012 – Rehabilitation (Distinct part or unit) | - IHCP Hospital and Facility provider enrollment packet or online application, which includes:
  - Provider Agreement
  - Federal W-9 form
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  - Copy of Indiana State Department of Health (ISDH) certification
  - Medicare number required for each service location
  - Application fee required  
| | | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:
  - Provider Agreement
  - Federal W-9 form
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  - Copy of license from appropriate state
  - Medicare number required for each service location
  - Proof of participation in own state’s Medicaid program, if enrolled
  - Application fee required  

01 – Hospital | 013 – Long Term Acute Care (LTAC) | - IHCP Hospital and Facility provider enrollment packet or online application (indicate update to a current provider number), which includes:
  - Provider Agreement
  - Federal W-9 form
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
  - Copy of Indiana State Department of Health (ISDH) license complying with IC 16-21 for LTAC
  - Copy of Centers for Medicare & Medicaid Services (CMS) LTAC approval letter
  - Medicare number required for each service location
  - Application fee required  
| | | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 – Ambulatory Surgical Center</td>
<td>020 – Ambulatory Surgical Center (ASC)</td>
<td>• IHCP <strong>Hospital and Facility</strong> provider enrollment packet or online application, which includes: &lt;br&gt;  ○ Provider Agreement &lt;br&gt;  ○ Federal W-9 form &lt;br&gt;  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable &lt;br&gt;  • Copy of Indiana State Department of Health (ISDH) certification &lt;br&gt;  • Medicare number, if enrolled in Medicare &lt;br&gt;  • Application fee required ¹</td>
<td>• IHCP <strong>Hospital and Facility</strong> provider enrollment packet or online application, which includes: &lt;br&gt;  ○ Provider Agreement &lt;br&gt;  ○ Federal W-9 form &lt;br&gt;  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable &lt;br&gt;  • Copy of license from appropriate state &lt;br&gt;  • Medicare number, if enrolled in Medicare &lt;br&gt;  • Proof of participation in own state’s Medicaid program, if enrolled &lt;br&gt;  • Application fee required ¹</td>
</tr>
</tbody>
</table>

| 03 – Extended Care Facility      | 030 – Nursing Facility <br> 031 – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) <br> 032 – Pediatric Nursing Facility <br> 033 – Residential Care Facility | • IHCP **Hospital and Facility** provider enrollment packet or online application, which includes: <br>  ○ Provider Agreement <br>  ○ Federal W-9 form <br>  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable <br>  • Copy of Indiana State Department of Health (ISDH) certification <br>  • Medicare number, if enrolled in Medicare <br>  • Application fee required ¹ | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 03 – Extended Care Facility       | 034 – Psychiatric Residential Treatment Facility (PRTF) | - IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  - Copy of Indiana State Department of Health (ISDH) certification  
  - Indiana Department of Child Services (DSC) residential child care license for a private, secure care facility  
  - Copy of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Council on Accreditation (COA) credentials  
  - Attestation letter for facility compliance  
  - Medicare number, if enrolled in Medicare  
  - Application fee required  
  | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |

| 04 – Rehabilitation Facility     | 040 – Rehabilitation Facility        | - IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  - Copy of Indiana State Department of Health (ISDH) certification  
  - Medicare number, if enrolled in Medicare  
  - Application fee required  
  | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |

---

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 04 – Rehabilitation Facility    | 041 – Comprehensive Outpatient Rehabilitation Facility | • IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of Indiana State Department of Health (ISDH) certification  
  • Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
  • Medicare number required for each service location  
  • Application fee required ¹  
  **Note:** Per CMS requirements – Facility must have on staff: **physician** and **HSPP mental health provider** and **physical therapist**  
  Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 05 – Home Health Agency         | 050 – Home Health Agency               | • IHCP **Hospital and Facility** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of Indiana State Department of Health (ISDH) license  
  • Medicare number, if enrolled in Medicare  
  • Application fee required ¹  
  • Fingerprinting and background check required ²  
  Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprinting and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>06 – Hospice</td>
<td>060 – Hospice</td>
<td>• IHCP Hospital and Facility provider enrollment packet or online application, which includes:</td>
<td>Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Provider Agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Federal W-9 form</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of hospice license</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare number required for each service location</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Application fee required ¹</td>
<td></td>
</tr>
<tr>
<td>08 – Clinic</td>
<td>080 – Federally Qualified Health Center (FQHC)</td>
<td>• IHCP Group and Clinic provider enrollment packet or online application, which includes:</td>
<td>Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Provider Agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Federal W-9 form</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of CMS approval letter verifying FQHC enrollment for each location</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Application fee required ¹</td>
<td></td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
## IHCP Provider Enrollment
### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 08 – Clinic                      | 081 – Rural Health Clinic (RHC)      | - IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  ○ Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  ○ Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
  ○ Copy of CMS approval letter verifying RHC enrollment for each location, if applicable  
  ○ Medicare number, if enrolled in Medicare  
  ○ Application fee required  
|                                  |                                      |                                        | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 08 – Clinic                      | 082 – Medical Clinic                 | - IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  ○ Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  ○ Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
  ○ Medicare number, if enrolled in Medicare  | - IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  ○ Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  ○ Copy of license from appropriate state for rendering providers linked to the group  
  ○ Medicare number, if enrolled in Medicare  
  ○ Proof of participation in own state’s Medicaid program, if enrolled |

---

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
# IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 08 – Clinic                      | 083 – Family Planning Clinic         | • IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
• Medicare number, if enrolled in Medicare | • IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Copy of license from appropriate state for rendering providers linked to the group  
• Medicare number, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled |  |
| 08 – Clinic                      | 084 – Nurse Practitioner Clinic      | • IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
• Medicare number, if enrolled in Medicare | • IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Copy of license from appropriate state for rendering providers linked to the group  
• Medicare number, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled |  |

---

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
# IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 08 – Clinic                       | 086 – Dental Clinic                  | - IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
- Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
- For a sole proprietorship, partnership, or professional services corporation, all entities with an ownership or control interest, as disclosed on the provider enrollment application, must have dental licenses  
- Medicare number, if enrolled in Medicare  
*Note: A dental practice must be owned by a dentist.* | - IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
- Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
- For a sole proprietorship, partnership, or professional services corporation, all entities with an ownership or control interest, as disclosed on the provider enrollment application, must have dental licenses  
- Medicare number, if enrolled in Medicare  
- Proof of participation in own state’s Medicaid program, if enrolled  
*Note: A dental practice must be owned by a dentist.* |
| 08 – Clinic                       | 087 – Therapy Clinic                 | - IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
- Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
- Medicare number, if enrolled in Medicare  
- Application fee required ¹  
*Note: Per CMS requirements – Clinic must have two enrolled physicians plus one or more therapists.* | - IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
- Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
- Medicare number, if enrolled in Medicare  
- Proof of participation in own state’s Medicaid program, if enrolled  
- Application fee required ¹  
*Note: Per CMS requirements – Clinic must have two enrolled physicians plus one or more therapists.* |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 08 – Clinic                     | 088 – Birthing Center                 | • IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Medicare number, if enrolled in Medicare  
*Note: Per CMS requirements – Clinic must have a physician and/or midwife on staff.* | • IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Medicare number, if enrolled in Medicare  
*Note: Per CMS requirements – Clinic must have a physician and/or midwife on staff.* |
| 09 – Advanced Practice Registered Nurse | 090 – Pediatric Nurse Practitioner  
091 – Obstetric Nurse Practitioner  
092 – Family Nurse Practitioner  
093 – Nurse Practitioner (other, for example, clinical nurse specialist)  
094 – Certified Registered Nurse Anesthetist (CRNA)  
095 – Certified Nurse Midwife | • IHCP provider enrollment packet or online application for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Copy of license from Indiana Professional Licensing Agency (IPLA)  
• Copy of Nurse Practitioner (NP) certification from accredited NP certifying organization  
• Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Copy of license from the appropriate state  
• If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification  
• Copy of Nurse Practitioner (NP) certification from accredited NP certifying organization  
• Medicare number, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the **Provider Enrollment Application Fee** web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the **Provider Enrollment Risk Levels and Screening** web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 10 – Physician Assistant | 100 – Physician Assistant | - IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  - Copy of license from Indiana Professional Licensing Agency (IPLA)  
  - Medicare number, if enrolled in Medicare | - IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  - Copy of license from the appropriate state  
  - If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification  
  - Medicare number, if enrolled in Medicare  
  - Proof of participation in own state’s Medicaid program, if enrolled |

| 11 – Mental Health Providers | 110 – Outpatient Mental Health Clinic | - IHCP Group and Clinic provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  ○ Outpatient Mental Health Addendum  
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  - Medicare number, if enrolled in Medicare | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |

1. Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

2. Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 11 – Mental Health Provider | 111 – Community Mental Health Center (CMHC) | • IHCP Group and Clinic provider enrollment packet or online application, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  o Outpatient Mental Health Addendum  
  • Copy of certification from FSSA Division of Mental Health and Addiction (DMHA)  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare  
  • Application fee required |
| 11 – Mental Health Provider | 114 – Health Service Provider in Psychology (HSPP) | • IHCP provider enrollment packet or online application for your classification, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  • Copy of license from Indiana Professional Licensing Agency (IPLA)  
  • Medicare number, if enrolled in Medicare |
| 11 – Mental Health Provider | 115 – Adult Mental Health and Habilitation (AMHH) Service Provider | • IHCP Group provider enrollment packet or online application for your classification, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  o Outpatient Mental Health Addendum  
  • Copy of certification from FSSA Division of Mental Health and Addiction (DMHA)  
  • Medicare number, if enrolled in Medicare  
  • Application fee required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
## IHCP Provider Enrollment

### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 11 – Mental Health Provider      | 611 – Children’s Mental Health Wraparound (CMHW) | • IHCP Group provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  ○ Outpatient Mental Health Addendum  
  • Copy of certification from FSSA Division of Mental Health and Addiction (DMHA)  
  • Medicare number, if enrolled in Medicare  
  • Application fee required | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 11 – Mental Health Provider      | 612 – Behavioral and Primary Healthcare Coordination (BPHC) | Not a stand-alone specialty; specialty can only be added to an enrolled community mental health center (CMHC).  
• IHCP provider enrollment packet or online application for your classification to update specialty  
• Copy of certification from FSSA Division of Mental Health and Addiction (DMHA) | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 11 – Mental Health Provider      | 613 – MRO Clubhouse | Not a stand-alone specialty; specialty can only be added as a rendering provider contracted with an IHCP-enrolled community mental health center (CMHC).  
• IHCP Rendering provider enrollment packet or online application – To enroll as a rendering provider of psychosocial rehabilitation services  
• IHCP MRO Clubhouse Provider Enrollment Addendum  
• Copy of certification from the FSSA Division of Mental Health and Addiction (DMHA) | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |

---

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 11 – Mental Health               | 615 – Applied Behavior Analysis (ABA) Therapist | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of Behavior Analyst Certification Board (BACB) certification as a Board Certified Behavior Analyst (BCBA), Board Certified Behavior Analyst-Doctoral (BCBA-D), or professional license as Health Service Provider in Psychology (HSPP)  
  • Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from the appropriate state agency  
  • Medicare number, if enrolled in Medicare Proof of participation in own state’s Medicaid program, if enrolled |
| 12 – School Corporation          | 120 – School Corporation             | • IHCP School Corporation provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Must be listed on the approved Indiana Department of Education’s school corporation list and charter school list | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 13 – Public Health Agency        | 130 – County Health Department      | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Application fee required ¹ | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 14 – Podiatrist                  | 140 – Podiatrist                     | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from Indiana Professional Licensing Agency (IPLA)  
  • Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from appropriate state  
  • If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification  
  • Medicare number, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled |
| 15 – Chiropractor               | 150 – Chiropractor                   | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license from Indiana Professional Licensing Agency (IPLA)  
  • Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license from appropriate state  
  • Medicare number, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 17 – Therapist                   | 170 – Physical Therapist             | • IHCP provider enrollment packet or online application for your classification, which includes:  
   ○ Provider Agreement  
   ○ Federal W-9 form  
   • Copy of license from Indiana Professional Licensing Agency (IPLA)  
   • Medicare number, if enrolled in Medicare  
   • Application fee required if enrolling as a group 1 | • IHCP provider enrollment packet or online application for your classification, which includes:  
   ○ Provider Agreement  
   ○ Federal W-9 form  
   • Copy of license from appropriate state  
   • Medicare number, if enrolled in Medicare  
   • Proof of participation in own state’s Medicaid program, if enrolled  
   • Application fee required if enrolling as a group 1 |
|                                  | 171 – Occupational Therapist         |                                        |                                             |
|                                  | 173 – Speech/Hearing Therapist       |                                        |                                             |
| 18 – Optometrist                 | 180 – Optometrist                    | • IHCP provider enrollment packet or online application for your classification, which includes:  
   ○ Provider Agreement  
   ○ Federal W-9 form  
   • Copy of license from Indiana Professional Licensing Agency (IPLA)  
   • Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
   ○ Provider Agreement  
   ○ Federal W-9 form  
   • Copy of license from appropriate state  
   • If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification  
   • Medicare number, if enrolled in Medicare  
   • Proof of participation in own state’s Medicaid program, if enrolled |
| 19 – Optician                    | 190 – Optician                       | • IHCP provider enrollment packet or online application for your classification, which includes:  
   ○ Provider Agreement  
   ○ Federal W-9 form  
   • Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
   ○ Provider Agreement  
   ○ Federal W-9 form  
   • Copy of license from appropriate state, if that state licenses opticians  
   • Medicare number, if enrolled in Medicare  
   • Proof of participation in own state’s Medicaid program, if enrolled |

1 Application fee required — Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 – Audiologist</td>
<td>200 – Audiologist</td>
<td>- IHCP provider enrollment packet or online application for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Copy of license from Indiana Professional Licensing Agency (IPLA) ○ Medicare number, if enrolled in Medicare</td>
<td>- IHCP provider enrollment packet or online application for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Copy of license from appropriate state, if that state licenses audiologists ○ Medicare number, if enrolled in Medicare ○ Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
<tr>
<td>22 – Hearing Aid Dealer</td>
<td>220 – Hearing Aid Dealer</td>
<td>- IHCP provider enrollment packet or online application for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Copy of Indiana Hearing Aid Dealer’s License ○ Medicare number, if enrolled in Medicare ○ Application fee required ¹ ○ Fingerprint and background check required ²</td>
<td>- IHCP provider enrollment packet or online application for your classification, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Copy of appropriate state’s Hearing Aid Dealer’s License ○ Medicare number, if enrolled in Medicare ○ Proof of participation in own state’s Medicaid program, if enrolled ○ Application fee required ¹ ○ Fingerprint and background check required ²</td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](#) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](#) web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 24 – Pharmacy                     | 240 – Pharmacy                       | • IHCP **Pharmacy** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Indiana Pharmacy License  
  • Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy, if applicable  
  • Medicare number, if enrolled in Medicare  
  • Application fee required  
  • If DME 250 – Fingerprint and background check required  
  • If HME 251 – Fingerprint and background check required | • IHCP **Pharmacy** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license or permit from appropriate state  
  • If supplying to residents of Indiana via mail or other delivery services, you must have an Indiana nonresident pharmacy license  
  • Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy, if applicable  
  • Medicare number, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled  
  • Application fee required  
  • If DME 250 – Fingerprint and background check required  
  • If HME 251 – Fingerprint and background check required |
| 24 – Pharmacy                     | 250 – Durable Medical Equipment (DME) Supply Dealer | • IHCP **Durable Medical Equipment** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Medicare number, if enrolled in Medicare  
  • Application fee required  
  • Fingerprint and background check required | • IHCP **Durable Medical Equipment** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license if state licenses DME providers  
  • Medicare number, if enrolled in Medicare  
  • If not Medicare enrolled, proof of participation in own state’s Medicaid program required  
  • Application fee required  
  • Fingerprint and background check required |
| 24 – Pharmacy                     | 251 – Home Medical Equipment (HME) Supply Dealer | • IHCP **Pharmacy** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Medicare number, if enrolled in Medicare  
  • Application fee required  
  • Fingerprint and background check required | • IHCP **Pharmacy** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license if state licenses DME providers  
  • Medicare number, if enrolled in Medicare  
  • If not Medicare enrolled, proof of participation in own state’s Medicaid program required  
  • Application fee required  
  • Fingerprint and background check required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

**Note:** Prior Authorization (PA) for services required.
IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 25 – DME/Medical Supply Dealer   | 251 – HME/Home Medical Equipment Supply Dealer | • IHCP Durable Medical Equipment provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy  
• Medicare number, if enrolled in Medicare  
• Application fee required  
• Fingerprint and background check required | • IHCP Durable Medical Equipment provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Home Medical Equipment License from the Indiana State Board of Pharmacy (physical service location does not have to be in the state of Indiana, but you must obtain an Indiana HME license to provide services to Indiana residents)  
• Medicare number, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Application fee required  
• Fingerprint and background check required |

| 26 – Transportation | 260 – Ambulance | • IHCP Transportation provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of Indiana Emergency Medical Services (EMS) Commission certification  
• Medicare number, if enrolled in Medicare  
• Application fee required | • IHCP Transportation provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Copy of appropriate state’s emergency medical services (EMS) commission certification  
• Medicare number, if enrolled in Medicare  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Application fee required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
## IHCP Provider Enrollment
### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 26 – Transportation               | 261 – Air Ambulance                  | • IHCP Transportation provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Indiana Emergency Medical Services (EMS) Commission Air Ambulance certification  
  • Medicare number, if enrolled in Medicare  
  • Application fee required  
  | • IHCP Transportation provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of appropriate state’s emergency medical services (EMS) commission certification  
  • Medicare number, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled  
  • Application fee required |
| 26 – Transportation               | 262 – Bus                            | • IHCP Transportation provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Motor Carrier Service (MCS) certificate from the Indiana Department of Revenue  
  • Proof of insurance coverage as required by the Indiana motor carrier authority  
  • Copy of driver’s license for all drivers  
  • Application fee required  
  • Fingerprint and background check required  
  | • IHCP Transportation provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of appropriate state’s certification for buses  
  • Copy of Motor Carrier Service (MCS) certificate showing interstate authority, if the provider crosses state lines  
  • Proof of insurance, as indicated by local ordinances  
  • Copy of driver’s license for all drivers  
  • Application fee required  
  • Fingerprint and background check required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 26 – Transportation              | 263 – Taxi                           | • IHCP Transportation provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Document showing operating authority from the local governing body (city taxi or livery license)  
  • Copy of retail merchant’s certificate (providers that have nonprofit status are exempt from this requirement)  
  • Proof of nonprofit status, if applicable  
  • Proof of insurance, as indicated by local ordinances (if unspecified by local ordinance, a minimum of $25,000/$50,000 public livery insurance covering all vehicles used in the business)  
  • Copy of driver’s license for all drivers  
  • Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years  
  • Application fee required  
  • Fingerprint and background check required | • IHCP Transportation provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Document showing operating authority from the local governing body as a common carrier  
  • Copy of retail merchant’s certificate (providers that have nonprofit status are exempt from this requirement)  
  • Proof of nonprofit status, if applicable  
  • Proof of insurance as indicated by local ordinances (if unspecified by local ordinance, a minimum of $25,000/$50,000 public livery insurance covering all vehicles used in the business)  
  • Copy of driver’s license for all drivers  
  • Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years  
  • Application fee required  
  • Fingerprint and background check required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 – Transportation</td>
<td>264 – Common Carrier (Ambulatory)</td>
<td><strong>IHCP Transportation</strong> provider enrollment packet or online application, which includes:</td>
<td><strong>IHCP Transportation</strong> provider enrollment packet or online application, which includes:</td>
</tr>
<tr>
<td></td>
<td>265 – Common Carrier (Non-Ambulatory)</td>
<td>- Provider Agreement ○ Federal W-9 form</td>
<td>- Provider Agreement ○ Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Copy of Motor Carrier Service (MCS) certificate from the Indiana Department of Revenue (for-profit providers only)</td>
<td>- For interstate carriers, submission of the USDOT number for verification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Proof of nonprofit status, if applicable</td>
<td>- Copy of appropriate state’s certification for common carriers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Interstate carriers must submit their U.S. Department of Transportation (USDOT) number for verification</td>
<td>- Copy of Motor Carrier Service (MCS) certificate showing interstate authority, if the provider crosses state lines (for-profit providers only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Proof of insurance</td>
<td>- Proof of nonprofit status, if applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Copy of driver’s license for all drivers</td>
<td>- Proof of insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years (for-profit providers only)</td>
<td>- Copy of driver’s license for all drivers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Application fee required ¹</td>
<td>- Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years (for-profit ambulatory and for-profit non-ambulatory only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Fingerprint and background check required ²</td>
<td>- Application fee required ¹</td>
</tr>
<tr>
<td></td>
<td>266 – Family Member</td>
<td><strong>IHCP Family Member/Associate Transportation</strong> provider enrollment packet or online application, which includes:</td>
<td><strong>IHCP Family Member/Associate Transportation</strong> provider enrollment packet or online application, which includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- IHCP Family Member/Associate Transportation Provider Agreement ○ Federal W-9 form</td>
<td>- Provider Agreement ○ Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Medicaid Family Member or Associate Transportation Services Form, completed and signed by the member being transported</td>
<td>- For interstate carriers, submission of the USDOT number for verification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Copy of current driver’s license</td>
<td>- Copy of appropriate state’s certification for common carriers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Copy of current auto insurance for the vehicle being used</td>
<td>- Copy of Motor Carrier Service (MCS) certificate showing interstate authority, if the provider crosses state lines (for-profit providers only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Copy of current auto registration for the vehicle being used</td>
<td>- Proof of nonprofit status, if applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Proof of insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Copy of driver’s license for all drivers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Proof of Indiana surety bond of at least $50,000 for a minimum duration of three years (for-profit ambulatory and for-profit non-ambulatory only)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Application fee required ¹</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Fingerprint and background check required ²</td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 27 – Dentist                    | 270 – Endodontist                    | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from Indiana Professional Licensing Agency (IPLA)  
  • For a sole proprietorship, partnership, or professional services corporation (PSC), the owners listed as disclosed entities on the provider enrollment application must have dental licenses  
  • Medicare number, if enrolled in Medicare  
  
  *Note: A dental practice must be owned by a dentist.* |
|                                 | 271 – General Dentistry Practitioner |                                       |                                            |
|                                 | 272 – Oral Surgeon                   |                                       |                                            |
|                                 | 273 – Orthodontist                   |                                       |                                            |
|                                 | 274 – Pediatric Dentist              |                                       |                                            |
|                                 | 275 – Periodontist                   |                                       |                                            |
|                                 | 277 – Prosthesis                     |                                       |                                            |
| 27 – Dentist                    | 276 – Mobile Dental Van              | • IHCP **Group and Clinic** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of registration from Indiana Professional Licensing Agency (IPLA)  
  • Copy of license from IPLA for rendering providers  
  • Copy of valid Indiana driver’s license for all drivers  
  • Medicare number, if enrolled in Medicare  
  
  *Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.* |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.
IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 28 – Laboratory                   | 280 – Independent Lab                | • IHCP Billing provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required  
  • Medicare number, if enrolled in Medicare  
  • Application fee required ¹ | • IHCP Billing provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required  
  • Medicare number, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled  
  • Application fee required ¹ |
| 28 – Laboratory                   | 281 – Mobile Lab                     | • IHCP Billing provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required  
  • Copy of valid driver’s license for all drivers  
  • Medicare number, if enrolled in Medicare  
  • Application fee required ¹ | • IHCP Billing provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required  
  • Copy of valid driver’s license for all drivers  
  • Medicare number, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled  
  • Application fee required ¹ |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 28 – Laboratory                  | 282 – Independent Diagnostic Testing Facility (IDTF) | - IHCP **Group** provider enrollment packet or online application, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  - Medicare number, if enrolled in Medicare  
  - Application fee required  
  *Note: Per CMS requirements – Must have a physician on staff* | - IHCP **Group** provider enrollment packet or online application, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  - Medicare number, if enrolled in Medicare  
  - Proof of participation in own state’s Medicaid program, if enrolled  
  - Application fee required  
  *Note: Per CMS requirements – Must have a physician on staff* |
| 28 – Laboratory                  | 283 – Mobile Independent Diagnostic Testing Facility (IDTF) | - IHCP **Billing** or **Group** provider enrollment packet or online application, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  - Copy of valid driver’s license for all drivers  
  - Medicare number, if enrolled in Medicare  
  - Application fee required  
  *Note: Per CMS requirements – Must have a physician on staff* | - IHCP **Billing** or **Group** provider enrollment packet or online application, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  - Copy of appropriate state’s valid driver’s license for all drivers  
  - Medicare number, if enrolled in Medicare  
  - Proof of participation in own state’s Medicaid program, if enrolled  
  - Application fee required  
  *Note: Per CMS requirements – Must have a physician on staff* |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](#) web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](#) web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 – Radiology</td>
<td>290 – Freestanding X-Ray Clinic</td>
<td>• IHCP Radiology provider enrollment packet or online application, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Copy of registration certificate ○ Notice of Indiana State Department of Health (ISDH) compliance ○ Copy of operator certificates for all employee operators, except positron emission tomography – computed tomography (PET CT) scanner operators ○ PET and magnetic resonance imaging (MRI) services do not require certification or notice of compliance ○ Copy of valid driver’s license for all drivers, if applicable ○ Medicare number, if enrolled in Medicare ○ Application fee required ¹</td>
<td>• IHCP Radiology provider enrollment packet or online application, which includes: ○ Provider Agreement ○ Federal W-9 form ○ Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable ○ Copy of registration certificate ○ Out-of-state mobile radiology providers (specialty 291) performing services in Indiana must be certified in Indiana and possess a Notice of Compliance in Indiana ○ Copy of operator certificates for all employee operators, except positron emission tomography – computed tomography (PET CT) scanner operators ○ PET and magnetic resonance imaging (MRI) services do not require certification or notice of compliance ○ For out-of-state mobile radiology providers (specialty 291), all operators (except PET CT scanner operators) must be certified in the state of Indiana ○ Copy of license from appropriate state ○ Copy of valid driver’s license for all drivers, if applicable ○ Medicare number, if enrolled in Medicare ○ Proof of participation in own state’s Medicaid program, if enrolled ○ Application fee required ¹</td>
</tr>
<tr>
<td>291 – Mobile X-Ray Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 30 – End-Stage Renal Disease (ESRD) Clinic | 300 – Freestanding Renal Dialysis Clinic | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required  
  • Copy of Indiana State Department of Health (ISDH) certification  
  • Medicare number, if enrolled in Medicare  
  • Application fee required ¹ | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 31 – Physician | 310 – Allergist  
  311 – Anesthesiologist  
  312 – Cardiologist  
  313 – Cardiovascular Surgeon  
  314 – Dermatologist  
  315 – Emergency Medicine Practitioner  
  316 – Family Practitioner  
  317 – Gastroenterologist  
  318 – General Practitioner  
  319 – General Surgeon  
  320 – Geriatric Practitioner  
  321 – Hand Surgeon  
  323 – Neonatologist  
  324 – Nephrologist  
  325 – Neurological Surgeon  
  326 – Neurologist  
  327 – Nuclear Medicine Practitioner  
  328 – Obstetrician/Gynecologist | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from the Indiana Professional Licensing Agency (IPLA)  
  • Copy of board certification for specialty requested, if applicable  
  • Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Copy of license from appropriate state  
  • If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification  
  • Copy of board certification for specialty requested, if applicable  
  • Medicare number, if enrolled in Medicare  
  • Proof of participation in own state’s Medicaid program, if enrolled |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
**IHCP Provider Enrollment Type and Specialty Matrix**

1. Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](#) web page at in.gov/medicaid/providers.

2. Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](#) web page at in.gov/medicaid/providers.

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>329 – Oncologist</td>
<td>330 – Ophthalmologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>331 – Orthopedic Surgeon</td>
<td>332 – Otologist, Laryngologist, Rhinologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>333 – Pathologist</td>
<td>334 – Pediatric Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>336 – Physical Medicine and Rehabilitation Practitioner</td>
<td>337 – Plastic Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>338 – Proctologist</td>
<td>340 – Pulmonary Disease Specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>341 – Radiologist</td>
<td>342 – Thoracic Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>343 – Urologist</td>
<td>344 – General Internist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>345 – General Pediatrician</td>
<td>346 – Dispensing Physician</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## IHCP Provider Enrollment
### Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>34 – MRT Copy Center</td>
<td>366 – MRT Copy Center</td>
<td>• IHCP Billing provider enrollment packet or online application, which includes:  ○ Provider Agreement  ○ Federal W-9 form</td>
<td>• IHCP Billing provider enrollment packet or online application, which includes:  ○ Provider Agreement  ○ Federal W-9 form  • Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
<tr>
<td>35 – Addiction Services</td>
<td>835 – Opioid Treatment Program</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:  ○ Provider Agreement  ○ Federal W-9 form  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  • Copy of Drug Enforcement Agency (DEA) registration certificate  • Copy of Division of Mental Health and Addiction (DMHA) Opioid Treatment Program certification  • Medicare number, if enrolled</td>
<td>Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment.</td>
</tr>
</tbody>
</table>

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 35 – Addiction Services          | 836 – Substance Use Disorder (SUD) Residential Addiction Treatment Facility | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Provider must provide one of the following:  
    ○ Copy of a Division of Mental Health and Addiction (DMHA) certification as a Sub-Acute Facility that includes an American Society of Addiction Medicine (ASAM) designation of offering either Level 3.1 or Level 3.5 residential services  
    ○ Proof of Department of Child Services (DCS) licensing as a child care institution or private secure-care institution with a DMHA Addiction Services Provider Regular Certification that includes an ASAM designation of offering either Level 3.1 or Level 3.5 residential services  
    • Facilities that have designations to offer both ASAM Level 3.1 and Level 3.5 services within the facility must include proof of both designations with their enrollment application.  
    • Copy of Drug Enforcement Agency (DEA) registration certificate (optional)  
    • Medicare number, if enrolled in Medicare  
    • Application fee required¹ | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Provider must provide one of the following:  
    ○ Copy of a Division of Mental Health and Addiction (DMHA) certification as a Sub-Acute Facility that includes an American Society of Addiction Medicine (ASAM) designation of offering either Level 3.1 or Level 3.5 residential services  
    ○ Proof of Department of Child Services (DCS) licensing as a child care institution or private secure-care institution with a DMHA Addiction Services Provider Regular Certification that includes an ASAM designation of offering either Level 3.1 or Level 3.5 residential services  
    • Facilities that have designations to offer both ASAM Level 3.1 and Level 3.5 services within the facility must include proof of both designations with their enrollment application.  
    • Copy of Drug Enforcement Agency (DEA) registration certificate (optional)  
    • Medicare number, if enrolled in Medicare  
    • Proof of participation in own state’s Medicaid program, if enrolled  
    • Application fee required¹ |

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.
# IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 – Genetic Counselor</td>
<td>800 – Genetic Counselor</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:  ○ Provider Agreement  ○ Federal W-9 form  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  • Copy of license from Indiana Professional Licensing Agency (IPLA)  • Medicare number, if enrolled in Medicare</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:  ○ Provider Agreement  ○ Federal W-9 form  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  • Copy of license from the appropriate state  • Medicare number, if enrolled in Medicare  • Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
</tbody>
</table>

1. Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](#) web page at in.gov/medicaid/providers.

2. Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](#) web page at in.gov/medicaid/providers.
### IHCP Provider Enrollment Type and Specialty Matrix

#### Home and Community-Based Services (HCBS) Waiver Providers

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 32 – Waiver        | 350 – Aged and Disabled (AD) Waiver | • A00 – Adult Day Services (Level 1)  
• A01 – Adult Day Services (Level 2)  
• A02 – Adult Day Services (Level 3)  
• A03 – Adult Foster Care  
• A04 – Assisted Living  
• A05 – Attendant Care  
• A06 – Case Management  
• A07 – Community Transition Services  
• A08 – Environmental Modifications  
• A09 – Healthcare Coordination  
• A10 – Home-Delivered Meals  
• A11 – Homemaker  
• A12 – Nutritional Supplements  
• A13 – Pest Control  
• A14 – Respite  
• A15 – Self-Directed Attendant Care  
• A16 – Specialized Medical Equipment Supplies  
• A17 – Transportation  
• A18 – Vehicle Modifications  
• A19 – Personal Emergency Response Systems  
• A20 – Environmental Modifications Assessment  
• A21– Structured Family Caregiving | • IHCP **Waiver** provider enrollment packet or online application for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Certification letter from the appropriate waiver administering division  
• A03 – Application fee required  
• A05 – Fingerprint and background check required  
• A16 – Application fee, fingerprint, and background check required  
• A17 – Application fee required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the [Provider Enrollment Application Fee](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the [Provider Enrollment Risk Levels and Screening](https://in.gov/medicaid/providers) web page at in.gov/medicaid/providers.

3 Out-of-state providers must contact the appropriate waiver division for requirements.
IHCP Provider Enrollment
Type and Specialty Matrix

| Provider Type Code | Provider Specialty Codes | Provider Secondary Specialty Codes | In-State Provider Document Requirements
|---------------------|---------------------------|------------------------------------|----------------------------------|
| 32 – Waiver         | 356 – Traumatic Brain Injury (TBI) Waiver | • B00 – Adult Day Services (Level 1)  
• B01 – Adult Day Services (Level 2)  
• B02 – Adult Day Services (Level 3)  
• B03 – Adult Foster Care  
• B04 – Attendant Care  
• B05 – Behavior Management/Behavior Program & Counseling  
• B06 – Case Management  
• B07 – Community Transition Services  
• B08 – Environmental Modifications  
• B09 – Healthcare Coordination  
• B10 – Home-Delivered Meals  
• B11 – Homemaker  
• B12 – Nutritional Supplements  
• B14 – Personal Emergency Response Systems  
• B15 – Pest Control  
• B17 – Residential Habilitation and Support  
• B18 – Respite  
• B19 – Specialized Medical Equipment & Supplies  
• B21 – Structured Day Program  
• B22 – Supported Employment Follow Along  
• B23 – Transportation  
• B24 – Vehicle Modifications  
• B25 – TBI Assisted Living | • IHCP Waiver provider enrollment packet or online application for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Certification letter from the appropriate waiver administering division  
• B03 – Application fee required  
• B04 – Fingerprint and background check required  
• B19 – Application fee, fingerprint, and background check required  
• B23 – Application fee required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.

3 Out-of-state providers must contact the appropriate waiver division for requirements.
IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>32 – Waiver</td>
<td>359 – Community Integration and Habilitation Waiver</td>
<td>• C00 – Adult Day Services (Level 1, 2, 3)&lt;br&gt;• C01 – Adult Foster Care ¹&lt;br&gt;• C02 – Behavior Management/Behavior Program &amp; Counseling&lt;br&gt;• C03 – Community-Based Habilitation – Group&lt;br&gt;• C04 – Community-Based Habilitation – Individual&lt;br&gt;• C05 – Community Transition Services&lt;br&gt;• C06 – Electronic Monitoring&lt;br&gt;• C07 – Environmental Modifications&lt;br&gt;• C08 – Facility-Based Habilitation – Group&lt;br&gt;• C09 – Facility-Based Habilitation – Individual&lt;br&gt;• C10 – Facility-Based Support Services&lt;br&gt;• C11 – Family and Caregiver Training&lt;br&gt;• C12 – Intensive Behavioral Intervention&lt;br&gt;• C13 – Music Therapy ¹&lt;br&gt;• C14 – Occupational Therapy&lt;br&gt;• C15 – Personal Emergency Response Systems&lt;br&gt;• C16 – Physical Therapy ¹&lt;br&gt;• C17 – Prevocational Services&lt;br&gt;• C18 – Psychological Therapy&lt;br&gt;• C19 – Recreational Therapy ¹&lt;br&gt;• C20 – Rent/Food for Unrelated Live-In Caregiver&lt;br&gt;• C21 – Residential Habilitation and Support&lt;br&gt;• C22 – Respite&lt;br&gt;• C23 – Specialized Medical Equipment &amp; Supplies ¹, ²&lt;br&gt;• C24 – Speech/Language Therapy ¹&lt;br&gt;• C25 – Extended Services&lt;br&gt;• C26 – Transportation Level ¹ ¹&lt;br&gt;• C27 – Workplace Assistance</td>
<td>• IHCP Waiver provider enrollment packet or online application for your classification, which includes:&lt;br&gt;  o Provider Agreement&lt;br&gt;  o Federal W-9 form&lt;br&gt;  • Certification letter from the appropriate waiver administering division&lt;br&gt;  • C01 – Application fee required ¹&lt;br&gt;  • C13 – Application fee required, if group ¹&lt;br&gt;  • C14 – Application fee required, if group ¹&lt;br&gt;  • C16 – Application fee required, if group ¹&lt;br&gt;  • C19 – Application fee required, if group ¹&lt;br&gt;  • C23 – Application fee, fingerprint, and background check required ¹, ²&lt;br&gt;  • C24 – Application fee required, if group ¹&lt;br&gt;  • C26 – Application fee required ¹&lt;br&gt;  • C29 – Application fee required ¹&lt;br&gt;  • C30 – Application fee required ¹</td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.

³ Out-of-state providers must contact the appropriate waiver division for requirements.
IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 32 – Waiver        | 360 – Family Supports Waiver | • D00 – Adult Day Services (Level 1, 2, 3)  
• D01 – Behavior Management/Behavior Program & Counseling  
• D02 – Community-Based Habilitation – Group  
• D03 – Community-Based Habilitation – Individual  
• D04 – Facility-Based Habilitation – Group  
• D05 – Facility-Based Habilitation – Individual  
• D06 – Facility-Based Support Services  
• D07 – Family and Caregiver Training  
• D08 – Intensive Behavioral Intervention  
• D09 – Music Therapy  
• D10 – Occupational Therapy  
• D11 – Personal Emergency Response Systems  
• D12 – Speech/Language Therapy  
• D13 – Physical Therapy  
• D14 – Prevocational Services  
• D15 – Psychological Therapy  
• D16 – Recreational Therapy  
• D17 – Respite  
• D18 – Specialized Medical Equipment & Supplies  
• D19 – Extended Services  
• D20 – Transportation  
• D21 – Workplace Assistance  
• D22 – Case Management  
• D23 – Participant Assistance and Care | • IHCP Waiver provider enrollment packet or online application for your classification, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Certification letter from the appropriate waiver administering division  
• D09 – Application fee required, if group  
• D10 – Application fee required, if group  
• D12 – Application fee required, if group  
• D13 – Application fee required, if group  
• D16 – Application fee required, if group  
• D18 – Application fee, fingerprint, and background check required  
• D20 – Application fee required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.

3 Out-of-state providers must contact the appropriate waiver division for requirements.
## IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 32 – Waiver | 363 – Money Follows the Person (MFP) Demonstration Grant | • F00 – Adult Day Services (Level 1)  
• F01 – Adult Day Services (Level 2)  
• F02 – Adult Day Services (Level 3)  
• F03 – Adult Foster Care  
• F04 – Assisted Living  
• F05 – Attendant Care  
• F06 – Behavior Management/Behavior Program & Counseling  
• F07 – Case Management  
• F08 – Community-Based Habilitation – Individual  
• F09 – Community-Based Habilitation – Group  
• F10 – Community Transition Services  
• F11 – Electronic Monitoring  
• F12 – Environmental Modifications  
• F13 – Facility-Based Habilitation – Group  
• F14 – Facility-Based Habilitation – Individual  
• F27 – Prevocational Services  
• F28 – Psychological Therapy  
• F29 – Recreational Therapy  
• F30 – Rent/Food for Unrelated Live-In Caregiver  
• F31 – Residential Habilitation and Support  
• F32 – Respite  
• F33 – Self-Directed Attendant Care  
• F34 – Specialized Medical Equipment & Supplies  
• F35 – Speech/Language Therapy  
• F36 – Structured Day Program  
• F37 – Supported Employment Follow-Along  
• F38 – Transportation  
• F39 – Vehicle Modifications | • IHCP Waiver provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  ○ Certification letter from the appropriate waiver administering division  
  • F03 – Application fee required  
  • F05 – Fingerprint and background check required  
  • F21 – Application fee required, if group  
  • F23 – Application fee required, if group  
  • F26 – Application fee required, if group  
  • F29 – Application fee required, if group  
  • F34 – Application fee, fingerprint, and background check required  
  • F35 – Application fee required, if group  
  • F38 – Application fee required |

1 Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

2 Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.

3 Out-of-state providers must contact the appropriate waiver division for requirements.
IHCP Provider Enrollment Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type Code</th>
<th>Provider Specialty Codes</th>
<th>Provider Secondary Specialty Codes</th>
<th>In-State Provider Document Requirements³</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• F40 – Workplace Assistance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F41 – Environmental Modifications Assessment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F42 – Structured Family Caregiving</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F43 – Wellness Coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• F44 – Extended Services</td>
<td></td>
</tr>
</tbody>
</table>

¹ Application fee required – Can be satisfied by paying application fee in another state or to Medicare. Providers may request a waiver of the application fee due to financial hardship. Proof of payment or proof of approved hardship waiver is required. For more information, see the Provider Enrollment Application Fee web page at in.gov/medicaid/providers.

² Fingerprint and background check required – Can be satisfied if performed as part of a Medicaid enrollment in another state or if Medicare enrolled. Proof of fingerprinting and background check performed is required. For more information, see the Provider Enrollment Risk Levels and Screening web page at in.gov/medicaid/providers.

³ Out-of-state providers must contact the appropriate waiver division for requirements.