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 Indiana State Department of Health (ISDH) certification  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• 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 license from appropriate state  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Medicare number required for each service location  
• Proof of participation in own state’s Medicaid program, if enrolled  
• Application fee required  |
| 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 Division of Mental Health and Addiction (DMHA) Private Mental Health Facility license or Indiana State Department of Health (ISDH) certification  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• 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  
○ IHCP Psychiatric Hospital Bed Addendum (for facilities with 16 beds or less), if applicable  
• Copy of appropriate license from appropriate state  
• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
• Medicare number required for each service location  
• 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>
| 01 – Hospital                    | 012 – Rehabilitation                  | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Indiana State Department of Health (ISDH) certification  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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 license from appropriate state  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number **required** for each service location  
  • Proof of participation in own state’s Medicaid program, if enrolled  
  • Application fee required  
  1 |
| 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 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  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number **required** for each service location  
  • 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>
| 02 – Ambulatory Surgical Center   | 020 – Ambulatory Surgical Center (ASC) | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Indiana State Department of Health (ISDH) certification  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare  
  • Application fee required 1 | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license from appropriate state  
  • 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 | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 03 – Extended Care Facility      | 030 – Nursing Facility  
  031 – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)  
  032 – Pediatric Nursing Facility  
  033 – Residential Care Facility | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Indiana State Department of Health (ISDH) certification  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare  
  • 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.
<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 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  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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. |
| 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 Indiana State Department of Health (ISDH) certification  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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. |

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>
| 04 – Rehabilitation Facility    | 041 – Comprehensive Outpatient Rehabilitation Facility (CORF) | • IHCP Group and Clinic provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • 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  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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 Indiana State Department of Health (ISDH) license  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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](#) 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>
| 06 – Hospice                     | 060 – Hospice                        | • IHCP Hospital and Facility provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of hospice license  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number **required** for each service location  
  • Application fee required ¹ | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 08 – Clinic                      | 080 – Federally Qualified Health Center (FQHC) | • IHCP Group and Clinic provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of CMS approval letter verifying FQHC enrollment for each location  
  • Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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. |

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                      | 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 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  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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. |
| 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 license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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 license from appropriate state for rendering providers linked to the group  
  • 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 |

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                     | 083 – Family Planning Clinic          | • IHCP Group and Clinic provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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 license from appropriate state for rendering providers linked to the group  
  • 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 |
| 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 license from the Indiana Professional Licensing Agency (IPLA) for rendering providers linked to the group  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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 license from appropriate state for rendering providers linked to the group  
  • 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 |

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.

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.
## 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  
  • 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  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • 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  
  • 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  
  • 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  
  *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  
  *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  
  *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 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                     | 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  • Proof of participation in own state’s Medicaid program, if enrolled  
*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 license from Indiana Professional Licensing Agency (IPLA)  • Copy of Nurse Practitioner (NP) certification from accredited NP certifying organization  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 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  • 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 |

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](http://www.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](http://www.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>
| 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 license from Indiana Professional Licensing Agency (IPLA)  
  - Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 license from the appropriate state  
  - If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification  
  - 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 |
| 11 – Behavioral Health Provider  | 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 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 – Behavioral Health Provider   | 111 – Community Mental Health Center (CMHC) | • IHCP Group and Clinic provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  ○ 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 1 | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 11 – Behavioral Health Provider   | 114 – Health Service Provider in Psychology (HSPP) | • 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 |
| 11 – Behavioral Health Provider   | 115 – Adult Mental Health and Habilitation (AMHH) Service Provider | • 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 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>
| 11 – Behavioral 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 – Behavioral 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 – Behavioral 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](#) 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 – Behavioral Health Provider  | 615 – Applied Behavior Analysis (ABA) Therapist | • IHCP provider enrollment packet or online application for your classification, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  • 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)  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  • Copy of license from the appropriate state agency  
  • 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 |
| 11 – Behavioral Health Provider  | 616 – Licensed Psychologist            | • IHCP provider enrollment packet or online application for your classification, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  • Copy of Psychologist license  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare | • IHCP provider enrollment packet or online application for your classification, which includes:  
  o Provider Agreement  
  o Federal W-9 form  
  • Copy of Psychologist license from the appropriate state agency  
  • 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 |

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 – Behavioral Health Provider   | 617 – Licensed Independent Practice School Psychologist | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of School Services – School Psychologist license through Indiana Department of Education (IDOE)  
    **Note:** The individual must be recognized by IDOE as an Initial Practitioner, a Proficient Practitioner, or an Accomplished Practitioner.  
  • Documentation that the individual maintains an Independent Practice Endorsement (IPE)  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 School Services – School Psychologist license through the appropriate state’s department of education  
    **Note:** The individual must be recognized by their state’s Department of Education as an Initial Practitioner, a Proficient Practitioner, or an Accomplished Practitioner.  
  • Documentation that the individual maintains an Independent Practice Endorsement (IPE)  
  • 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 |
| 11 – Behavioral Health Provider   | 618 – Licensed Clinical Social Worker (LCSW) | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Social Worker license  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 Social Worker license from the appropriate state agency  
  • 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 |

---

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 – Behavioral Health Provider   | 619 – Licensed Marriage and Family Therapist (LMFT) | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Marriage & Family Therapist license  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 Marriage & Family Therapist license from the appropriate state agency  
  • 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 |
| 11 – Behavioral Health Provider   | 620 – Licensed Mental Health Counselor (LMHC) | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Mental Health Counselor license  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 Mental Health Counselor license from the appropriate state agency  
  • 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 |

---

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 – Behavioral Health Provider   | 621 – Licensed Clinical Addiction Counselor (LCAC) | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Clinical Addiction Counselor license  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 Addiction Counselor license from the appropriate state agency  
  • 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 |
| 11 – Behavioral Health Provider   | 835 – Opioid Treatment Program       | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Drug Enforcement Agency (DEA) registration certificate  
  • Copy of Division of Mental Health and Addiction (DMHA) Opioid Treatment Program certification  
  • 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](#) 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>
| 11 – Behavioral Health Provider   | 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  
  • 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)  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare  
  • Application fee required ¹ | • IHCP **Hospital and Facility** provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • 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  
    ○ 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)  
  • 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 |

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>
| 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 | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 14 – Podiatrist                   | 140 – Podiatrist                      | • 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)  
                                           • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 license from appropriate state  
                                           • If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification  
                                           • 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 |

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>15 – Chiropractor</td>
<td>150 – Chiropractor</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Provider Agreement</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Federal W-9 form</td>
<td>○ Provider Agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of license from Indiana Professional Licensing Agency (IPLA)</td>
<td>○ Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
<td>• Copy of license from appropriate state</td>
</tr>
<tr>
<td>17 – Therapist</td>
<td>170 – Physical Therapist</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>171 – Occupational Therapist</td>
<td>○ Provider Agreement</td>
<td>• Medicare number, if enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td>173 – Speech/Hearing Therapist</td>
<td>○ Federal W-9 form</td>
<td>• Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of license from Indiana Professional Licensing Agency (IPLA)</td>
<td>• Application fee required if enrolling as a group ¹</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 if enrolling as a group ¹</td>
<td></td>
</tr>
<tr>
<td>18 – Optometrist</td>
<td>180 – Optometrist</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Provider Agreement</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Federal W-9 form</td>
<td>○ Provider Agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of license from Indiana Professional Licensing Agency (IPLA)</td>
<td>○ Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
<td>• Copy of license from appropriate state</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 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.
<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>19 – Optician</td>
<td>190 – Optician</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Provider Agreement</td>
<td>○ Provider Agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Federal W-9 form</td>
<td>○ Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
<td>• Copy of license from appropriate state, if that state licenses opticians</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
<tr>
<td>20 – Audiologist</td>
<td>200 – Audiologist</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Provider Agreement</td>
<td>○ Provider Agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Federal W-9 form</td>
<td>○ Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of license from Indiana Professional Licensing Agency (IPLA)</td>
<td>• Copy of license from appropriate state, if that state licenses audiologists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable</td>
<td>• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
<td>• Medicare number, if enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 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:</td>
<td>• IHCP provider enrollment packet or online application for your classification, which includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Provider Agreement</td>
<td>○ Provider Agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Federal W-9 form</td>
<td>○ Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Copy of Indiana Hearing Aid Dealer’s License</td>
<td>• Copy of appropriate state’s Hearing Aid Dealer’s License</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
<td>• Medicare number, if enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Application fee required 1</td>
<td>• Proof of participation in own state’s Medicaid program, if enrolled</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></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 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:  
  o Provider Agreement  
  o 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:  
  o Provider Agreement  
  o 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  |
| 25 – DME/Medical Supply Dealer   | 250 – DME/Medical Supply Dealer      | • IHCP Durable Medical Equipment 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  
  • Fingerprint and background check required  | • IHCP Durable Medical Equipment provider enrollment packet or online application, which includes:  
  o Provider Agreement  
  o 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. 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.

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    | • 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 Provider    | 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.
<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 Provider     | 261 – Air Ambulance                  | • IHCP Transportation provider enrollment packet or online application, which includes:  
|                                 |                                     | ▪ Provider Agreement                    | • IHCP Transportation provider enrollment packet or online application, which includes:  
|                                 |                                     | ▪ Federal W-9 form                      | ▪ Provider Agreement                    |
|                                 |                                     | ▪ Copy of Indiana Emergency Medical Services (EMS) Commission Air Ambulance certification  | ▪ Federal W-9 form                      |
|                                 |                                     | ▪ Medicare number, if enrolled in Medicare | ▪ Copy of appropriate state’s emergency medical services (EMS) commission certification |
|                                 |                                     | ▪ Application fee required ¹                | ▪ Medicare number, if enrolled in Medicare |
|                                 |                                     |                                         | ▪ Proof of participation in own state’s Medicaid program, if enrolled |
|                                 |                                     |                                         | ▪ Application fee required ¹              |

<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 Provider     | 262 – Bus                           | • IHCP Transportation provider enrollment packet or online application, which includes:  
|                                 |                                     | ▪ Provider Agreement                    | • IHCP Transportation provider enrollment packet or online application, which includes:  
|                                 |                                     | ▪ Federal W-9 form                      | ▪ Provider Agreement                    |
|                                 |                                     | ▪ Copy of Motor Carrier Services (MCS) certificate from the Indiana Department of Revenue  | ▪ Federal W-9 form                      |
|                                 |                                     | ▪ Proof of insurance coverage as required by the Indiana motor carrier authority  | ▪ Copy of appropriate state’s certification for buses |
|                                 |                                     | ▪ Copy of driver’s license for all drivers  | ▪ Copy of Motor Carrier Service (MCS) certificate showing interstate authority, if the provider crosses state lines |
|                                 |                                     | ▪ Application fee required ¹                | ▪ Proof of insurance, as indicated by local ordinances |
|                                 |                                     | ▪ Fingerprint and background check required ² | ▪ Copy of driver’s license for all drivers |
|                                 |                                     |                                         | ▪ Application fee required ¹              |
|                                 |                                     |                                         | ▪ Fingerprint and background check required ² |

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 Provider      | 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 from the Internal Revenue Service (IRS), 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 3 years (not required for 501(c)(3) nonprofit organizations or other exempted providers per IC 12-15-11-2.5(b))  
• Application fee required ¹  
• Fingerprint and background check required ² | • IHCP Transportation provider enrollment packet or online application, which includes:  
○ Provider Agreement  
○ Federal W-9 form  
• Document showing taxi 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 from the IRS, 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 3 years (not required for 501(c)(3) nonprofit organizations or other exempted providers per IC 12-15-11-2.5(b))  
• Application fee required ¹  
• Fingerprint and background check required ² |

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 Provider     | 264 – Common Carrier (Ambulatory)    | • IHCP *Transportation* provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of Motor Carrier Services (MCS) certificate from the Indiana Department of Revenue (for-profit providers only)  
  • Proof of nonprofit status from the Internal Revenue Service (IRS), if applicable  
  • Interstate carriers must submit their U.S. Department of Transportation (USDOT) number for verification  
  • Proof of insurance (providers with nonprofit status must have a minimum of $500,000 of combined single-limit commercial automobile liability)  
  • Copy of driver’s license for all drivers  
  • Proof of Indiana surety bond of at least $50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations, providers owned or controlled by a hospital or pharmacy licensed in Indiana, or other exempted providers per IC 12-15-11-2.5(b))  
  • Application fee required \(^1\)  
  • Fingerprint and background check required \(^2\) | • IHCP *Transportation* provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • For interstate carriers, submission of the USDOT number for verification  
  • Copy of appropriate state’s certification for common carriers  
  • Copy of Motor Carrier Service (MCS) certificate showing interstate authority, if the provider crosses state lines (for-profit providers only)  
  • Proof of nonprofit status from the IRS, if applicable  
  • Proof of insurance (providers with nonprofit status must have a minimum of $500,000 of combined single-limit commercial automobile liability)  
  • Copy of driver’s license for all drivers  
  • Proof of Indiana surety bond of at least $50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations or other exempted providers per IC 12-15-11-2.5(b))  
  • Application fee required \(^1\)  
  • Fingerprint and background check required \(^2\) |

\(^1\) 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>
| 26 – Transportation Provider     | 266 – Family Member                 | • IHCP Family Member/Associate Transportation provider enrollment packet or online application, which includes:  
  ○ IHCP Family Member/Associate Transportation Provider Agreement  
  ○ Federal W-9 form  
  • Medicaid Family Member or Associate Transportation Services Form, completed and signed by the member being transported  
  • Copy of current driver’s license  
  • Copy of current auto insurance for the vehicle being used  
  • Copy of current auto registration for the vehicle being used | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 26 – Transportation Provider     | 267 – Transportation Network Company (TNC) | • IHCP Transportation provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of TNC permit from the Indiana Department of Revenue  
  • Proof of insurance  
  • Proof of Indiana surety bond of at least $50,000 for a minimum duration of 3 years (not required for providers owned or controlled by a hospital or pharmacy licensed in Indiana or for other exempted providers per IC 12-15-11-2.5(b))  
  • 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.
### 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 Provider     | 268 – Nursing Home Transportation    | - IHCP Transportation provider enrollment packet or online application, which includes:  
  - Provider Agreement  
  - Federal W-9 form  
  - Proof of nonprofit status from the Internal Revenue Service (IRS), if applicable  
  - Proof of insurance  
  - Copy of driver’s license for all drivers  
  - Proof of Indiana surety bond of at least $50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations, providers owned or controlled by a hospital or pharmacy licensed in Indiana, or other exempted providers per IC 12-15-11-2.5(b)) | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 26 – Transportation Provider     | 269 – Broker Fleet                  | - IHCP Transportation provider enrollment packet or online application, which includes:  
  - Provider Agreement  
  - Federal W-9 form  
  - Copy of Motor Carrier Services (MCS) certificate from the Indiana Department of Revenue  
  - Proof of insurance  
  - Copy of driver’s license for all drivers  
  - Proof of Indiana surety bond of at least $50,000 for a minimum duration of 3 years (not required for 501(c)(3) nonprofit organizations, providers owned or controlled by a hospital or pharmacy licensed in Indiana, or other exempted providers per IC 12-15-11-2.5(b)) | 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>
</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 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  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare  
  *Note: A dental practice must be owned by a dentist.* | • IHCP provider enrollment packet or online application for your classification, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of license from state where services are performed  
  • For a sole proprietorship, a partnership, or professional services corporation, the owners listed as disclosed entities on the provider enrollment application must have dental licenses  
  • 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  
  *Note: A dental practice must be owned by a dentist.* | Out-of-state providers with this type and specialty are ineligible for IHCP provider enrollment. |
| 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 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  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare | |

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>
| 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 valid driver’s license for all drivers  
  • 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 valid driver’s license for all drivers  
  • 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 | |

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:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Medicare number, if enrolled in Medicare  
  • Application fee required ¹  
  *Note: Per CMS requirements – Must have a physician on staff* | • IHCP Group provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • 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 – 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:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • Copy of valid driver’s license for all drivers  
  • Medicare number, if enrolled in Medicare  
  • Application fee required ¹  
  *Note: Per CMS requirements – Must have a physician on staff* | • IHCP Billing or Group provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ 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 ¹  
  *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](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>
| 29 – Radiology                   | 290 – Freestanding X-Ray Clinic      | • IHCP Radiology provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • 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  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable  
  • Medicare number, if enrolled in Medicare  
  • Application fee required ¹ | • IHCP Radiology provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form  
  • 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  
  • 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 |
| 291 – Mobile X-Ray Clinic        |                                      |                                        |                                            |

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>Provider Specialty</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 – End-Stage Renal Disease (ESRD) Clinic</td>
<td>300 – Freestanding Renal Dialysis Clinic</td>
<td>Renal Disease</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></td>
<td>• Provider Agreement</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Federal W-9 form</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Copy of Indiana State Department of Health (ISDH) certification</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate required</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Application fee required 1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Type Code &amp; Description</th>
<th>Provider Specialty Code &amp; Description</th>
<th>Provider Specialty</th>
<th>In-State Provider Document Requirements</th>
<th>Out-of-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>31 – Physician</td>
<td>310 – Allergist</td>
<td>Physician</td>
<td>IHCP provider enrollment packet or online application for your classification, which includes:</td>
<td>IHCP provider enrollment packet or online application for your classification, which includes:</td>
</tr>
<tr>
<td></td>
<td>311 – Anesthesiologist</td>
<td></td>
<td>• Provider Agreement</td>
<td>• Provider Agreement</td>
</tr>
<tr>
<td></td>
<td>312 – Cardiologist</td>
<td></td>
<td>• Federal W-9 form</td>
<td>• Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td>313 – Cardiovascular Surgeon</td>
<td></td>
<td>• Copy of license from the Indiana Professional Licensing Agency (IPLA)</td>
<td>• Copy of license from appropriate state</td>
</tr>
<tr>
<td></td>
<td>314 – Dermatologist</td>
<td></td>
<td>• Copy of board certification for specialty requested, if applicable</td>
<td>• If applicable, copy of license from Indiana Professional Licensing Agency (IPLA) with the Telemedicine Provider Certification</td>
</tr>
<tr>
<td></td>
<td>315 – Emergency Medicine Practitioner</td>
<td></td>
<td>• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable</td>
<td>• Copy of board certification for specialty requested, if applicable</td>
</tr>
<tr>
<td></td>
<td>316 – Family Practitioner</td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
<td>• Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable</td>
</tr>
<tr>
<td></td>
<td>317 – Gastroenterologist</td>
<td></td>
<td></td>
<td>• Medicare number, if enrolled in Medicare</td>
</tr>
<tr>
<td></td>
<td>318 – General Practitioner</td>
<td></td>
<td></td>
<td>• Proof of participation in own state’s Medicaid program, if enrolled</td>
</tr>
<tr>
<td></td>
<td>319 – General Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>320 – Geriatric Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>321 – Hand Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>323 – Neonatologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>324 – Nephrologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>325 – Neurological Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>326 – Neurologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>327 – Nuclear Medicine Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>328 – Obstetrician/Gynecologist</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](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>329 – Oncologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>330 – Ophthalmologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>331 – Orthopedic Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>332 – Otologist, Laryngologist, Rhinologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>333 – Pathologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>334 – Pediatric Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>336 – Physical Medicine and Rehabilitation Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>337 – Plastic Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>338 – Proctologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>339 – Psychiatrist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>340 – Pulmonary Disease Specialist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>341 – Radiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>342 – Thoracic Surgeon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>343 – Urologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>344 – General Internist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>345 – General Pediatrician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>346 – Dispensing Physician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32 – Waiver Provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See pages 36–40.</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.
## 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>
| 34 – MRT Copy Center             | 366 – MRT Copy Center                | • IHCP Billing provider enrollment packet or online application, which includes:  
  ○ Provider Agreement  
  ○ Federal W-9 form | • 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 |
| 36 – Genetic Counselor           | 800 – Genetic Counselor              | • 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)  
  • Copy of Clinical Laboratory Improvement Amendments (CLIA) certificate, 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 license from the appropriate state  
  • 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 |

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</th>
<th>Provider Specialty</th>
<th>Provider Secondary Specialty</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 32 – Waiver Provider | 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 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</th>
<th>Provider Specialty</th>
<th>Provider Secondary Specialty</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>32 – Waiver Provider</td>
<td>356 – Traumatic Brain Injury (TBI) Waiver</td>
<td>• B00 – Adult Day Services (Level 1)</td>
<td>• IHCP Waiver provider enrollment packet or online application for your classification, which includes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B01 – Adult Day Services (Level 2)</td>
<td>o Provider Agreement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B02 – Adult Day Services (Level 3)</td>
<td>o Federal W-9 form</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B03 – Adult Foster Care 1</td>
<td>• Certification letter from the appropriate waiver administering division</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B04 – Attendant Care 2</td>
<td>• B03 – Application fee required 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B05 – Behavior Management/Behavior Program &amp; Counseling</td>
<td>• B04 – Fingerprint and background check required 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B06 – Case Management</td>
<td>• B19 – Application fee, fingerprint, and background check required 1, 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B07 – Community Transition Services</td>
<td>• B23 – Application fee required 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B08 – Environmental Modifications</td>
<td>• B24 – Vehicle Modifications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B09 – Healthcare Coordination</td>
<td>• B25 – TBI Assisted Living</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• B10 – Home-Delivered Meals</td>
<td></td>
</tr>
</tbody>
</table>
IHCP Provider Enrollment
Type and Specialty Matrix

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider Specialty</th>
<th>Provider Secondary Specialty</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 32 – Waiver Provider | 359 – Community Integration and Habilitation Waiver | • C00 – Adult Day Services (Level 1, 2, 3)  
• C01 – Adult Foster Care  
• C02 – Behavior Management/Behavior Program & Counseling  
• C03 – Community-Based Habilitation – Group  
• C04 – Community-Based Habilitation – Individual  
• C05 – Community Transition Services  
• C06 – Electronic Monitoring  
• C07 – Environmental Modifications  
• C08 – Facility-Based Habilitation – Group  
• C09 – Facility-Based Habilitation – Individual  
• C10 – Facility-Based Support Services  
• C11 – Family and Caregiver Training  
• C12 – Intensive Behavioral Intervention  
• C13 – Music Therapy  
• C14 – Occupational Therapy  
• C15 – Personal Emergency Response Systems  
• C16 – Physical Therapy  
• C17 – Prevocational Services  
• C18 – Psychological Therapy  
• C19 – Recreational Therapy  
• C20 – Rent/Food for Unrelated Live-In Caregiver  
• C21 – Residential Habilitation and Support  
• C22 – Respite  
• C23 – Specialized Medical Equipment & Supplies  
• C24 – Speech/Language Therapy  
• C25 – Extended Services  
• C26 – Transportation Level 1  
• C27 – Workplace Assistance  
• C28 – Case Management  
• C29 – Transportation Level 2  
• C30 – Transportation Level 3  
• C31 – Wellness Coordination | • 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  
• C01 – Application fee required  
• C13 – Application fee required, if group  
• C14 – Application fee required, if group  
• C16 – Application fee required, if group  
• C19 – Application fee required, if group  
• C23 – Application fee, fingerprint, and background check required  
• C24 – Application fee required, if group  
• C26 – Application fee required  
• C29 – Application fee required  
• C30 – 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</th>
<th>Provider Specialty</th>
<th>Provider Secondary Specialty</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 32 – Waiver Provider | 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  
2 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.
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Provider Specialty</th>
<th>Provider Secondary Specialty</th>
<th>In-State Provider Document Requirements</th>
</tr>
</thead>
</table>
| 32 – Waiver Provider | 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  
• F40 – Workplace Assistance  
• F41 – Environmental Modifications Assessment  
• F42 – Structured Family Caregiving  
• F43 – Wellness Coordination  
• F44 – Extended Services | • 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 |