IHCP Provider Disenrollment Form

in.gov/medicaid/providers

This form may be used to disenroll:

- An entire group or billing provider enrollment from the Indiana Health Coverage Programs (IHCP)
- A specific service location from an IHCP group or billing provider
- Rendering provider linkages from an IHCP provider group or from one or more service locations for a group
- Waiver rendering provider linkages from an IHCP waiver provider group or from one or more service locations for a waiver group

Providers enrolled as primary medical providers (PMPs) with a managed care entity (MCE) must contact the MCE to begin the disenrollment process before submitting this form. Please see the *IHCP Quick Reference Guide* at in.gov/medicaid/providers.

Waiver providers must contact the waiver divisions at the State before submitting this form.

Next Steps

1. After completing this form, perform a quality check using the checklist below. The quality check helps ensure that your transaction can be processed and that it does not have to be returned for corrections.

For Provider Use Only	Quality Check
☐	If the provider is a PMP with an MCE, contact the MCE to start the disenrollment process **before** submitting this form.
☐	If the provider is a waiver provider, contact the waiver divisions at the State **before** submitting this form.
☐	Double-check that the correct service locations are indicated on the form.
☐	Make sure that an owner or authorized official has signed the form. Delegated administrators may sign if disenrolling a specific service location or disenrolling rendering provider linkages from a provider group. Delegated administrators may not sign this form to disenroll an entire group or billing provider.

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

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

IHCP Provider Disenrollment Form

in.gov/medicad/providers

Provider Disenrollment Request

Complete this section to disenroll an entire group or billing provider enrollment. **ALL** provider service locations and any rendering provider enrollments associated with those service locations will be disenrolled for the submitted provider number.

1. Legal name of provider's business

2. Is the provider a PMP or does the provider have rendering providers who are PMPs with an MCE? If yes, you must contact the MCEs regarding disenrollment **before** submitting this form.

☐ No ☐ Yes – If yes, please indicate the date on which the MCEs were contacted:

3. Requested disenrollment effective date	4. IHCP Legacy Provider Identifier (LPI)	5. National Provider Identifier (NPI)

6. Forwarding address

Service Location Disenrollment Request

Complete this section to disenroll a specified service location and, if applicable, to remove all associated rendering provider linkages to that service location. Other service locations and associated rendering provider linkages (if applicable) will not be affected.

7. Are any rendering providers at this service location PMPs with an MCE? If yes, you must contact the MCEs regarding PMP disenrollment from this service location **before** submitting this form.

☐ No ☐ Yes – If yes, please indicate the date on which the MCEs were contacted:

8. Requested disenrollment effective date	9. LPI	10. Service location alpha suffix	11. NPI

Rendering Provider Disenrollment Request

Complete this section to disenroll the specified rendering provider linkages from one or more service locations for this group. Other rendering providers linked to the service locations (if applicable) will not be affected.

12. Are any rendering providers PMPs with an MCE? If yes, you must contact the MCEs regarding PMP disenrollment from the service locations before submitting this form.

☐ No ☐ Yes – If yes, please indicate the date on which the MCEs were contacted:

13. Legal name of group's business	14. Group LPI	15. Group NPI

16. Rendering provider IHCP Legacy Provider Identifier (LPI)	**17. Rendering provider NPI**	**18. IHCP service locations and alpha suffix**	**19. Requested disenrollment effective date**

Contact Information

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

20. Contact name	21. Telephone

22. Contact email

Authorized Signature Information

The undersigned, being the provider or having the specific authority to bind the provider to the terms of the Provider Agreement, does hereby agree to abide by and comply with all the stipulations, conditions, and terms set forth herein. The undersigned acknowledges that the commission of any Medicaid or CHIP-related offense, as set out in *42 USC 1320a-7b* may be punishable by a fine of up to $25,000 or imprisonment of up to five years or both.

The owner or an authorized official of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. Delegated administrators may sign if disenrolling a specific service location or disenrolling rendering provider linkages to a provider group AND it has been expressly indicated on an IHCP Delegated Administrator Addendum/Maintenance Form, on file or attached. Delegated administrators may not sign this form to disenroll an entire group or billing provider. The form will be returned if the appropriate signature is not submitted.

23. Authorized official's name (please print)	24. Title
25. Authorized official's signature	26. Date