



IHCP Provider Name and Address Maintenance Form

in.gov/medicaid/providers

Enrolled providers use this form to update the name and address information that is part of their Provider Profile.

Four name/address types are maintained for each provider service location enrolled in the Indiana Health Coverage Programs (IHCP).

Name and address type	Description
Service location	The service location is owned or rented by the provider and is the site where members obtain services. This address must be a physical location. A post office box is not a valid service location address. See additional details in the Service Location Name and Address area on this form.
Home office	The home office name is considered the legal entity maintaining ownership of the service location. The home address must be a physical location. A post office box is not a valid home office address. See details in the Legal Name and Home Office Address area on this form.
Mail-to	The mailing address is the location where the IHCP sends general correspondence. A post office box is acceptable for a mailing address.
Pay-to	The pay-to name appears as the payee on all checks. The pay-to address is the location where the IHCP mails payments. A post office box is acceptable for a mailing address.

Who Completes This Form

- Billing and group providers use this form to report name changes (business and personal) and address changes. Provider name changes require a new W-9. Group providers use this form to submit name changes on behalf of rendering providers linked to their service locations. A rendering provider name change does not require a new W-9. However, proof of a legal name change must accompany any such requests. An updated practitioner's license is acceptable in lieu of the name change court document. When the practitioner's license does not show the new name, a legal name change document must be submitted. The IHCP does not maintain address information for rendering providers.
- Waiver providers must contact the appropriate waiver division at the Family and Social Services Administration (FSSA) before submitting the *IHCP Provider Name and Address Maintenance Form*.
- If the name/address change is the result of a change of ownership, do not complete this form. For a change of ownership, complete and submit the appropriate IHCP provider packet. Go to [Complete an IHCP Provider Packet](https://in.gov/medicaid/providers) at in.gov/medicaid/providers and select your provider type to find the appropriate provider packet. Be sure to include supporting documentation and a copy of the purchase agreement or bill of sale with this packet.

Sections to Complete

When completing this form, complete the following sections:

- Provider Identification
- Maintenance Request Information
- Any section where the information has changed. If the information in a section has not changed, leave that section blank. For example, if your mailing address has changed but the pay-to address has not, complete the Mailing Name and Address Change section but leave the Pay-To Name and Address Change section blank.
- Contact Information
- Authorized Signature Information

Some name and address changes require a revised W-9. If the change you are making requires a revised W-9, follow these steps:

1. Go to the irs.gov website.
2. Locate the W-9 form and click the link to download it.
3. Complete the W-9 based on the instructions provided by the Internal Revenue Service.
4. Print the W-9 and mail it to the Provider Enrollment Unit as an attachment to this form.

Next Steps

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

For Provider Use Only	Quality Check
	<p>The following sections must be completed in all submissions:</p> <ul style="list-style-type: none"> • Provider Identification • Maintenance Request Information • Contact Information • Authorized Signature Information
	<p>Follow the directions in fields 5 – 8 carefully to ensure that you completed all required sections for the type of change you are submitting.</p>
	<p>For a service location name change:</p> <ul style="list-style-type: none"> • Submit a new W-9. • Submit registration documentation from the Secretary of State for the business. (Exception: A business name that is a nonregistered personal name) • Indicate whether the name change applies to only the service location listed or to all service locations. • Indicate whether the address change applies to only the service location listed or to all service locations.
	<p>For home office name or address changes:</p> <ul style="list-style-type: none"> • Submit a new W-9. • Submit registration documentation from the Secretary of State for the business. (Exception: A business name that is a nonregistered personal name) • Indicate whether the name change applies to only the service location listed or to all service locations. • Indicate whether the address change applies to only the service location listed or to all service locations.
	<p>For a personal name change:</p> <ul style="list-style-type: none"> • Submit documentation showing proof of a personal name change. A provider’s updated license or appropriate certification may be presented as proof of a name change. • If a provider license does not show the new name, an official document showing the legal name change is required.
	<p>For mailing and pay-to name or address changes:</p> <ul style="list-style-type: none"> • Indicate whether the name change applies to only the service location listed or to all service locations. • Indicate whether the address change applies to only the service location listed or to all service locations.

2. Make a copy of the maintenance form and other documentation for your records.
3. If additional maintenance forms are needed, return to [in.gov/medicaid/providers](https://www.in.gov/medicaid/providers) and select another form.
4. Mail the maintenance forms and other required documentation to the following address:

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



Provider Identification		
1. Legacy Provider Identifier (LPI) and service location alpha suffix	2. National Provider Identifier (NPI) for service location	
3. Taxonomy	4. ZIP + 4 (Nine digits required)	
Maintenance Request Information		
5. Is the address change a result of a change of ownership ? If yes, do not complete this form. For a change of ownership, complete and submit the appropriate IHCP provider packet; include supporting documentation and a copy of the purchase agreement or bill of sale.	Yes	No
6. Is the change a rendering provider name change ? If yes, complete fields 9-12 and 48-56. Submit proof of legal name change. Contact information and authorized signatures from the group provider are required.	Yes	No
7. Is the change a billing or group name change ? If yes, complete fields 13-32 and 48-56. Submit copies of registration documentation from the Secretary of State or county recorder's office showing your filed business name and assumed business names, if the names differ from your personal name. Contact information and authorized signatures are required.	Yes	No
8. Is the change a billing or group provider address change ? Complete the information for only those addresses that changed, as well as fields 48-56. Contact information and authorized signatures are required.	Yes	No
Rendering Provider Name Change		
Submit documentation showing proof of a personal name change. A provider's updated license or appropriate certification may be presented as proof of a name change. If a provider license does not show the new name, an official document showing the legal name change is required.		
9. Rendering provider's current (new) name		
10. Rendering provider's previous name		
11. Rendering provider's LPI	12. Rendering provider's NPI	

Service Location Name and Address Change

- **The service location address must be a physical location. A post office box is not a valid service location.**
- The service location is the site where members obtain services and is either owned or rented by the provider; it is usually where supporting documentation related to claims is maintained.
- If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State or your county recorder’s office showing the business name or DBAs (*405 IAC 1-19.1b*) has been registered. This document must be attached to the packet.
- If you are using this packet to change your business name, you must include a revised W-9 form as an attachment to the packet. You must also submit registration documentation from the Secretary of State or your county recorder’s office as an attachment, except when the business name is your nonregistered personal name.
- For a personal name change, submit documentation showing proof of the name change. A provider's updated license or appropriate certification may be presented as proof of a name change. If a provider license does not show the new name, an official document showing the legal name change is required.
- If your legal name and business name changes are the same, one set of attached documents will support both changes.
- Providers that provide services at a “place of service site,” such as at a hospital or nursing facility, should enter their home/business office as their service location address.

13. Current (new) service location (DBA) name

14. Previous service location (DBA) name

15. Current (new) service location street address

16. Indiana county (Indiana providers)

17. City

18. State

19. ZIP + 4 **(Nine digits required)**

20. Telephone

21. Effective date of change

22. Is claim documentation kept at this location? Yes No

23. Are services provided in Indiana? Yes No

Legal Name and Home Office Address Change

- The legal name is considered to be the entity maintaining ownership of the named business. The legal name must be the current name on tax, corporation, and other legal documents.
- The legal name and home office address must match **exactly** the information currently registered with the Secretary of State, if registered. This does not apply to informal associations such as sole proprietorships and general partnerships that are not registered.
- If your business name differs from your legal name, submit copies of registration documentation from the Secretary of State or your county recorder's office showing your filed business name and DBAs (*405 IAC 1-19.1b*) as an attachment to the packet.
- **The legal name, as well as the home office address and Tax Identification Number (TIN), must match exactly the information reported on the W-9.**
- If you are using this packet to change your legal name or home office address, you must include a revised W-9 form as an attachment to the packet. You must also submit registration documentation from the Secretary of State or your county recorder's office as an attachment, except when the legal name is a nonregistered personal name.
- For a personal name change, submit documentation showing proof the name change. A provider's updated license or appropriate certification may be presented as proof of a name change. If a provider license does not show the new name, an official document showing the legal name change is required. If the legal name changes on the W-9, a new W-9 must be submitted.
- If your legal name and business name change is the same, one set of attached documents will support both changes.

24. Current (new) legal name

25. Previous legal name

26. Current (new) home office street address

27. City

28. State

29. ZIP + 4 (**Nine digits required**)

30. Telephone number

31. TIN

- A single TIN can be used for multiple LPIs. If you are changing the TIN and the TIN change applies to multiple LPIs, submit one form for each LPI.
- LPIs can have multiple service locations. Indicate whether the changes apply only to the service location listed previously or to all service locations. If the change applies to multiple service locations, but not all, submit one form per service location.

- | | | |
|--|-----|----|
| 32a. Change the legal name for only the service location listed? | Yes | No |
| 32b. Change the legal name for all service locations associated with the identified provider? | Yes | No |
| 32c. Change the home office address for only the service location listed? | Yes | No |
| 32d. Change the home office address for all service locations associated with the identified provider? | Yes | No |

Mailing Name and Address Change

The mailing address is the location where the IHCP sends general correspondence. A post office box is acceptable for a mailing address.

33. Addressee

34. Telephone

35. Street address

36. City

37. State

38. ZIP + 4 (**Nine digits required**)

Indicate whether the changes apply only to the service location listed previously or to all service locations. If the change applies to multiple service locations, but not all, submit one form per service location.

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|--|-----|----|
| 39a. Change the mail-to name for only the service location listed? | Yes | No |
| 39b. Change the mail-to name for all service locations associated with the identified provider? | Yes | No |
| 39c. Change the mail-to address for only the service location listed? | Yes | No |
| 39d. Change the mail-to address for all service locations associated with the identified provider? | Yes | No |

Pay-To Name and Address Change

- The pay-to address is the location where the IHCP sends checks and general claims payment information. If this is a billing agent's address, please provide the name, address, and telephone number of the billing agent. A post office box is acceptable for this address.
- The pay-to name is the name that will appear as the payee on all checks.
- **If the provider is using a billing agent, proof of authorization for the billing agent must be included as an attachment to the packet.**

40. Payee name

41. Billing agent name

42. Telephone

43. Street address

44. City

45. State

46. ZIP + 4 **(Nine digits required)**

Indicate whether the changes apply only to the service location listed previously or to all service locations. If the change applies to multiple service locations, but not all, submit one form per service location.

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|---|-----|----|
| 47a. Change the pay-to name for only the service location listed? | Yes | No |
| 47b. Change the pay-to name for all service locations associated with the identified provider? | Yes | No |
| 47c. Change the pay-to address for only the service location listed? | Yes | No |
| 47d. Change the pay-to address for all service locations associated with the identified provider? | Yes | No |

Contact Information

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

48. Contact name

49. Telephone

50. 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 Children's Health Insurance Program (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 to avoid return of the form. The *IHCP Delegated Administrator Addendum/Maintenance Form* must be completed before a delegated administrator can sign forms. The delegated administrator can sign only for items expressly delegated. The IHCP can process provider maintenance requests only when the appropriate signature is present. **The form will be returned if the appropriate signatures are not submitted.**

51. Legal name of provider's business (please print)

52. TIN

53. Authorized official's name (please print)

54. Title

55. Authorized official's signature

56. Date