IHCP Provider Enrollment Recertification of Licenses and Certifications Form

in.gov/medicaid/providers

> *Note: The Indiana Health Coverage Programs (IHCP) encourages providers to use the IHCP Provider Healthcare Portal (IHCP Portal) to update their provider profiles. However, all profile updates may be made by mail using the appropriate paper forms, if needed.*

When an Indiana Health Coverage Programs (IHCP) provider is required to recertify their IHCP enrollment due to an expiring credential – such as a license, certification or insurance policy – this form can be used to submit the updated documentation to the IHCP **before** the expiration date of the credential on file.

If the provider **fails to recertify** before their eligibility end date (the date the credential expires), they must **reenroll** with the IHCP by submitting a new IHCP provider enrollment application in its entirety. Reenrolling providers will be issued a *new* IHCP Provider ID.

The *IHCP Provider Type and Specialty Matrix* (available at in.gov/medicaid/providers) indicates which, if any, of the provider enrollment credentials for each provider type and specialty require provider recertification.

> *Note: Any license, certification or insurance that is required for a provider's enrollment in the IHCP must be kept current and active for continued IHCP eligibility. However, for certain kinds of licensure and certification, no provider recertification is required because the IHCP can automatically verify that the credential has been updated.*

Who Is Required to Recertify?

The following providers are required to recertify for designated documentation, as indicated on the *IHCP Provider Type and Specialty Matrix*:

- Type 01 – Hospital
  - Specialty 010 – Acute Care – ***Out of state only***
  - Specialty 011 – Psychiatric
  - Specialty 012 – Rehabilitation – ***Out of state only***
- Type 02 – Ambulatory Surgical Center (ASC)
  - Specialty 020 – Ambulatory Surgical Center (ASC) – ***Out of state only***
- Type 09 – Advanced Practice Registered Nurse (APRN)
  - Specialty 094 – Certified Registered Nurse Anesthetist (CRNA)
- Type 11 – Behavioral Health Provider
  - Specialty 111 – Community Mental Health Center (CMHC)
  - Specialty 115 – Adult Mental Health and Habilitation (AMHH) Service Provider
  - Specialty 611 – Children's Mental Health Wraparound (CMHW) Service Provider
  - Specialty 612 – Behavioral and Primary Healthcare Coordination (BPHC) Service Provider
  - Specialty 613 – Medicaid Rehabilitation Option (MRO) Clubhouse
  - Specialty 615 – Applied Behavior Analysis (ABA) Therapist (Masters/Doctoral or Health Service Provider in Psychology [HSPP])
  - Specialty 623 – Certified Community Behavioral Health Clinic (CCBHC)
  - Specialty 624 – ABA Therapist (Bachelors)
  - Specialty 625 – ABA Therapist (Registered Behavior Technician [RBT])
  - Specialty 835 – Opioid Treatment Program (OTP)
  - Specialty 836 – Substance Use Disorder (SUD) Residential Addiction Treatment Facility
- Type 24 – Pharmacy
  - Specialty 251 – Home Medical Equipment (HME)

- Type 25 – Durable Medical Equipment (DME)/Medical Supply Dealer
  - Specialty 251 – Home Medical Equipment (HME)
  - Specialty 252 – Donor Milk Bank
- Type 26 – Transportation Provider
  - Specialty 260 – Ambulance
  - Specialty 261 – Air Ambulance
  - Specialty 263 – Taxi
  - Specialty 264 – Common Carrier Ambulatory
  - Specialty 265 – Common Carrier Non-Ambulatory
  - Specialty 266 – Family Member
  - Specialty 267 – Transportation Network Company (TNC)
  - Specialty 269 – Broker Fleet
- Type 27 – Dentist
  - Specialty 276 – Mobile Dental Van
- Type 32 – Waiver Provider
  - Subspecialty A04/B25/F04 – Assisted Living
  - Subspecialty A05/B04/F05 – Attendant Care
  - Subspecialty A11/B11/F19 – Home and Community Assistance
  - Subspecialty A14/B18/C22/D17/F32 – Respite

Next Steps

1. After completing this form, perform a quality check using the following checklist. The quality check helps ensure that your recertification can be processed in a timely manner.

For Provider Use Only	Quality Check
☐	**All providers** complete fields 1–6 and 23–29.
☐	**Group and clinic providers** also complete fields 7–9. A separate form is required to recertify each rendering provider.
☐	**As applicable**, complete information in fields 10a–22 about updated documentation being submitted for recertification. Skip fields in this range that are not applicable to your current provider recertification.
☐	Double-check that all required supporting documentation, including copies of applicable professional and operating licenses, is included as an attachment to the packet. Required documentation is listed on the *IHCP Provider Enrollment Type and Specialty Matrix* at in.gov/medicaid/providers.
☐	Be sure to obtain the appropriate signature and business information in fields 26–29.

2. Make a copy of the completed 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. Mail the maintenance forms and other required documentation to the following address:

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

| Maintenance Form

IHCP Provider Enrollment Recertification of Licenses and Certifications Form

in.gov/medicaid/providers

Recertifying Billing or Group/Clinic Provider Information

1. Provider name (as it appears on the W-9):		2. IHCP Provider ID (including alpha character, if applicable):	
3. National Provider Identifier (NPI):	4. Taxonomy codes:	5. ZIP Code + 4:	6. Taxpayer identification number (TIN):

Group/Clinic Recertifying Rendering Provider Information

7. Rendering provider name:	
8. Rendering provider's IHCP Provider ID (including alpha character, if applicable):	9. Rendering provider's NPI:

Updated Documentation

Complete the fields in this section related to any licensing, certification or other documentation that is required for recertification of your enrollment. A copy of the updated document must be submitted with this form. Check the *IHCP Provider Enrollment Type and Specialty Matrix* for specific licensure and certification requirements for your provider type and specialty.

Professional Licensure/Certification

10a. License/certificate number:	10b. Effective date:	10c. Expiration date:	10d. Issuing state:
11a. License/certificate number:	11b. Effective date:	11c. Expiration date:	11d. Issuing state:
12a. License/certificate number:	12b. Effective date:	12c. Expiration date:	12d. Issuing state:

USDOT Registration or MCS Certification

13. U.S. Department of Transportation (USDOT) Authority Registration or Motor Carrier Services (MCS) number:

Vehicle Insurance Information

14a. Insurance company name:	14b. Policy number:	14c. Effective date:	14d. Expiration date:
15a. Insurance company name:	15b. Policy number:	15c. Effective date:	15d. Expiration date:
16a. Insurance company name:	16b. Policy number:	16c. Effective date:	16d. Expiration date:

Updated Documentation

Driver's License Information and Attestation

Providers enrolling under specialties 263, 264, 265 or 269 must complete the following attestation and provide the required information for each individual driver. Copies of the driver's licenses must also be attached to the application, as indicated on the *IHCP Provider Enrollment Type and Specialty Matrix* at in.gov/medicaid/providers.

17. Select the check boxes below to indicate agreement with each attestation statement:

☐ I attest to having a process necessary for addressing any violation of state drug law.

☐ I attest to having a process to disclose to the Indiana Health Coverage Programs (IHCP) the driving history, including any traffic violations, of each individual driver employed by this provider upon request by the IHCP.

☐ I attest that all individuals who currently provide transportation for this provider have been reported and that I will be responsible for updating this enrollment with additional drivers as needed.

#	Driver's Name	Driver's License #	License State	License Effective Date	License Expiration Date	Driver's Date of Birth	Driver's Social Security Number
18.							
19.							
20.							
21.							
22.							

Contact Information

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

23. Contact name:	24. Telephone:
25. 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, authorized official of the business, or delegated administrator 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 for only items expressly delegated. The IHCP can process provider maintenance requests only when the appropriate signature is present.

26. Authorized official's name (please print):	27. Title:
28. Authorized official's signature:	29. Date: