| Overview

IHCP Rendering Provider Enrollment and Profile Maintenance Packet

in.gov/medicaid/providers

Before You Begin!

The Indiana Health Coverage Programs (IHCP) encourages providers to use the IHCP Provider Healthcare Portal (IHCP Portal) for submitting enrollment transactions. You will find the online process quick and easy, with online help features to guide you. When you complete your transaction, the portal will provide a paper confirmation of your enrollment transaction that you will be able to print for your records.

For additional help using the IHCP Portal, online web-based training is available on the *IHCP Provider Healthcare Portal Training* webpage at in.gov/medicaid/providers.

If you are not able to use the IHCP Portal, you may use paper forms.

Who Uses This Packet

Newly enrolling or existing groups and clinics use this packet to link practitioners (*rendering providers*) to their business. Group or clinic providers complete and submit this enrollment packet on behalf of rendering providers associated with the group or clinic.

The following provider types may be enrolled as rendering providers linked to groups or clinics:

- 09 – Advanced Practice Registered Nurse
- 10 – Physician Assistant
- 11 – Behavioral Health Provider *with any of the following specialties:*
  - 114 – Health Service Provider in Psychology (HSPP)
  - 611 – Child Mental Health Wraparound (CMHW) Provider
  - 613 – Medicaid Rehabilitation Option (MRO) Clubhouse
  - 615 – Applied Behavior Analysis (ABA) Therapist (Masters/Doctoral or HSPP)
  - 616 – Licensed Psychologist
  - 617 – Licensed Independent Practice School Psychologist
  - 618 – Licensed Clinical Social Worker (LCSW)
  - 619 – Licensed Marriage and Family Therapist (LMFT)
  - 620 – Licensed Mental Health Counselor (LMHC)
  - 621 – Licensed Clinical Addiction Counselor (LCAC)
  - 624 – ABA Therapist (Bachelors)
  - 625 – ABA Therapist (Registered Behavior Technician [RBT])
- 14 – Podiatrist
- 15 – Chiropractor
- 17 – Therapist
- 18 – Optometrist
- 19 – Optician (with optometry groups only)
- 20 – Audiologist
- 24 – Pharmacy with the following specialty:
  - 241 – Pharmacist
- 27 – Dentist
- 31 – Physician
- 36 – Genetic Counselor

General Instructions

This enrollment and maintenance packet can be used to do the following:

- **Establish an initial linkage between your business and a rendering provider** – Complete all fields in each section unless a section is optional and does not apply to you.
- **Update the information about a rendering provider** (also known as a *provider profile*) already linked to your business, including changing service locations, terminating linkages and so on. Only the following sections are required when using the packet to update a rendering provider's profile:
  - Schedule A – Type of request
  - Schedule A – Group or clinic information
  - Schedule A – In the *Rendering Provider Information* section, the rendering provider's current name and rendering provider's IHCP Provider ID fields
  - Schedule A – Any other field where the information has changed; if the information in a field has not changed, leave the field blank. For example, if the rendering provider's name has not changed, leave the *Rendering provider's former name* field blank.
  - Schedule B – All fields
- **Enroll in specific Indiana Medicaid programs** such as the Medical Review Program and 590 Program.

Provider Profile Updates

Providers that use the IHCP Provider Healthcare Portal (accessible from the homepage at in.gov/medicaid/providers) to update their provider profile will find the process much quicker and easier than sending paper forms. Delegates with the proper authorization can also access the IHCP Portal to make profile changes.

Tips for Completing This Packet

- Read the instructions in each section of the packet carefully.
- Some rendering providers are considered high-risk and are subject to additional screening activities, including a Medicaid fingerprint-based background check. Please see the *IHCP Provider Enrollment Risk Category and Application Fee Matrix* to determine if the applicable provider type/specialty is high-risk. If so, be sure the practitioner completes fingerprint activities (as specified on the *Provider Enrollment Risk Levels and Screening* webpage at in.gov/medicaid/providers) before this packet is submitted.
- Where sections of the packet request supporting documentation (such as a copy of a certification), the required documentation must be included as an attachment to the packet.
- All packet documents are interactive PDF files, allowing users to enter information into the fields directly from the computer. This information can then be saved to a file and printed for mailing. Using these interactive features facilitates both the packet's completion and review processes.

Next Steps

1. After completing this packet, including all applicable addenda, and collecting the necessary supporting documentation, perform a quality check using the following checklist. The quality check helps ensure that your packet can be processed in a timely manner. Incomplete packets cannot be processed. Failure to include all the required information will significantly delay your enrollment.

For Provider Use Only	Quality Checklist
☐	**If you are enrolling one or more rendering providers:** Double-check that you have included a separate rendering packet for each rendering provider , and that ***all sections*** have been fully completed.
	If you are updating an existing rendering provider's profile: Complete ***only*** the following sections: ☐ Schedule A – Type of request ☐ Schedule A – Group or clinic information ☐ Schedule A – In the *Rendering Provider Information* section, the rendering provider's current name and rendering provider's IHCP Provider ID fields ☐ Schedule A – Any other field where the information has changed; if the information in a field has not changed, leave the field blank. For example, if the rendering provider's name has not changed, leave the *Rendering provider's former name* field blank. ☐ Schedule B – All fields
☐	If the rendering practitioner's specialty is considered high risk, be sure to include the ***IHCP Rendering Provider Screening Addendum***. The practitioner should complete Medicaid fingerprint activities before this packet is submitted. For detailed instructions, see the *Provider Enrollment Risk Levels and Screening* webpage at in.gov/medicaid/providers.
☐	Double-check that all required supporting documentation for each rendering provider is included as an attachment to his or her packet. Required documentation for rendering provider types is listed on the *IHCP Provider Enrollment Type and Specialty Matrix* at in.gov/medicaid/providers. Additional documentation is required for out-of-state providers requesting in-state status for any of the circumstances listed in the *Out-of-State Questionnaire* section.
☐	Double-check that the *IHCP Provider Signature Authorization* section of this packet has been completed and signed by both an authorized official and the rendering provider.
☐	Double-check that taxpayer identification number (TIN) entered in the field across from the rendering provider name on the *Rendering Provider Agreement* is the **rendering provider's** Social Security number (or the rendering provider's employer identification number, if the rendering provider is an organization). The number in that field *cannot* be the *group's* TIN.
☐	Double-check that the ***Rendering Provider Agreement*** has been signed by an authorized official who is listed on Schedule C for the group/clinic provider **and** by the rendering provider. (The *Rendering Provider Agreement* must not be signed by a delegated administrator.)

2. Print the completed packet. It is important to return all pages in the packet, in the correct page number order, with all required documents.
3. Make a copy of the packet for your records.
4. Mail the packet, including all required addenda and supporting documentation, to the following address:

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

5. If the packet needs corrected or is missing required documentation, the IHCP Provider Enrollment Unit will contact you by telephone, email or mail. This contact is intended to communicate what needs to be submitted or corrected and resubmitted before the IHCP can process the transaction. If an application is rejected for missing information, a letter will be sent indicating what needs to be corrected or attached; you must include a copy of the letter as a cover sheet when you submit the missing or corrected pages.
6. You will be notified via regular mail after your application has been approved. Please allow 15 business days plus mailing time before inquiring about the status of your application.
7. After you are enrolled as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's managed care programs, you must apply directly with one or more of the managed care entities (MCEs). Please see the *Enrolling as a Managed Care Program Provider* webpage at in.gov/medicaid/providers for information about the programs and the MCEs with which the state contracts for each.

| Schedule A

IHCP Rendering Provider Enrollment and Profile Maintenance Packet | in.gov/medicaid/providers

To enroll multiple rendering providers, complete a separate *IHCP Rendering Provider Enrollment and Profile Maintenance Packet* for each.

Type of Request

1. Type of request:

- This form can be used for multiple purposes; select the purpose that applies:

☐ **New enrollment** – The rendering provider is enrolling for the first time.

☐ **Profile update** – The rendering provider is already enrolled but changes to the provider's profile information are needed.

☐ **Conversion from OPR to rendering –** The provider is enrolled as an ordering, prescribing or referring (OPR) provider and is applying to convert the enrollment to a rendering provider classification. Upon conversion, the effective date of the rendering enrollment will be the same as the end date of the OPR enrollment, with no enrollment gap.

☐ **Terminate linkage** – The rendering provider is already enrolled but the provider's linkage to a service location is being terminated.

- Only groups and clinics have rendering providers. The group or clinic's service location must be enrolled before the rendering provider can be linked to the service location.
- Groups and clinics do not need to submit rendering provider packets during revalidation. See the revalidation instructions in the *IHCP Group and Clinic Provider Enrollment and Profile Maintenance Packet*.

Group or Clinic Service Location Information

Enter information about an associated group or clinic for this rendering provider. The information provided in this section – including service location name and address, taxpayer identification number (TIN), IHCP Provider ID, and National Provider Identifier (NPI) – must match information provided to the IHCP for the associated group or clinic's IHCP enrollment. (Note: Additional information about this service location, as well as all *other* service locations to which this rendering provider will be linked, must be provided in the *Group Service Location Linkage Information* section.)

2. Group or clinic's service location name:	3. Group or clinic's TIN:		
4. Service location address:	5. City:	6. State:	7. ZIP+4 (nine digits required):
8. Group or clinic's IHCP Provider ID (if currently enrolled):	9. Group or clinic's Medicare number:		
10. Group or clinic's NPI:	11. Taxonomy codes:		

Rendering Provider Information

- See the *IHCP Provider Enrollment Type and Specialty Matrix* at in.gov/medicaid/providers to determine the appropriate provider type and specialty codes as well as enrollment requirements for this packet.
- A **healthcare practitioner** enrolling as a rendering provider must use a Type 1 NPI, his or her personal name as the provider name and his or her Social Security number (SSN) as the TIN on the enrollment application.
- If the rendering provider is a behavioral health provider with a provider specialty **613 – MRO Clubhouse**, the entity must use a Type 2 NPI, the business' legal name and the business' EIN as the TIN on the enrollment application and must also complete the *IHCP MRO Clubhouse Provider Enrollment Addendum*.
- Only one provider type code is permitted per packet. Only one **primary** specialty code is permitted per packet. Submit a separate packet for each additional provider type or primary specialty.
- A **taxonomy code** identifies a healthcare provider type and specialty. A taxonomy code identifies a healthcare provider type and specialty. The taxonomy code set is maintained by the National Uniform Claim Committee (NUCC), which provides an online lookup tool at taxonomy.nucc.org.
- By entering the rendering provider's Social Security number, you are providing consent to the Indiana Family and Social Services Administration and its contractors to use the Social Security number for the sole purpose of verifying initial and continuing eligibility to participate in the Medicaid program with the Office of the Inspector General, the Centers for Medicare & Medicaid Services, licensing bodies and other appropriate state and federal agencies.
- If the rendering provider's name has changed, 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. Rendering provider name changes do not require a new *W-9*.
- If the rendering provider is a qualified provider (QP) for presumptive eligibility (PE), terminating any specialties that qualified the provider may result in termination of QP PE status.

12. Rendering provider's current name (please print):	13. Rendering provider's former name (required only for name changes):

14. Rendering provider's IHCP Provider ID (if currently enrolled):	15. Rendering provider's TIN (SSN for practitioners; EIN for organizations):	16. Date of birth (enter N/A if an organization):

17. Rendering provider's NPI:	18. Rendering provider's taxonomy codes:

19. Provider type (two-digit code):	20. Primary specialty (three-digit code):	21. Additional specialties (three-digit codes):

Group Service Location Linkage Information

A rendering provider may be linked to more than one service location. Also, because rendering providers can perform services across state lines for groups that are in multiple states, the license number for each service location is required. If all the service locations are in the same state, fill in the license number one time and indicate "same" for the remaining linkage lines. When requesting a retroactive start date, you must submit proof to support the retroactive date requested.

22a. Group service location NPI/ Provider ID	22b. ZIP+4 for service location (nine digits required)	22c. Requested start date at service location	22d. Termination date at service location	22e. Rendering provider Medicare number for service location	22f. Rendering provider license number for service location	22g. Issuing state of license at service location

Licensure/Certification

The licensing or certification requirements for all rendering provider types are listed in the *IHCP Provider Enrollment Type and Specialty Matrix* at in.gov/medicaid/providers. A copy of the license or certificate from the appropriate board or authority must be included as an attachment to the packet.

Out-of-State Telemedicine

Certain out-of-state providers can perform telemedicine services without having to fulfill the out-of-state prior authorization requirement. Check the **Subtype Telemedicine** box if all the following apply:

- The provider is located outside Indiana.
- The enrollment is for one of the following IHCP provider types:
  - 09 – *Advanced Practice Registered Nurse*
  - 10 – *Physician Assistant*
  - 14 – *Podiatrist*
  - 18 – *Optometrist*
  - 31 – *Physician*
- The provider has a license issued from the **Indiana Professional Licensing Agency** (IPLA) with the **Telemedicine Provider Certification**. (A copy must be attached to this packet.)

23. Telemedicine indicator:

☐ Subtype Telemedicine

Out-of-State Questionnaire

- The IHCP has designated certain areas outside of Indiana to be treated as "in-state" for the purposes of prior authorization. For a list of applicable counties and ZIP Codes, refer to the *Out-of-State Areas Designated as In-State for IHCP Providers* spreadsheet, available at in.gov/medicaid/providers.
- Out-of-state providers **not** located in an area designated as in-state may still claim in-state enrollment under the circumstances identified in this questionnaire. **Supporting documentation is required.**
- Some provider types and specialties are **excluded** from enrollment in the IHCP if they are located outside of Indiana. To confirm whether a particular provider type or specialty is eligible out-of-state enrollment, see the *IHCP Provider Enrollment Type and Specialty Matrix* at in.gov/medicaid/providers.

24. Circumstances qualifying out-of-state providers for in-state enrollment status:

If you are providing services out of state and are not located in an area designated for in-state enrollment, you may still claim in-state enrollment if you are providing services under one of the following circumstances (please select all circumstances that apply and **attach applicable documentation** to this application):

☐ To increase access to medically necessary services in areas where the distance to an in-state facility would subject the member, or member's family, to significant financial hardship or create an unnecessary significant burden on the Medicaid member.

☐ To allow members to retain a primary medical provider or obtain specialty services from a facility, such as centers for excellence, when the care may not be available from an in-state provider or would require significant hardship due to geographic location.

☐ Transportation to an appropriate Indiana facility would cause significant undue expense or hardship to the member or the office.

☐ To address an emergency health crisis.

Additional Programs Requested

This packet is for enrollment to serve traditional Medicaid members and is the first step in the process of enrollment to serve members in the managed care programs. You may also use this packet to be considered for enrollment as a provider in other IHCP programs, serving particular member populations. Please indicate if you are interested in enrolling as a provider in one or more of the following programs:

- The **590 Program** is a state medical assistance program providing reimbursement for medically necessary covered medical services provided at off-site facilities to individuals who reside in state institutions. The following provider types cannot be 590 providers: transportation, hospice, home health, durable medical equipment (DME) and long-term care facilities. Out-of-state providers cannot enroll as 590 providers.
- The **Medical Review Program** provides determination of an applicant's eligibility for Medicaid under the disability category. A provider enrolled in the Medical Review Program is authorized to complete a medical assessment of an applicant and submit the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT issues a favorable or unfavorable eligibility decision based on medical evidence that supports whether the applicant has a significant impairment. After the documentation has been filed, the provider may submit claims for payment of certain examinations and reports. There are two options for participation in the Medical Review Program:
  - **Medical Review Program/IHCP** – Providers that elect to enroll as an IHCP provider and choose to provide MRT assessment services.
  - **Medical Review Program Only** – Providers that do not elect to enroll in the IHCP but choose to provide MRT assessment services only.

25. 590 Program participation:

☐ Yes ☐ No

26. Participate in the Medical Review Program:

☐ Medical Review Program/IHCP
☐ Medical Review Program Only
☐ None

Languages

27. Languages:

List all languages available, and indicate if the language is spoken and/or translated. **At least one language must be listed as spoken.**

Language	Spoken	Translated
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Gender and Ethnicity

28. Gender:

☐ Male ☐ Female ☐ Prefer Not to Answer

29. Ethnicity:

☐ African American/Black
☐ Asian
☐ Caucasian/White
☐ Hispanic/Latino
☐ Native American
☐ Pacific Islander
☐ Other
☐ Prefer Not to Answer

Mental Health and Substance Use Disorder Services

The two following questions are required only for providers enrolling under provider type 11 – *Behavioral Health Provider*.

30. Do you provide substance use disorder (SUD) services?

☐ Yes ☐ No

31. Do you provide mental health services?

☐ Yes ☐ No

Pharmacist Training Attestation

The following question is required for rendering providers enrolling under provider specialty 241 – *Pharmacist*.

32. Pharmacist training attestation:

I attest to having completed the applicable training requirements related to the scope in which I intend to practice.

☐ Yes ☐ No

Managed Care Information

After you are enrolled as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's managed care programs, you must apply directly with one or more of the managed care entities (MCEs). See the *Enrolling as a Managed Care Program Provider* webpage at in.gov/medicaid/providers for information about the MCEs with which the state contracts.

| Schedule B

IHCP Rendering Provider Enrollment and Profile Maintenance Packet | in.gov/medicaid/providers

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Contact Information

- The contact name and email relate to the person who can answer questions about the information provided in this packet.
- Providers will be signed up to receive email notifications when new information is published to in.gov/medicaid/providers. Enter the email address where these notifications should be sent.
- Email addresses will be used for IHCP business only and will not be sold or shared for other purposes.

1. Contact name:	2. Title:
3. Contact email address:	4. Contact telephone:

5. Preferred method of communication:

☐ Email ☐ Phone ☐ Mail

IHCP Provider Signature Authorization

The owner or an authorized official of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. Both the authorized official and the rendering provider must sign this section. A delegated administrator may sign this form as the authorized official if it has been expressly indicated on an *IHCP Delegated Administrator Addendum/Maintenance Form*, on file or attached. The IHCP can process provider maintenance requests only when the appropriate signatures are present. The form will be returned if the appropriate signatures are not submitted.

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 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.

5. Group or clinic's business name (please print):	6. Group/clinic taxpayer identification number (TIN):
7. Authorized official's name (please print):	8. Title:
9. Authorized official's signature:	10. Date:
11. Rendering provider's name (please print):	12. TIN (SSN for practitioners; EIN for organizations):
13. Rendering provider's signature:	14. Date:

To enroll multiple rendering providers, complete a separate *IHCP Rendering Provider Enrollment and Profile Maintenance Packet* for each.

Overview

The Rendering Provider Agreement details the requirements for participation in the Indiana Health Coverage Programs (IHCP). Included are provider responsibilities regarding updating provider information and protecting patient health information as well as requirements for claim processing, overpayments and record retention. In addition, the Agreement details obligations regarding the appeals process; civil rights regulation compliance; and utilization, control and disclosure rules. The entire Agreement must be read, signed and returned with the application. A signed copy must be retained by the provider.

Rendering Provider Agreement

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This agreement must be completed, signed, and returned to the IHCP for processing.

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs ("IHCP"). As an enrolled provider in the IHCP, the undersigned entity agrees to provide covered services and/or supplies to Indiana Health Coverage Program members ("members"). As a condition of enrollment, this agreement cannot be altered and the Provider agrees to all of the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("FSSA").
2. To comply with all federal and state statutes and regulations pertaining to the IHCP, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.
4. To notify FSSA or its agent within ten (10) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.
5. To provide covered services and/or supplies for which federal financial participation is available for members pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about members including at a minimum:
   a. members' name, address, and social and economic circumstances;
   b. medical services provided to members;
   c. members' medical data, including diagnosis and past history of disease or disability;
   d. any information received for verifying members' income eligibility and amount of medical assistance payments;
   e. any information received in connection with the identification of legally liable third party resources.
7. To release information about members only to the FSSA or its agent and only when in connection with:
   a. providing services for members; and
   b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of IHCP covered services.
8. To maintain a written contract with all subcontractors, which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.
9. To notify the IHCP in writing of the name, address, and phone number of any entity acting on Provider's behalf for electronic submission of Provider's claims. Provider understands that the State requires 30 days prior written notice of any changes concerning Provider's use of entities acting on Provider's behalf for electronic submission of Provider's claims and that such notice shall be provided to the IHCP.
10. To submit claims, using only the billing number assigned to it by FSSA or its fiscal agent, for services rendered by the Provider or employees of the Provider and not to submit claims for services rendered by contractors unless the provider is a healthcare facility (such as hospital, ICF-IID, or nursing home), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide services covered by the IHCP pursuant to this Agreement.
11. To abide by the state's *Medical Policy Manual* and *IHCP Provider Reference Modules* as amended from time to time, as well as all provider bulletins, banner pages, and notices. Any amendments to the policy manual or reference modules, including provider bulletins, banner pages, and notices, will be communicated on the official state Medicaid website and shall be binding upon publication.
12. To update and maintain a current service location address as required.
13. To submit timely billing on IHCP-approved electronic or paper claims, as outlined in the policy manual, reference modules, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

Rendering Provider Agreement

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14. To certify that any and all information contained on any IHCP billings submitted on the Provider's behalf by electronic, telephonic, mechanical, or standard paper means of submission shall be true, accurate, and complete. The Provider accepts total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (whether by the Provider, the Provider's employees, agents, or a third party acting on the Provider's behalf, such as a service bureau). The Provider fully recognizes that any billing intermediary or service bureau that submits billings to the FSSA or its fiscal agent contractor is acting as the Provider's representative and not that of the FSSA or its fiscal agent contractor. The Provider further acknowledges that any third party that submits billings on the Provider's behalf shall be deemed to be the Provider's agent for the purposes of submission of the IHCP claims. The Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable federal and state laws.
15. The Provider understands that the standard paper claim form may include a signature line. The Provider understands that all the stipulations, conditions, and terms of the provider agreement apply in the event that the Provider fails, for any reason, to sign the paper claim, even if the claim is approved for payment. The Provider agrees that payment of a paper claim that does not contain the Provider's signature in no way absolves the Provider of the terms stated in the provider agreement.
16. To submit claim(s) for IHCP reimbursement only after first exhausting all other sources of reimbursement as required by the policy manual, reference modules, bulletins, and banner pages.
17. To submit claim(s) for IHCP reimbursement utilizing the appropriate claim forms specified in the policy manual, reference modules, bulletins, banner pages, and notices.
18. To submit claims that can be documented by Provider as being strictly for:
    a. medically necessary medical assistance services;
    b. medical assistance services actually provided to the person in whose name the claim is being made; and
    c. compensation that Provider is legally entitled to receive.
19. To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for IHCP covered services provided to members. Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for IHCP covered services, excluding any co-payment permitted by law.
20. To refund duplicate or erroneous payments to FSSA or its fiscal agent within fifteen (15) days of receipt.
21. To make repayments to FSSA or its fiscal agent, or arrange to have future payments from the IHCP withheld, within sixty (60) days of receipt of notice from FSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. Outstanding overpayments made under prior provider agreements will remain collectable under this provider agreement.
22. To pay interest on overpayments in accordance with *Indiana Code (IC) 12-15-13-3, IC 12-15-21-3*, and *IC 12-15-23-3*.
23. To make full reimbursement to FSSA or its fiscal agent of any federal disallowance incurred by FSSA when such disallowance relates to payments previously made to Provider under the IHCP.
24. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
25. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of IHCP payments made to Provider, to assure the proper administration of the IHCP and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 Indiana Administrative Code (IAC) 1-5* and in the policy manual, reference modules, bulletins, and banner pages, and shall include, without being limited to, the following:
    a. medical records as specified by *42 United States Code (USC) 1396(a)(27)*, and any amendments thereto;
    b. records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs, or services;

c. any records determined by FSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the IHCP;

d. documentation in each patient's record that will enable the FSSA or its agent to verify that each charge is due and proper;

e. financial records maintained in the standard, specified form;

f. all other records as may be found necessary by the FSSA or its agent in determining compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the FSSA; and

g. any other information regarding payments claimed by the provider for furnishing services to the plan.

26. To cease any conduct that FSSA or its representative deems to be abusive of the IHCP.

27. To promptly correct deficiencies in Provider's operations upon request by FSSA or its fiscal agent.

28. To make a good faith effort to provide and maintain a drug-free workplace. Provider will give written notice to the State within ten (10) days after receiving actual notice that the provider or an employee of the provider has been convicted of a criminal drug violation occurring in the provider's workplace.

29. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:

    a. the petitioner is the person to whom the order is specifically directed;

    b. the petitioner is aggrieved or adversely affected by the order; or

    c. the petitioner is entitled to review under the law.

30. Provider must file a statement of issues within the time limits listed below, setting out in detail:

    a. the specific findings, actions, or determinations of FSSA from which the Provider is appealing; and

    b. with respect to each finding, action, or determination, all statutes or rules supporting the Provider's contentions of error and why the Provider believes that the office's determination was in error.

31. Time limits for filing an appeal and the statement of issues are as follows:

    a. A provider must file an appeal of any of the following actions within sixty days of receipt of FSSA's determination:

        (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.

        (2) A notice of overpayment.

    The statement of issues must be filed with the request for appeal.

    b. All appeals of actions not described in (a) must be filed within 15 days of receipt of FSSA's determination. The statement of issues must be filed within 45 days of receipt of FSSA's determination.

32. To cooperate with FSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

33. To comply with the advance directives requirements as specified in *42 Code of Federal Regulations (CFR) Part 489, Subpart I*, and *42 CFR 417.436(d)*, as applicable.

34. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of an IHCP covered service.

35. The Provider and its agents shall abide by all ethical requirements that apply to persons who have a business relationship with the State, as set forth in *IC § 4-2-6 et seq.*, *IC § 4-2-7, et seq.*, the regulations promulgated thereunder, and *Executive Order 04-08*, dated April 27, 2004. If the Provider is not familiar with these ethical requirements, the Provider should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission Web site at http://www.in.gov/ethics/. If the Provider or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Agreement immediately upon notice to the Provider. In addition, the Provider may be subject to penalties under *IC § 4-2-6, IC 4-2-7, IC 35-44-1-3*, and under any other applicable laws.

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36. To disclose information on ownership and control, information related to business transactions, information on change of ownership, and information on persons convicted of crimes in accordance with *42 CFR, Part 455, Subpart B*, and *405 IAC 1-19*. Long term care providers must comply with additional requirements found in *405 IAC 1-20*. Pursuant to *42 Code of Federal Regulations, part 455.104(c)*, OMPP shall terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
37. To submit within 35 days of the date of request by the federal or state agency full and complete information about:
    a. ownership of subcontractors with whom the provider has had more than $25,000 in a twelve month hearing period;
    b. any significant business transactions between the provider and any wholly owned supplier; and
    c. any significant business transactions between the provider and any subcontractor, during five-year period ending with the date of request.
38. To furnish to FSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in the IHCP Provider Application and maintenance forms, which are incorporated here by reference, and to update this information as it may be necessary.
39. The effective date of this Agreement will be the date set out in the provider enrollment notification letter. This Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider. This Agreement shall remain in effect until terminated in accordance with item 40 below.
40. That this Agreement may be terminated as follows:
    a. By FSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by FSSA pursuant to *405 IAC 1-1-6*; or
    b. By FSSA or its fiscal agent, or by Provider, without cause upon 60 days' written notice.
41. For long term care providers involved in a change of ownership, this agreement acts as an amendment to the transferor's agreement with IHCP to bind the transferee to the terms of the previous agreement; and any existing plan of correction and pending audit findings in accordance with *405 IAC 1-20*.
42. New owners of nursing facilities or intermediate care facilities for the intellectually disabled, must accept the assignment of the provider agreement executed by the previous owner(s) as required by *42 CFR 442.14.*
43. For any entity that receives or makes annual payments totaling at least $5,000,000 annually as described in *42 U.S.C. 1396a(a)(68)*, shall add written policies to their employee handbook that provide detailed information about federal and state False Claims Acts, whistleblower protections, and entity policies and procedures for preventing and detecting fraud and abuse. In any inspection, review, or audit of the entity by FSSA or its contractors, the entity shall provide copies of the entity's written policies regarding fraud, waste, and abuse upon request. Entity shall submit to FSSA a corrective action plan within 60 days if the entity is found not to be in compliance with any part of the requirements stated in this paragraph.
44. To verify and maintain proof of verification that no employee or contractor is an excluded individual or entity with the Health and Human Services (HHS) Office of the Inspector General (OIG). Providers shall review the HHS-OIG List of Excluded Individuals/Entities (LEIE) database for excluded parties. This LEIE database is accessible to the general public at http://www.oig.hhs.gov/fraud/exclusions.asp.
45. To allow FSSA and its representatives to perform safety inspections of motor vehicles used for transportation services of Medicaid recipients. The Provider shall require all of its contractors and subcontractors to agree to the same.
46. To receive email updates and communication from IHCP at the email address(es) provided on its enrollment application. Providers may opt-out of receiving these email communications by clicking the link found at the bottom of each email following the message prompts. Opting out does not affect the provider's obligation to stay abreast of IHCP updates and communications as required by this agreement.

AS A CONDITION OF PAYMENT AND CONTINUED ENROLLMENT IN THE IHCP THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, 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 INDIANA HEALTH COVERAGE PROGRAM 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.

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Rendering Provider Agreement Authorized Signature – All Schedules and Addenda as applicable

The owner or an authorized representative of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. This Agreement must be signed by both the authorized representative of the business entity and the rendering provider. A delegated administrator may not sign this form.

For the group or clinic's taxpayer identification number (tax ID), use the business' federal employer identification number (EIN). For the rendering provider's tax ID, use the practitioner's Social Security number (SSN) (or, if the rendering provider is an organization, use its EIN).

Group or clinic's business name (please print):	Tax ID:
Authorized official's name (please print):	Title:
Authorized official's signature:	Date:
Rendering provider's name (please print):	Tax ID (SSN for practitioners; EIN for organizations):
Rendering provider's signature:	Date:

| Addendum

IHCP Rendering Provider Screening Addendum

Version 1.0, Oct. 9, 2025 Page 1 of 1

in.gov/medicaid/providers

Overview

Federal and state laws require that Indiana Health Coverage Programs (IHCP) providers in the **high-risk category** submit to Medicaid fingerprint background checks. To determine the risk category associated with a given provider type/specialty, refer to the *IHCP Provider Enrollment Risk Category and Application Fee Matrix*.

Please note that the risk level assignment of an individual provider may be increased at any time at the discretion of the state. In these instances, the provider is notified by the IHCP, and the new risk level will apply to processing enrollment-related transactions.

If a rendering practitioner is assigned to the high-risk category, this addendum must be submitted with their IHCP provider packet when enrolling by mail. This form must include the rendering practitioner's name, date of birth and Social Security number, as well as the confirmation number they received at the fingerprint collection center as proof of compliance. For more information, including instructions for obtaining a Medicaid fingerprint background check, see the *Provider Enrollment Risk Levels and Screening* webpage.

High-Risk Rendering Practitioner Information

1. Legal name of practitioner:	2. Date of birth:
3. Social Security number:	4. Fingerprint confirmation number:

Group Provider Information

5. Group provider name:		6. Group NPI:	
7. Service location address:	8. City:	9. State:	10. ZIP+4 (nine digits):

Contact Information

11. Contact name (individual who can answer questions about the information on this form):	
12. Contact telephone number:	13. Contact email address:

| Addendum

IHCP MRO Clubhouse Provider Enrollment Addendum

Version 2.2, April 26, 2021

in.gov/medicaid/providers

Overview

This addendum must be completed by behavioral health providers with a provider specialty **613 – MRO Clubhouse.**

The purpose of this addendum is to provide the Indiana Health Coverage Programs (IHCP) with information about the rendering clubhouse provider that will be providing psychosocial rehabilitation services. The rendering clubhouse provider must:

- Be certified by the Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DHMA).
- Be enrolled as an IHCP rendering provider linked to a DMHA-approved IHCP-enrolled Medicaid Rehabilitation Option (MRO) provider.

A copy of the DMHA certification must be attached to this addendum and included with the enrollment packet.

Please complete all sections of this form. Nonprofit providers must provide information for the business entity that owns their taxpayer identification number (TIN).

Disclosure Information
When completing this form to make changes to the list of disclosed individuals, make sure to include the names of **all** individuals that meet the disclosure requirements, even if the individuals had been previously disclosed. When an update is processed, any previously disclosed individuals that are not shown on the update form will be removed. In other words, the previous list of disclosed individuals will be **replaced** with the updated list of disclosed individuals.

Disclosure of Social Security Numbers
This addendum is used to collect information required by state and federal regulations. Social Security numbers disclosed on this form are used to determine whether persons and entities named in an enrollment packet are federally excluded parties. Refusal to provide a Social Security number will result in rejection of this enrollment packet.

Consent to Release Social Security Numbers
Submission of information on this schedule indicates that consent has been given to the Indiana FSSA and its contractors to use the information, including the Social Security number, for the sole purpose of verifying eligibility to participate in the Medicaid program through the Office of the Inspector General, the Centers for Medicare & Medicaid Services, relevant licensing bodies and other appropriate state and federal agencies. It is further understood that the FSSA and its contractors may use a Social Security number so the office may determine eligibility for continued participation in the Medicaid program.

This addendum must be submitted with your *IHCP Rendering Provider Enrollment and Profile Maintenance Packet*.

General Information

1. Community mental health center (CMHC) provider name	2. CMHC taxpayer identification number (TIN)
3. Contracting clubhouse provider name	4. Clubhouse taxpayer identification number (TIN)

Signature

I certify the information stated on this addendum is correct and complete to the best of my knowledge. I further certify that I am an authorized official of the MRO Clubhouse provider and have authority to provide and attest to the information listed on this addendum.

5. Authorized official's name (please print)	6. Title
7. Authorized official's signature	8. Date

Individuals with an Ownership or Control Interest and Managing Individuals

Please list **all** individuals with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers and government-owned businesses must also list their managing individuals: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of the provider entity.

Include each person's name, address, date of birth and Social Security number. Also indicate the title (for example, chief executive officer, owner, board member) and, if an owner, the percent of ownership. Attach additional pages as needed.

1a. Name of individual			
2a. Address			
3a. Title	4a. % of ownership (if applicable)	5a. Social Security number	6a. Date of birth
1b. Name of individual			
2b. Address			
3b. Title	4b. % of ownership (if applicable)	5b. Social Security number	6b. Date of birth
1c. Name of individual			
2c. Address			
3c. Title	4c. % of ownership (if applicable)	5c. Social Security number	6c. Date of birth
1d. Name of individual			
2d. Address			
3d. Title	4d. % of ownership (if applicable)	5d. Social Security number	6d. Date of birth
1e. Name of individual			
2e. Address			
3e. Title	4e. % of ownership (if applicable)	5e. Social Security number	6e. Date of birth
1f. Name of individual			
2f. Address			
3f. Title	4f. % of ownership (if applicable)	5f. Social Security number	6f. Date of birth
1g. Name of individual			
2g. Address			
3g. Title	4g. % of ownership (if applicable)	5g. Social Security number	6g. Date of birth

Relationships and Background Information

Attach additional copies of this page if space is needed for additional names.

1. Indicate whether any of the individuals listed are related through blood or marriage, or as spouse, parent, child or sibling. Use N/A as appropriate.

1a. Name of person 1	Name of person 2	Relationship
1b. Name of person 1	Name of person 2	Relationship
1c. Name of person 1	Name of person 2	Relationship

2. Indicate whether any persons or entities listed, or any secured creditors of the provider entity, have ever been sanctioned through criminal conviction or exclusion from participation in any program under Medicare, Medicaid or Title XX services since the inception of the programs.

2a. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction		Date sanction ended (please attach supporting documentation)
2b. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction		Date sanction ended (please attach supporting documentation)
2c. Name	NPI or IHCP Provider ID	Date of sanction
Type of sanction		Date sanction ended (please attach supporting documentation)

3. Indicate if any persons or entities listed, or any secured creditors of the provider entity, have ever been placed on prepayment review.

3a. Name	NPI or IHCP Provider ID
3b. Name	NPI or IHCP Provider ID
3c. Name	NPI or IHCP Provider ID

4. Indicate if any persons or entities listed have an ownership or controlling interest in any other current or prospective IHCP provider.

4a. Name	NPI or IHCP Provider ID
4b. Name	NPI or IHCP Provider ID
4c. Name	NPI or IHCP Provider ID

5. Indicate any former agent, officer, director, partner or managing employee who has transferred ownership to a family member (spouse, parent, child or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion.

5a. Name of person 1	Name of person 2	Relationship
5b. Name of person 1	Name of person 2	Relationship
5c. Name of person 1	Name of person 2	Relationship