# IHCP School Corporation 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

You should use this packet if you are a provider type 12 – *School Corporation*.

## General Instructions

This enrollment and maintenance packet can be used for the following tasks:

- **Enrolling in the Indiana Health Coverage Programs (IHCP) for the first time** – Complete all fields in each section unless a section is optional and does not apply to you.
- **Submitting a change of ownership (CHOW) –** Complete all fields in each section, unless a section is optional and does not apply to you.
- **Revalidating your current enrollment in the IHCP** – Complete all fields in each section unless a section is optional and does not apply to you.
- **Making updates to information about your business (known as your *provider profile*)** – Do not complete the entire packet; complete and submit only the pages of the packet and the supporting documentation that apply to the update. Only the following sections are required when using the packet to update your profile:
    - Schedule A – *Type of Request*
    - Schedule A – *Provider Information*
    - Schedule A – *Contact Information*
    - *IHCP Provider Signature Authorization Addendum*
    - Any section where the information has changed; if the information in a section has not changed, leave the section blank. For example, if the mailing address has changed but the pay-to address has not, complete the mailing address section and leave the pay-to address blank.

## Provider Profile Updates and Revalidations

Providers that use the IHCP Provider Healthcare Portal (accessible from the homepage at in.gov/medicaid/providers) to revalidate their enrollment or 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 Portal to make profile changes.

## Tips for Completing This Packet

- Read the instructions in each section of the packet carefully.
- Required addenda are included with this packet and must be submitted with the packet.
- 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 screen. 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.

| Provider Use Only | Quality Checklist |
|---|---|
| ☐ | **If you are enrolling for the first time, submitting a change of ownership, or revalidating your enrollment:** Double-check that ***all sections*** of this packet, and all required addenda, have been completed and signed. If a question or section is not applicable, you should indicate N/A to attest that it does not apply. |
| | **If you are updating your existing provider profile:** Do not complete the entire packet; double-check that the following sections, and ***only these sections***, have been completed:<br>☐ Schedule A – Type of Request<br>☐ Schedule A – Provider Information<br>☐ Schedule A – Contact Information<br>☐ *IHCP Provider Signature Authorization Addendum*<br>☐ Any section where the information has changed (If the information in a section has not changed, leave the section blank.)<br>Submit only the pages of the packet and the supporting documentation that apply to the update. |
| ☐ | Make sure you have attached a completed **current *Form W-9*** from the Internal Revenue Service (IRS) website at irs.gov. Failure to use the most current version of *Form W-9* available at the time of submission may result in the application being returned to the provider. |
| ☐ | Double-check that the service location name, or doing business as (DBA) name, in the ***Service Location Name and Address*** section of Schedule A **exactly** matches the business name on the attached *W-9* form (see line 2 of the *W-9)*. |
| ☐ | Double-check that the name and address in the ***Provider Name and Address (As Entered on the W-9)*** section of Schedule A **exactly** match the information on the attached *W-9* form (see lines 1, 5 and 6 of the *W-9)*. |
| ☐ | Double-check that the **Provider Agreement** has been signed by an owner or authorized official of the business who is directly or ultimately responsible for operating the business and who is listed on Schedule C.<br>(Note: If the person named as the delegated administrator is not reported as having ownership or controlling interest, that person cannot sign the Provider Agreement.) |
| ☐ | Double-check that the required addenda, as applicable, are completed and included with the packet.<br>☐ *IHCP Provider Signature Authorization Addendum (all)*<br>☐ *IHCP Provider Agreement* (all)<br>☐ Current version of the Federal *W-9* Form (all)<br>☐ *IHCP Provider Application Fee Addendum* (all)<br>☐ *IHCP Provider Screening Addendum* (as applicable)<br>☐ *IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form* (as applicable)<br>☐ *IHCP Provider Change of Ownership Addendum* (as applicable)<br>☐ *IHCP Provider Delegated Administrator Addendum/Maintenance Form* (as applicable) |
| ☐ | If you are required to remit an application fee to the IHCP, include the electronic payment confirmation number on the ***IHCP Provider Application Fee Addendum***. For more information, see the *Provider Enrollment Application Fee* webpage at in.gov/medicaid/providers. |

| | |
|---|---|
| ☐ | 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. |
| ☐ | If you are registered with the Secretary of State or the county recorder's office, please include documentation as an attachment to the packet. |
| ☐ | If you are submitting the ***IHCP Electronic Funds Transfer Addendum/Maintenance Form***, double-check to ensure that all fields have been completed appropriately; that the account number and routing numbers are correct; and that the *Authorized Signature* section has been signed by an authorized official or owner of the billing provider or a delegated administrator. |
| ☐ | If you are completing this packet to report a **change of ownership (CHOW)**, complete the ***IHCP Provider Change of Ownership Addendum*** and include a copy of the purchase or sales agreement as an attachment to the packet. |

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 correcting 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 corrected, completed and submitted before the IHCP can process your enrollment transaction. If an application is rejected for missing or incomplete information, a letter will be sent indicating what needs to be corrected or attached; you must include a copy of this 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.

# IHCP School Corporation Provider Enrollment and Profile Maintenance Packet

in.gov/medicaid/providers

## Type of Request

1.Type of request

This packet is used for multiple purposes; select the purpose that applies:

- ☐ **New Enrollment** – You are enrolling in the IHCP for the first time.
- ☐ **Change of Ownership** – The ownership of your business has changed.
- ☐ **Revalidate Enrollment** – You received a letter indicating you must revalidate your IHCP enrollment.
- ☐ **Profile Update** – You are already enrolled in the IHCP and you need to change your provider profile information.

## Provider Information

The **taxonomy code** requested in field 4 is the taxonomy associated with the NPI in field 2. 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 look-up tool at taxonomy.nucc.org.

| 2. National Provider Identifier (NPI): | 3. ZIP+4 (nine digits required): | 4. Taxonomy code: |
|---|---|---|
| 5a. Are you currently enrolled as an IHCP provider? ☐ Yes ☐ No | 5b. If yes, what is your IHCP Provider ID? | |
| 6a. Were you previously enrolled as an IHCP provider? ☐ Yes ☐ No | 6b. If yes, what was your previous IHCP Provider ID? | |

## 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.

| 7. Contact name: | 8. Title: |
|---|---|
| 9. Contact email address: | 10. Contact telephone: |

11. Preferred method of communication:

☐ Email ☐ Phone ☐ Mail

## Service Location Name and Address

- The service location is generally 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.
  - **School corporations should use their school corporation name as the service location name.**
  - The service location address must be a physical location. A post office box is not a valid service location address.
- If you are using this packet to update a service location name currently on file with the IHCP, the following apply:
  - 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 name change is required.
  - If the same change applies to both your provider name (see the *Provider Name and Address* section) and your service location/DBA name, one set of attached documents will support both changes.

| 12. Service location (DBA) name (must be the same as the school corporation provider name entered in field 21): | | |
|---|---|---|
| 13. Indiana county (Indiana providers): | | 14. Telephone: |
| 15. Service location street address: | | |
| 16. City: | 17. State: | 18. ZIP+4 (nine digits required): |
| 19. Is claim documentation kept at this location? ☐ Yes ☐ No | 20. Are services provided in Indiana? ☐ Yes ☐ No | |

## Provider Name and Address (As Entered on the W-9)

- The name, address and taxpayer identification number (TIN) entered in this section must **exactly match** the information reported on the *W-9* form attached to your IHCP enrollment.
- In this section, the provider name is considered to be the entity maintaining ownership of the business. The provider name must be the name in line 1 of the current *W-9* form, which is the name on the tax return on which the income should be reported.
- The provider address is the address of the entity that maintains ownership of the business for tax purposes. For most providers, the provider address is the home office address.
- If you are using this packet to **update** your provider name or address currently on file with the IHCP, the following apply:
  - You **must** include a revised *W-9* form as an attachment to the packet.
  - For a personal name change, attach 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 name change is required. If the provider name changes on the *W-9* form, a new *W-9* must be submitted.
  - If the same change applies to both your provider name and your service location/DBA name, one set of attached documents will support both changes.

| 21. Provider name (as it appears on the *W-9*): | | |
|---|---|---|
| 22. Provider street address (as it appears on the *W-9*): | | |
| 23. City: | 24. State: | 25. ZIP+4 (nine digits required): |
| 26. Telephone: | 27. Current TIN: | 28. Former TIN (required only for reporting TIN change): |

## Mailing Name and Address

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

| 29. Mail-to name (addressee): | | 30. Telephone: |
|---|---|---|
| 31. Mailing street address: | | |
| 32. City: | 33. State: | 34. ZIP+4 (nine digits required): |

## Pay-To Name and Address

- The pay-to address is where the IHCP sends checks and general claim-payment information. If this is a billing agent's address, provide the name, address and phone 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.**

| 35. Pay-to name (payee): | | |
|---|---|---|
| 36. Billing agent name (if applicable): | | 37. Pay-to telephone: |
| 38. Pay-to street address: | | |
| 39. City: | 40. State: | 41. ZIP+4 (nine digits required): |

## Provider Specialty Information

- See the *IHCP Provider Enrollment Type and Specialty Matrix* at in.gov/medicaid/providers to determine the appropriate supporting documentation requirements for enrollment.
- The School Corporation provider type is 12 and the specialty is 120.
- **Taxonomy codes** identify a healthcare provider type and specialty. The NUCC provides an online lookup tool for the complete taxonomy code set at taxonomy.nucc.org. You may enter up to 15 taxonomies; enter only those that apply to this service location.

| 42. Provider type (two-digit code): | 43. Primary specialty (three-digit code): |
|---|---|
| **12** | **120** |
| 44. Taxonomy codes associated with this specialty and used for billing: | |

## Languages

45. 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 |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

## Accessibility Information

46. Are you accepting new Medicaid patients at this practice? ☐ Yes ☐ No

47. Does your practice have a website? ☐ Yes ☐ No

If yes, provide website URL:

48. Does your practice offer telehealth services? ☐ Yes ☐ No

49. Does your practice offer American Sign Language? ☐ Yes ☐ No

50. Is your practice ADA accessible? ☐ Yes ☐ No

If yes, select any of the following accommodations provided by your office or facility:

- ☐ Accessible examination rooms
- ☐ Accessible exam tables
- ☐ Accessible chairs
- ☐ Patient lifts
- ☐ Floor lifts
- ☐ Overhead track lifts
- ☐ Accessible radiologic equipment
- ☐ Accessible mammography equipment
- ☐ Accessible scales

# IHCP School Corporation Provider Enrollment and Profile Maintenance Packet

in.gov/medicaid/providers

## Organizational Structure

- If your business is chain-affiliated, the information about the company or organization must be included in the disclosure information in Schedule C.
- If your business is operated by a management company or leased (in whole or in part) by another organization, information about the management company or organization must be included in the disclosure information in Schedule C.
- See the IRS website for instructions about reporting disregarded entity status.

1. Provider entity legally organized and structured as (check only one) (this must match the information provided on the attached *W-9*):

☐ Individual/sole proprietor
☐ C Corporation
☐ S Corporation
☐ Partnership
☐ Trust/estate
☐ Limited liability company; select tax classification:
☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Reset
☐ Other (please explain; see instructions on Federal *W-9* form):

2. Registered with Secretary of State? (Entities doing business in Indiana, except for informal associations such as sole proprietorships or general partnerships, must be registered with the Secretary of State. Go to www.in.gov/sos/ to find out how to complete the registration process.)
☐ Yes ☐ No

| 3. Date business started: | 4. Entity incorporated? ☐ Yes ☐ No | 5. Incorporation date (if answered yes in 4): |
|---|---|---|

| 6. Chain affiliated? ☐ Yes ☐ No | 7. Operated by management company or leased (whole or part) by another organization? ☐ Yes ☐ No |
|---|---|

8. Are you a charter school?
☐ Yes ☐ No

## Other IHCP Program Participation

This packet is for enrollment to serve Indiana Medicaid members. 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 **Medical Review Program** provides information to help determine 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 submits the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT issues favorable or unfavorable eligibility decisions, 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. Services should not be performed unless the applicant has presented the pre-Medicaid eligibility form. There are three options for participation in the Medical Review Program:
  - **Medical Review Program/IHCP** – Providers who elect to enroll in the IHCP and choose to provide MRT assessment services
  - **Medical Review Program Only** – Providers who do not elect to enroll in the IHCP but choose to provide MRT assessment services only
  - **Medical Review Program** – **Medical Records Only** – Providers who have been requested to supply MRT medical records only and want to bill for only those services

| 9. Participate in the 590 Program? | 10. Medical Review Program participation: |
|---|---|
| ☐ Yes ☐ No | ☐ Medical Review Program/IHCP<br>☐ Medical Review Program Only<br>☐ Medical Review Program – Medical Records Only<br>☐ None |

# IHCP Provider Schedule C – Disclosure Information

in.gov/medicaid/providers

## Overview

Please complete all four 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 schedule to make changes to the list of disclosed parties, be sure to include the names of all individuals and entities that meet the disclosure requirements, even if the individuals or entities had been previously disclosed. When an update is processed, any previously disclosed parties 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:** Schedule C 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 this form are federally excluded parties. Refusal to provide a Social Security number will result in rejection of this enrollment form.

**Consent To Release Social Security Numbers:** Submission of information on this schedule indicates that consent has been given to the Indiana Family and Social Services Administration (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.

## C.1 – Disclosure Information – Individuals and/or Corporations with an Ownership or Control Interest in the Applicant

**Section C.1.(A) – Individuals with an Ownership or Control Interest**

Please list **all** individuals with an ownership or control interest in the applicant. Include each person's name, address, date of birth and Social Security Number (SSN). Also indicate the title (e.g., chief executive officer, owner, board member) and if an owner, the percent of ownership. Attach additional pages as needed.

* Please refer to *42 CFR 455.101* for the definition of "person with an ownership or control interest" to ensure that all individuals are included. This should also include officers, directors, or partners as defined in sections *455.101(e)* and *(f)*.

| | | | |
|---|---|---|---|
| 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: |

**Section C.1.(B) — Corporations with an Ownership or Control Interest**

If a corporation, please list **all** corporations with an ownership or control interest in the applicant. Include the taxpayer identification number (TIN), the percent of ownership in the applicant, the primary business address, every business location, and P.O. Box address(es). Attach additional pages if needed.

| 1a. Name of corporation: | 2a. % of ownership: |
|---|---|
| 3a. Primary business address: | 4a. TIN: |
| 5a. Every business location: | 6a. P.O. Box address(es): |

| 1b. Name of corporation: | 2b. % of ownership: |
|---|---|
| 3b. Primary business address: | 4b. TIN: |
| 5b. Every business location: | 6b. P.O. Box address(es): |

| 1c. Name of corporation: | 2c. % of ownership: |
|---|---|
| 3c. Primary business address: | 4c. TIN: |
| 5c. Every business location: | 6c. P.O. Box address(es): |

**Section C.1.(B) – Corporations with an Ownership or Control Interest** (continued)

If a corporation, please list **all** corporations with an ownership or control interest in the applicant. Include the taxpayer identification number (TIN), the percent of ownership in the applicant, the primary business address, every business location, and P.O. Box address(es). Attach additional pages if needed.

| 1d. Name of corporation: | 2d. % of ownership: |
|---|---|
| 3d. Primary business address: | 4d. TIN: |
| 5d. Every business location: | 6d. P.O. Box address(es): |

| 1e. Name of corporation: | 2e. % of ownership: |
|---|---|
| 3e. Primary business address: | 4e. TIN: |
| 5e. Every business location: | 6e. P.O. Box address(es): |

| 1f. Name of corporation: | 2f. % of ownership: |
|---|---|
| 3f. Primary business address: | 4f. TIN: |
| 5f. Every business location: | 6f. P.O. Box address(es): |

## C.2 – Disclosure Information – Subcontractors

(Attach additional copies of this page if you need space for additional names.)

**Subcontractors** – Please list all subcontractors in which the applicant has a 5% or more ownership or control interest. Include any subcontractor and their address and taxpayer identification number (TIN). Attach additional pages as needed.

| Name of subcontractor | Address | TIN |
|---|---|---|
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## C.3 – Disclosure Information – Managing Individuals

(Attach additional copies of this page if you need space for additional names.)

**Managing Individuals** - List ALL agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers must also list their managing individuals.

- An agent is any person who has express or implied authority to obligate or act on behalf of the entity.
- An officer is any person whose position is listed as an officer in the provider's articles of incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing body.
- A director is a member of the provider's board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word director in his or her job title, such as director of operations or departmental director.
- A managing employee is 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.

| | | |
|---|---|---|
| 1a. Name of individual: | | |
| 2a. Address: | | |
| 3a. Title: | 4a. Social Security Number: | 5a. Date of birth: |
| 1b. Name of individual: | | |
| 2b. Address: | | |
| 3b. Title: | 4b. Social Security Number: | 5b. Date of birth: |
| 1c. Name of individual: | | |
| 2c. Address: | | |
| 3c. Title: | 4c. Social Security Number: | 5c. Date of birth: |
| 1d. Name of individual: | | |
| 2d. Address: | | |
| 3d. Title: | 4d. Social Security Number: | 5d. Date of birth: |
| 1e. Name of individual: | | |
| 2e. Address: | | |
| 3e. Title: | 4e. Social Security Number: | 5e. Date of birth: |
| 1f. Name of individual: | | |
| 2f. Address: | | |
| 3f. Title: | 4f. Social Security Number: | 5f. Date of birth: |

## C.4 – Disclosure Information – Relationships and Background Information

(Attach additional copies of this page if you need space for additional names.)

1. Are any parties listed in C.1 or C.3 related to each other as a spouse, parent, child, or sibling? If "Yes," please list their names and the relationship.

| Name of person 1 | Name of person 2 | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

2. Are any parties listed in C.1 or C.3 related to any individuals with an ownership or control interest in any of the subcontractors listed in C.2? If "Yes," please list their names and the relationship.

| Name of person 1 | Name of person 2 | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

3. Do any of the owners included in C.1. have an ownership or control interest in another organization(s) that would qualify as a disclosing entity?

*As defined under 42 CFR 455.101, "other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:*

*a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);*

*b) Any Medicare intermediary or carrier; and*

*c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.*

*Whereas "disclosing entity" is limited to Medicaid providers, "other disclosing entity" can include entities that are not enrolled in Medicaid.*

☐ Yes ☐ No

If yes, please list the name of each owner and the name of the other disclosing entity(ies) in which they have an ownership or control interest. If the entity is a non-profit organization and does not have any 'owners,' please check NA:

| Owner's name | Disclosing entity(ies) |
|---|---|
| | |
| | |
| | |
| | |

4. Please list any party with an ownership or control interest, or who is an agent or managing employee, who has ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid, or title XX services programs.

| Name of convicted party | Date of conviction |
|---|---|
| | |
| | |
| | |
| | |

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.

| Name of person 1 | Name of person 2 | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

| Addendum

# IHCP Provider Signature Authorization

in.gov/medicaid/providers

## Signature Authorization

**The owner or an authorized official of the business entity, directly or ultimately responsible for operating the business, is the authorized signatory of this form. A delegated administrator may sign this form if it has been expressly indicated on an *IHCP Delegated Administrator Addendum/Maintenance Form*, on file or attached.**

*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 therein. 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.*

| 1. Provider name (as it appears on the *W-9*): | 2. Taxpayer identification number (TIN): |
|---|---|
| 3. Authorized official's name: | 4. Title: |
| 5. Authorized official's signature: | 6. Date: |

| Overview

# IHCP Provider Agreement

in.gov/medicaid/providers

| IHCP Provider Agreement Overview |
|---|
| You must provide a completed and signed Provider Agreement in the following instances:<br>• If you are enrolling for the first time in the Indiana Health Coverage Programs (IHCP);<br>• If you are enrolling a new service location;<br>• If you are revalidating your enrollment with the IHCP;<br>• If you are reporting a change of ownership; or<br>• If you are changing your primary provider type.<br>In each of the above instances, a full enrollment packet, including a newly signed Provider Agreement must be submitted for processing. An owner or authorized official with your business must sign the *IHCP Provider Agreement*. An original signature is required. A delegated administrator must not sign this form. A new IHCP number (Provider ID) is assigned to each provider type enrolled in the IHCP.<br>The Provider Agreement details the requirements for participation in the 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, regulatory compliance, utilization controls, ownership and control, and disclosure rules. The entire agreement must be read, signed and returned with the packet. A signed copy must be retained by the provider. |

| Provider Agreement

IHCP Provider Agreement | in.gov/medicaid/providers

**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 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 the 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 the FSSA or its fiscal agent, for services rendered by Provider or employees of Provider and not to submit claims for services rendered by contractors unless Provider is a healthcare facility (such as hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities [ICD/IID]), 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 *IHCP Provider Reference Modules* as amended from time to time, as well as all provider bulletins and notices. Any amendments to the reference modules, including provider bulletins 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 reference modules and bulletins, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

14. To certify that any and all information contained on any IHCP billings submitted on Provider's behalf by electronic, telephonic, mechanical, or standard paper means of submission shall be true, accurate, and complete. 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 Provider, Provider's employees, agents, or a third party acting on Provider's behalf, such as a service bureau). Provider fully recognizes that any billing intermediary or service bureau that submits billings to the FSSA or its fiscal agent contractor is acting as Provider's representative and not that of the FSSA or its fiscal agent contractor. Provider further acknowledges that any third party that submits billings on Provider's behalf shall be deemed to be Provider's agent for the purposes of submission of the IHCP claims. 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.

    Provider understands that the standard paper claim form may include a signature line. Provider understands that all the stipulations, conditions, and terms of the provider agreement apply in the event that Provider fails, for any reason, to sign the paper claim, even if the claim is approved for payment. Provider agrees that payment of a paper claim that does not contain Provider's signature in no way absolves Provider of the terms stated in the provider agreement.

15. To submit claim(s) for IHCP reimbursement only after first exhausting all other sources of reimbursement as required by the reference modules and bulletins.

16. To submit claim(s) for IHCP reimbursement utilizing the appropriate claim forms specified in the reference modules, bulletins, and notices.

17. 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.

18. To accept as payment in full the amounts determined by the 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 anyone in the member's family, for any additional charge for IHCP covered services, excluding any copayment permitted by law.

19. To refund duplicate or erroneous payments to the FSSA or its fiscal agent within fifteen (15) days of receipt.

20. To make repayments to the FSSA or its fiscal agent, or arrange to have future payments from the IHCP withheld, within sixty (60) days of receipt of notice from the 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.

21. To pay interest on overpayments in accordance with *Indiana Code (IC) 12-15-12.7-7(e), 12-15-13-3.5, IC 12-15-13-4, IC 12-15-21-3*, and *IC 12-15-23-3*.

22. To make full reimbursement to the FSSA or its fiscal agent of any federal disallowance incurred by the FSSA when such disallowance relates to payments previously made to Provider under the IHCP.

23. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits. At the discretion of the Office of Medicaid Policy and Planning (OMPP), failure to cooperate or promptly make available requested documentation can result in provider sanctions pursuant to *405 IAC 1-1.4-4*, including suspension of payments, as well as exclusion from the Indiana Medicaid program for a period of up to three years.

24. 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* and in the reference modules and bulletins, and shall include, without being limited to, the following:

    a. medical records as specified by *42 United States Code (USC) 1396a(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 the 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 Provider for furnishing services to the plan.

25. To cease any conduct that the FSSA or its representative deems to be abusive of the IHCP. Abusive behavior includes but is not limited to:
    a. misconduct unbecoming of an IHCP provider;
    b. conduct that impacts the care provided to IHCP members; and
    c. conduct that is aggressive or threatening towards the IHCP, its employees, or its contractors.
26. To promptly correct deficiencies in Provider's operations upon request by the FSSA or its fiscal agent.
27. 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 Provider or an employee of Provider has been convicted of a criminal drug violation occurring in Provider's workplace.
28. To comply with the following procedures and time limits when filing an appeal request and statement of issues:
    a. Appeal requests must state facts demonstrating that:
        (1) the petitioner is the person to whom the order is specifically directed;
        (2) the petitioner is aggrieved or adversely affected by the order; or
        (3) the petitioner is entitled to review under the law.
    b. A statement of issues must be filed in conjunction with the appeal request, setting out in detail:
        (1) the specific findings, actions, or determinations of the FSSA from which Provider is appealing; and
        (2) with respect to each finding, action, or determination, all statutes or rules supporting Provider's contentions of error and why Provider believes that the office's determination was in error.
    c. To appeal any of the following actions, Provider must submit the appeal request and the statement of issues within sixty days of receipt of the 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
    d. All appeals of actions not described in (c) must be filed within 15 days of receipt of the FSSA's determination. The statement of issues must be filed within 45 days of receipt of the FSSA's determination.
29. To cooperate with the 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.
30. 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.
31. 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.
32. To abide by (and ensure its agents abide by) 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 Provider is not familiar with these ethical requirements, Provider should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission webpage at https://www.in.gov/ig/commission. If Provider or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Agreement immediately upon notice to Provider. In addition, Provider may be subject to penalties under *IC § 4-2-6, IC 4-2-7, IC 35-44.1-1*, and under any other applicable laws.
33. 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 CFR 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.
34. To immediately notify the FSSA of any felony arrest or conviction of anyone employed by or with ownership interest in the provider.
35. 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 Provider has had more than $25,000 in a twelve-month hearing period;
    b. any significant business transactions between Provider and any wholly owned supplier; and
    c. any significant business transactions between Provider and any subcontractor, during five-year period ending with the date of request.

36. 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.
37. That this Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by Provider. The effective date of this Agreement will be the date set out in the provider enrollment notification letter. This Agreement shall remain in effect until terminated in accordance with item 38 below.
38. That this Agreement may be terminated as follows:
    a. By the FSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by the FSSA pursuant to *405 IAC 1-1.4-4* and *IC 12-15-22*; or
    b. By the FSSA or its fiscal agent, or by Provider, without cause upon 60 days' written notice.
39. That this Agreement may be suspended as follows:
    a. By the FSSA or its agent pursuant to the provisions in *405 IAC 1-1.4-4*; or
    b. By the FSSA or its agent upon notice of a pending criminal investigation of an owner or employee for a felony or healthcare related fraud.
40. For long-term care providers involved in a change of ownership, this agreement acts as an amendment to the transferor's agreement with the 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*.
41. New owners of nursing facilities or ICF/IIDs, must accept the assignment of the provider agreement executed by the previous owner(s) as required by *42 CFR 442.14*.
42. For any entity that receives or makes annual payments totaling at least $5 million annually as described in *42 U.S.C. 1396a(a)(68)*, the entity 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 the 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 the 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.
43. 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 https://hhs.gov/exclusions.
44. To allow the FSSA and its representatives to perform safety inspections of motor vehicles used for transportation services of IHCP members. Provider shall require all of its contractors and subcontractors to agree to the same.
45. To receive email updates and communication from the 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 PROGRAMS (IHCP)-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.

| **Provider Agreement-Authorized Signature – All Schedules and Applicable Addenda** | |
|---|---|
| **The owner or an authorized representative of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. A delegated administrator must not sign this form.** | |
| 1. Legal name of provider's business (please print): | 2. Taxpayer Identification Number (TIN): |
| 3. Authorized official's name (please print): | 4. Title: |
| 5. Authorized official's signature: | 6. Date: |

| Addendum

# IHCP Provider Federal *W-9* Addendum

in.gov/medicaid/providers

## *W-9* Form Requirements

A *W-9 form* must be completed and submitted with each Indiana Health Coverage Programs (IHCP) provider enrollment application, revalidation or change of ownership. A *W-9* form is also required if there is a change to the provider name, address or taxpayer identification number (TIN).

The name in line 1 and the address in lines 5 and 6 of the *W-9* form must exactly match the information in the *Provider Name and Address* section of the IHCP provider packet. If the service location name or doing business as (DBA) name is different from the provider name, it must match the name in line 2 of the *W-9*.

Providers must use only the **current version** of the *W-9,* available on the Internal Revenue Service (IRS) website. Failure to submit the current version may result in the application being rejected and returned to the provider.

Follow these steps to obtain and complete the current version of the IRS *W-9* form:

1. Go to the IRS website at irs.gov.
2. Locate the *W-9* form and click the link to download the form.
3. Complete the *W-9* form following the instructions provided by the IRS – including special instructions for disregarded entities, if applicable.
4. Print the *W-9* form and mail it, along with your completed IHCP provider packet or maintenance form, to the IHCP Provider Enrollment Unit.

| Addendum

# IHCP Provider Application Fee Addendum

in.gov/medicaid/providers

## Overview

Federal and state laws require certain providers to remit an enrollment application fee. The Centers for Medicare & Medicaid Services (CMS) sets the fee amount annually. This fee is assessed at initial enrollment, revalidation, and change of ownership, as required, and is assessed in full for each service location enrolled in the Indiana Health Coverage Programs (IHCP). See the *Provider Enrollment Application Fee* page at in.gov/medicaid/providers for more information and payment options.

To determine whether you must pay a fee, see the *IHCP Provider Enrollment Risk Category and Application Fee Matrix*.

If a provider's service location is enrolled in Medicare or the provider pays an enrollment application fee to another state's Medicaid agency for a specific service location, the provider is not required to pay the IHCP an additional fee for that same service location.

On this form, please list your payment confirmation number and amount paid or reason for exemption. Submit this form with your IHCP provider packet.

1. Provider name

2. Does the application fee apply to your provider type? (Use the matrix linked above to verify whether you are required to pay a fee.)

☐ Yes ☐ No – If **No**, skip the rest of this form.

3. Is the service location enrolled in Medicare?

☐ No ☐ Yes – If **Yes**, make certain all Medicare information is provided, as requested, in your IHCP provider packet. A fee payment to the IHCP is not required for this service location.

4. Have you paid an application fee to **another state's Medicaid program** for the service location?

☐ No ☐ Yes – If **Yes**, please submit proof of payment with the IHCP provider packet. A fee payment to the IHCP is not required for this service location.

5. Have you received a waiver of the application fee from **Medicare or another state's Medicaid program** because of financial hardship?

☐ No ☐ Yes – If **Yes**, please submit a copy of the waiver letter with the IHCP provider packet. A fee payment to the IHCP is not required for this service location.

6. Are you requesting a waiver of the application fee because of financial hardship?

☐ No ☐ Yes – If **Yes**, please submit a letter explaining the financial hardship with the IHCP provider packet, including proof of inability to pay and a list of all attempts made to raise the required fee from outside sources, such as a loan denial.

7. If you answered **Yes** to question 2 and **No** to questions 3, 4, 5, and 6, you are required to remit an application fee to the IHCP. Payments can be made online or by telephone using a credit card, debit card, or electronic funds transfer from your checking account. Paper forms of payment are not accepted. See the *Provider Enrollment Application Fee* page at in.gov/medicaid/providers for more detailed instructions about the payment process.

   Indicate the electronic payment confirmation number:

8. Indicate the amount paid electronically:

| Addendum

# IHCP Provider Screening Addendum

in.gov/medicaid/providers

## Overview

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

Federal and state laws require that Indiana Health Coverage Programs (IHCP) providers in the high-risk category submit to Medicaid fingerprint background checks. You can determine the risk category of your provider type/provider specialty at enrollment and at revalidation by referencing 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 you are assigned to the high-risk category, this addendum must be submitted with your IHCP provider packet when enrolling or revalidating by mail. List the individuals from Schedule C, sections C.1 through C.3, who have at least 5% direct or indirect ownership or controlling interest in the business, including the board of directors if the business is a nonprofit entity, and provide the confirmation number they received at the fingerprint collection center as proof of compliance.

| 1. Provider name: | |
|---|---|
| 2. Business address: | |
| 3. Business telephone number: | 4. Email address of individual who can answer questions about this form: |

## Individuals Subject to Fingerprinting

| 5a. Legal name of disclosed individual: | 5b. Fingerprint confirmation number: |
|---|---|
| 5c. Social Security number: | 5d. Date of birth: |
| 6a. Legal name of disclosed individual: | 6b. Fingerprint confirmation number: |
| 6c. Social Security number: | 6d. Date of birth: |
| 7a. Legal name of disclosed individual: | 7b. Fingerprint confirmation number: |
| 7c. Social Security number: | 7d. Date of birth: |
| 8a. Legal name of disclosed individual: | 8b. Fingerprint confirmation number: |
| 8c. Social Security number: | 8d. Date of birth: |
| 9a. Legal name of disclosed individual: | 9b. Fingerprint confirmation number: |
| 9c. Social Security number: | 9d. Date of birth: |
| 10a. Legal name of disclosed individual: | 10b. Fingerprint confirmation number: |
| 10c. Social Security number: | 10d. Date of birth: |


| Addendum/Maintenance Form

IHCP Provider Electronic Funds Transfer Addendum/Maintenance Form | in.gov/medicaid/providers

## Electronic Funds Transfer Overview

The Indiana Health Coverage Programs (IHCP) will establish a direct deposit account with your financial institution for claims payment. After you have established electronic funds transfer (EFT), the IHCP will electronically transfer payments into the account you specify on this form. Please read the instructions on this form carefully and ensure that the appropriate information and signature are included.

All claims successfully processed by Wednesday at 4:30 p.m. will appear on the weekly Remittance Advice, which is available on Monday of the following week. EFT payments occur each Wednesday.

It takes approximately 18 days for the bank to process and completely establish your EFT account. If you bill claims before your EFT activation, paper checks are mailed to the pay-to address documented on Schedule A of the IHCP Provider Packet. When your EFT account becomes active, direct deposits begin. Thank you for considering EFT as a payment option.

| Electronic Funds Transfer Form Instructions | |
|---|---|
| 1. Provider name | Enter the legal name of the IHCP provider (institution, corporate entity, practice, or individual practitioner). |
| 2. Street address | Enter the street address of the provider's home office. |
| 3. City | Enter the city associated with provider's home office address. |
| 4. State/province | Enter the two-character state code associated with the provider's home office address. |
| 5. ZIP Code/postal code | Enter the U.S. postal-zone code (ZIP + 4) associated with the provider home office. |
| 6. Provider tax ID (Social Security number or federal employer identification number) | Enter the taxpayer identification number (tax ID) used to identify the business entity. The tax ID is either a Social Security number (SSN) or a federal employer identification number (EIN), depending on the type of business entity. |
| 7. National Provider Identifier (NPI) | The NPI is a unique identification number for registered healthcare providers; enter the provider's NPI. |
| 8. IHCP Provider ID | Enter the provider's IHCP Provider ID. |
| 9. Provider contact name | Enter the name of a contact in the provider's office who handles EFT issues. |
| 10. Telephone number | Enter the telephone number associated with the EFT contact person. |
| 11. Email address | Enter the electronic mail address associated with the EFT contact person. |
| 12. Does account belong to a provider agent (billing agency)? | **Select "Yes" if the EFT for the provider named on this document will be sent to an account belonging to a billing agency and not to the account of the provider.** Select "No" if the EFT for the provider named on this document will be sent to an account belonging to the provider. |
| 13. Provider agent name | Enter the name of provider's billing agent. |
| 14. Street | Enter the street address for the provider's billing agent. |
| 15. City | Enter the city associated with the street address for the provider's billing agent. |
| 16. State/province | Enter the two-character code for the state associated with the provider's billing agent. |
| 17. ZIP Code/postal code | Enter the U.S. postal-zone code (ZIP+4) associated with the provider's billing agent. |
| 18. Provider agent contact name | Enter the name of a contact in the provider's billing agent office who handles EFT issues. |
| 19. Title | Enter the title of the contact in the provider's billing agent office. |
| 20. Telephone number | Enter the telephone number associated with the contact in the provider's billing agent office. |
| 21. Email address | Enter the email address associated with the contact in the provider's billing agent office. |
| 22. Financial institution name | Enter the official name of the financial institution where the provider maintains an account where payments are to be deposited. |
| 23. Financial institution telephone number | Enter a contact telephone number at the financial institution where the provider maintains an account where payments are to be deposited. |
| 24. Financial institution routing number | Enter the nine-digit identifier of the financial institution where the provider maintains an account where payments are to be deposited. |
| 25. Type of account at financial institution | Enter the type of account the provider will use to receive EFT payments; for example, checking or savings. |
| 26. account number with financial institution | Enter the account number at the financial institution where EFT payments are to be deposited. |
| 27. Account number linkage to provider identifier – provider tax ID | Enter the nine-digit tax ID (SSN or EIN) that ties the provider to his or her EFT account where payments are to be deposited. |
| 28. Reason for submission | Select **New Enrollment**, **Change Enrollment**, or **Cancel Enrollment** to indicate the reason or type of EFT transaction being submitted. |
| Authorized signature: Written signature of authorized official | This signature must be an authorized official or owner of the provider, per the instructions outlined in the *Authorized Signature* section of the form. |
| Printed name of authorized official | Enter the name of the person signing the form. |
| Printed title of authorized official | Enter the title of the person signing the form. |
| Submission date | Enter the date on which the enrollment is submitted. |

## General Information

**Complete all fields on this form according to the instructions. Confirm financial institution routing number.**

| 1. Provider name | | 2. Street address | 3. City |
|---|---|---|---|
| 4. State/province | 5. ZIP Code/postal code | 6. Provider tax ID (Social Security number or federal employer identification number) | 7. National Provider Identifier (NPI) |
| 8. IHCP Provider ID | 9. Provider contact name | 10. Telephone number | 11. Email address |

## Provider Agent Information

12. Does account belong to a provider agent (billing agent)? If yes, please complete this section. If no, this section is not required:

☐ Yes ☐ No

The following section must be completed if the EFT for the provider named on this document will be sent to an account belonging to a provider billing agent and not an account of the provider.

The exception for a provider billing agent is limited to agents who furnish statements and receive payments in the name of the provider, and the service provided by the agent is: (1) related to the cost of processing the bill; (2) not related to a percentage or other basis to the amount billed or collected; and (3) not dependent on the collection of payment. Further, a payment for a provider may not be made to or through an individual or organization (collection agency or service bureau), or by power of attorney thereof, that advances money for accounts receivable a provider has assigned, sold, or transferred to the individual or organization for a fee or deduction of accounts receivable.

| 13. Provider agent name | 14. Street | 15. City |
|---|---|---|

| 16. State/province | 17. ZIP Code/postal code | 18. Provider agent contact name | 19. Title |
|---|---|---|---|
| 20. Telephone number | 21. Email address | | |

## Financial Institution Information

| 22. Financial institution name | 23. Financial institution telephone number | 24. Financial institution routing number | 25. Type of account at financial institution<br>☐ Checking ☐ Savings |
|---|---|---|---|
| 26. Account number with financial institution | | 27. Account number linkage to provider identifier–provider tax ID | 28. Reason for submission<br>◯ New enrollment<br>◯ Change enrollment<br>◯ Cancel enrollment |

## Authorized Signature

On behalf of the provider entity named above, I agree to keep, and disclose upon request to authorized agencies, records that fully disclose the extent of claim payments received from and services rendered to members of the Indiana Health Coverage Programs (IHCP). I accept, as payment in full, the amount paid by the IHCP for claims submitted with the exception of authorized cost sharing by members. I understand payment of IHCP claims is from State and federal funds and that any false claims, statements, documents or concealment of a material fact may be prosecuted under State or federal law. I ensure that this EFT request complies with the regulation set forth in *42 CFR 447.10*, which prohibits State payments for any IHCP service to be made to anyone other than an enrolled provider, a noncash member, or to one of the listed exceptions. I understand that an IHCP payment may be sent via EFT to an account held by the following only: (1) an enrolled provider; (2) a noncash member; (3) a government agency on reassignment by an enrolled provider (IRS); (4) a third party by court order on reassignment by an enrolled provider (child support); (5) a business agent (billing service, account firm) if three specific criteria are met (see *Provider Agent Information* section); (6) the employer of a practitioner (if a contract so requires); or (7) a healthcare facility, or a healthcare delivery system (if a contract so requires), if the organization itself submits the claim directly to the IHCP.

I authorize that electronic transfer of IHCP payments (including those for 590 Program, Medicaid, and Package C) be made to the above provider number. I understand that I am responsible for the validity of the above information. I agree to notify IHCP within 10 days of any change in any of the information included on this form.

**This section must be completed by an authorized official or owner of the billing provider. A delegated administrator may sign this 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 requests only when the appropriate signature is present.

| | |
|---|---|
| Authorized signature:<br><br>_____<br>Written signature of authorized official | _____<br>Printed title of authorized official |
| _____<br>Printed name of authorized official | Submission date: _____ |

| Overview

# IHCP Provider Change of Ownership Addendum

in.gov/medicaid/providers

## Change of Ownership Overview

Use the *IHCP Change of Ownership Addendum* to let the IHCP know when a change of ownership occurs or is anticipated. A change of ownership would include, but is not limited to, any of the following circumstances:

- **For a sole proprietorship** – When a provider of services is an entity owned by a single individual, and transfers title and property belonging to the enterprise to another person or firm, whether or not including a transfer of title to the real estate; or if the former sole proprietor becomes one of the members of a business entity succeeding him or her as the new owner.
- **For a partnership** – A new partnership, or the removal, addition, or substitution of an individual partner in an existing partnership, in the absence of an express statement to the contrary in the partnership agreement that dissolves the old partnership and creates a new partnership.
- **For a corporation** – A new corporation; the merger of the applicant or provider corporation into another corporation; the consolidation of two or more corporations; or any change resulting in the creation of a new corporation. In an incorporated provider entity, the corporation is the owner. The governing body of the corporation is the group having direct legal responsibility under state law for operation of the corporation's entity, whether that body is a board of trustees; a board of directors; the entire membership of the corporation; or known by some other name.

***Note:*** *A change of ownership can result in the assignment of a new provider number. Extended care facilities (provider type 03) with provider specialties 030 (Nursing Facilitiy), 031 (Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID]), 032 (Pediatric Nursing Facility), and 033 (Residential Care Facility) retain their provider number and service location when a change of ownership occurs. When these provider specialties change ownership, the new owner shall accept the responsibilities of the previous owner, as listed in the previous owner's provider agreement, and as required by 42 CFR 442.14. All providers under new ownership, including extended care facilities, are required to submit an entire IHCP provider packet, including a signed copy of the provider agreement.*

### New Ownership Document Requirements

When a change of ownership occurs, the *IHCP Change of Ownership Addendum* must be completed as part of the overall IHCP provider packet. An entire packet must be completed for each service location, including the submission of licenses and other supporting documentation and payment or proof of payment of an application fee. The new owner must also submit a copy of the purchase agreement, bill of sale, or other documentation to verify the change of ownership.

### Addendum Detail

The *IHCP Change of Ownership Addendum* is divided into the following sections:

- New Ownership Information – Helps the IHCP identify the person or entity that is acquiring a currently enrolled provider business. If the new owner is currently enrolled with the IHCP, all fields in this section must be completed. If the new owner is not currently enrolled, all fields except the IHCP Provider ID field must be completed.
- Previous Ownership Information – Helps the IHCP identify the business and specific service location being acquired.

| Addendum

# IHCP Provider Change of Ownership Addendum

in.gov/medicaid/providers

| Change of Ownership Information | | |
|---|---|---|
| 1. Has a change of ownership occurred? ☐ Yes ☐ No – Anticipated | 1a. Actual date of change | 1b. Date of expected change |

| New Ownership Information | | |
|---|---|---|
| 2. Business name | | |
| 3. Taxpayer identification number (TIN) | | 4. IHCP Provider ID (if currently enrolled) |
| 5. National Provider Identifier (NPI) | 6. ZIP + 4 **(Nine digits required)** | 7. Taxonomies |

| Previous Ownership Information | | | |
|---|---|---|---|
| 8. Business name | | | |
| 9. DBA name for service location being acquired | | | |
| 10. Service location address | | | |
| 11. City | | 12: State | 13. Service Location ZIP + 4 **(Nine digits required)** |
| 14. Taxpayer identification number (TIN) | 15. IHCP Provider ID | | 16. Familial relationship to previous owner |
| 17. National Provider Identifier (NPI) | 18. ZIP + 4 associated with NPI **(Nine digits required)** | | 19. Taxonomies |

## Long-Term Care Information

Submit the IHCP provider packet or send an impending change of ownership notification letter at least 45 days prior to the expected transfer date. A pay hold will be initiated on the expected date of transfer to ensure appropriate payee information for claim payments.

View the Long-Term Care Providers' Change of Ownership regulations at *405 IAC 1-20*.

## Long-Term Care Record Retention

**The following *Indiana Administrative Code* outlines the requirements for record retention:**
***405 IAC 1-20-5***

Authority: *IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3*

Affected: *IC 12-13-7-3; IC 12-15; 405 IAC 1-20-5*

A transferee shall take possession of the Medicaid records of the transferor and safeguard them for no less than three years from the date of the last claim reimbursed by the office or until any pending administrative or judicial appeal is closed, whichever is longer. (Office of the Secretary of Family and Social Services; *405 IAC 1-20-5*)

## Licensure or Certification Information

If a provider is licensed or certified by the Indiana State Department of Health (ISDH), the effective date of the change of ownership is determined by the date indicated on the ISDH Certificate and Transmittal form and amended by the ISDH, if necessary, to correspond with the transferor or transferee agreement of sale or transfer.

| Addendum/Maintenance Form

# IHCP Provider Delegated Administrator Addendum/Maintenance Form

in.gov/medicaid/providers

Use this form to grant authority to a specific individual to submit documents on behalf of the provider for Indiana Health Coverage Programs (IHCP) enrollment, profile maintenance, and claims submission. Please read the instructions carefully. Delegated administrators perform only those tasks specifically indicated on the form. The signature of an authorized official, as defined on the form, is required to delegate authority to the administrator. For example, a credentialing coordinator cannot delegate authority to himself or herself or to another party. The information on this form is logged by the IHCP and is used to verify that the individuals who sign requests are authorized to do so.

A delegated administrator may submit a provider enrollment packet; however, the delegated administrator may not sign the IHCP Provider Agreement. This form must contain the authorized official's and delegated administrator's original signatures.

You can also use this form to change or revoke the authority that was previously delegated to an individual. When a change is processed, any authority previously granted to the delegated administrator is removed and replaced with the authority indicated on the change form. In other words, the previous list of tasks the delegated administrator can sign for will be replaced with the list from the update form. When a delegated administrator's authority is revoked, all signature authority previously granted is removed.

## Next Steps

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

| For Provider Use Only | Quality Check |
|---|---|
| ☐ | In field 1, confirm that the type of request being made has been selected. |
| ☐ | Confirm that either field 2 or field 3 has been completed, as follows:<br>• If establishing or changing a delegated administrator's authority, double-check field 2 to ensure that only those items that the delegate is authorized to perform are checked. Note that any existing list on file for the delegated administrator will be replaced with this new list, so select all items that apply, even if they have been selected for the same administrator in the past.<br>• If revoking a delegated administrator's authority, ensure that the box in field 3 has been selected. |
| ☐ | In fields 4–6, ensure that contact information has been entered. |
| ☐ | In fields 7–12, double-check that all applicable fields are completed to clearly identify the provider. |
| ☐ | In fields 13–16, check that the authorized official's name and title have been entered, and that his or her original signature has been included along with the signature date. |
| ☐ | In fields 17–19, check that the delegated administrator's name and title have been entered, and that his or her original signature has been included along with the signature date. |

2. Make a copy of the form and other documentation for your records.
3. Submit this form as an addendum to your IHCP provider packet or separately to report changes to your provider profile.
4. Submissions should be mailed to the following address:

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

| Addendum/Maintenance Form

# IHCP Provider Delegated Administrator Addendum/Maintenance Form

in.gov/medicaid/providers

## Overview

An authorized official may establish, change or revoke signature authority for a delegated administrator. The authorized official that is listed in field 13 and signs in field 15 must be identified on Schedule C, sections C1 through C3, of the IHCP provider packet.

**Note:** Signature authority for the *IHCP Provider Agreement* cannot be delegated. An authorized official is required to sign the IHCP Provider Agreement.

**What is an authorized official?** An authorized official must be a general partner, agent, officer, director, or managing employee who has expressed or implied authority to obligate or act on behalf of the provider entity. An authorized official also includes any individual who has operational or managerial control over, or who directly or indirectly conducts the day-to-day operations for, the provider entity. An authorized official includes such individuals as a general manager, business manager, administrator, or director. Authorized officials are identified on Schedule C, sections C.1 through C.3, of the IHCP provider packet.

**What is a delegated administrator?** A delegated administrator is a person or entity (such as billing agency) to whom the enrolling provider's authorized official has granted the legal authority to do any or all of the following:

- Sign the IHCP provider enrollment and maintenance packet
- Make changes or updates to the organization's status in the IHCP
- Accept payment for services
- Submit claims for payment on behalf of the enrolled entity
- Commit the organization to the laws and regulations of the IHCP

1. Type of request

☐ **Establish a delegated administrator** – You are delegating authority to specific individual.

☐ **Change a delegated administrator's authority** – An individual has been previously set up as a delegated administrator and you are changing the tasks the individual is allowed to perform.

☐ **Revoke a delegated administrator's authority** – An individual has been previously set up as a delegated administrator and you are cancelling all signature authority.

2. To establish or change a delegated administrator's authority, select tasks from this list (to revoke authority, skip to field 3):

As an authorized official of the provider entity, I assign signature authority to the delegated administrator named herein for the following. Any authority previously assigned to this individual is superseded by this authorization:

☐ Change mail-to address (non-check-related info)

☐ Change provider *W-9* address

☐ Submit name change

☐ Change taxpayer identification number (TIN), submit *W-9*

☐ Submit provider specialty change

☐ Add, change, or stop electronic funds transfer (EFT)

☐ Submit the *IHCP Provider Signature Authorization*

☐ Change pay-to address (checks and remittance advice)

☐ Change service location address (cert code letters)

☐ Submit license or certification updates

☐ Submit updates to rendering provider information

☐ Submit the *IHCP Outpatient Behavioral Health Addendum*

☐ Submit the *IHCP Provider Disenrollment Form* for specific service location or to disenroll rendering provider linkages from a provider group only

3. Revoke all authority from the delegated administrator (when adding or changing authority, skip this field):

☐ As an authorized official of the provider entity, I revoke all authority from the delegated administrator named herein. Any authority previously assigned to this individual is superseded by this revocation.

| Addendum/Maintenance Form

IHCP Provider Delegated Administrator Addendum/Maintenance Form

in.gov/medicaid/providers

| Contact Information | | | |
|---|---|---|---|
| The contact name and email relate to the person who can answer questions about the information provided in this packet. | | | |
| 4. Contact name: | | 5. Telephone: | |
| 6. Contact email address: | | | |

| Authorized Signature Section | | | |
|---|---|---|---|
| The undersigned, being the provider or having the specific authority to bind the provider to the terms of the provider agreement, and the named delegated administrator do 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. | | | |
| 7. Provider name (as it appears on the *W-9*): | | 8. Taxpayer identification number (TIN): | |
| 9. IHCP Provider ID: | 10. National Provider Identifier (NPI): | 11. Taxonomies: | 12. ZIP+4 (Nine digits required): |
| 13. Authorized official's name (please print): | | 14. Authorized official's title (please print): | |
| 15. Authorized official's signature: | | | 16. Date: |
| 17. Delegated administrator's name (please print): | | | |
| 18. Delegated administrator's signature (required only to establish or change a delegated administrator's authority): | | | 19. Date: |
| **Please submit one form per delegated administrator.** | | | |