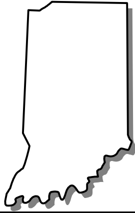


BILLING PROVIDER ENROLLMENT APPLICATION

Schedule A – Provider Information

1. Which of the following best describes this provider location?

Please check the box that best describes the provider location being enrolled. **Only one** box may be checked.

☐ Group Practice ☐ Facility or Organization ☐ Individual Practitioner

2. Service Location Name and Address

Please complete the Name, Telephone Number, Address, and ZIP Code for the site where services will be performed. You must complete a separate application for each location where services are performed, even if you bill claims from all locations under one provider number. Except for sole proprietors who use their own legal names for business purposes, each service location name must be the Doing Business As (DBA) name registered with the Secretary of State. The address must be a physical location. A post office box is not a valid service location address.

Are you registered with the Secretary of State? ☐ Yes ☐ No

DBA Name ______________________________ Telephone ( ) ______________

Street Address ____

City ______________________________ State __________ ZIP __________

*Taxpayer Identification Number for this Service Location: ______________________

**NOTE: A copy of a completed Federal W-9 Form must be attached with this form. Failure to attach this form will result in EDS returning this form for incomplete information.*

3. Legal Name and Home Office Address

Please complete the contact information for the home office of the legal entity maintaining ownership of this service location. The legal name must be the current name on tax, corporation, and other legal documents, and currently registered with the Secretary of State. The address must be a physical location. A post office box is not a valid home office address. If there is more than one legal name currently used by this business entity, attach an explanation listing each name, address, and tax ID number.

Legal Name ______________________________ Telephone ( ) ______________

Street Address ____

City ______________________________ State __________ ZIP __________

Tax ID Number ______________________________

Schedule A Continued

4. Mailing Name and Address

Please complete the contact information for the addressing of bulletins, provider manual updates, and general correspondence. A post office box is acceptable for a mailing address.

Name ______________________________ Telephone ( ) __________

Street Address ______________________________

City ______________________________ State ______ ZIP __________

5. Pay To Name and Address

Please complete the contact information for the addressing of checks, remittance advices, and general claims payment information. If this is a billing agent's address, please provide the name, address, and phone number of the billing agent. A post office box is acceptable for this address.

Name ______________________________ Telephone ( ) __________

Street Address ______________________________

City ______________________________ State ______ ZIP __________

Billing Agent? ☐ Yes ☐ No

6. E-mail Address

Please provide the e-mail address that is a primary contact for the service location.

E-mail Address: ______________________________

Note: Sections 7-10 require copies of the following documents for verification as applicable. Please see Attachment B for specific requirements by provider type.

- *Provider License from Licensing Board*
- *Clinical Laboratory Improvement Amendment (CLIA) Certificate*
- *Federal Drug Enforcement Administration (DEA) Certificate*
- *Medicare Provider Number Assignment Letter for Medicare Participation*

7. Provider Licensing Information

Please complete the information about your licensure as determined and maintained by the official licensing board for your provider type and specialty. Refer to Attachment A to determine the provider type and specialty numbers for your primary and secondary specialty. Refer to Attachment B for the enrollment requirements for the provider type and specialties selected.

Provider Type ______________________________

Primary Specialty ______________ Secondary Specialty ______________

Primary Sub-Specialty ______________ Secondary Sub-Specialty ______________

License Number ______________ Licensing Board ______________

License Effective Date ______________ License Expiration Date ______________

Note: A copy of the license from the appropriate licensing board must be attached to the application. Failure to attach a copy of the license will result in EDS returning this application for incomplete information.

Note: You may select only one provider type. If you want to enroll more than one type, a separate application must be completed for each type. Primary and secondary specialties must be listed under the same provider type on Attachment A.

Schedule A Continued

8. CLIA Certification

Please complete this section with the information from your Clinical Laboratory Improvement Amendment (CLIA) Certificate.

CLIA Number ____________________ Certification Type ____________________

Effective Date ____________________ Expiration Date ____________________

Note: A Copy of the certificate must be attached to the application. Failure to attach a copy of the certificate will result in denied claims for laboratory services.

9. Federal DEA Certification

Please complete this section with the information from your Federal Drug Enforcement Administration (DEA) Certificate.

DEA Number ____

Effective Date ____________________ Expiration Date ____________________

Note: A copy of the certificate must be attached to the application. Failure to attach a copy of the certificate will result in denied claims for prescriptions you prescribe.

10. Medicare Participation

Please complete the appropriate Medicare identification numbers.

Medicare Number ____________________ Medicare Number State ____________________

Universal Provider Identification Number (UPIN) ____________________

DME Supplier Number ____

Note: A copy of the Medicare Number assignment letter must be attached to the application. Failure to attach a copy of the letter may result in denied Medicare Crossover claims.

Schedule A Continued

11. Are you currently, or have you ever been enrolled as an IHCP provider?

If you are currently, or have ever been enrolled as an IHCP or Medicaid provider, please check the box labeled yes and list the provider number(s) you were assigned.

Yes ☐ No ☐ If yes, please indicate all current and previous IHCP or Medicaid numbers:

______________________ ______________________ ______________________

______________________ ______________________ ______________________

12. Do you wish to participate in the Health Watch Program?

HealthWatch is a preventative health care program offered to Medicaid eligible members less than 21 years of age. Physicians or nurse practitioners that are enrolled as Medicaid providers are qualified to perform HealthWatch screens. Reimbursement for HealthWatch services is higher than equivalent services billed using standard CPT codes. HealthWatch screens must be completed in accordance with recommendations set forth in the HealthWatch Provider Manual Periodicity Schedule. Check the box labeled yes if you wish to participate in this program.

Yes ☐ No ☐

13. Do you wish to participate in the 590 Program?

The 590 Program is a State medical assistance program providing reimbursement for medically necessary covered medical services provided off site to individuals who reside in State institutions. Check the box labeled yes if you wish to participate in this program.

Yes ☐ No ☐

Schedule B – Organization Structure

1. How is this provider entity legally organized and structured?

Check the entity type that best describes the structure of the enrolling provider entity. Please check **only one** box**.**

☐ For Profit Corporation ☐ Partnership ☐ Sole Proprietorship

☐ Not-for-Profit Corporation ☐ Government Owned

2. Peer group or locality

Please check the peer group or locality that best describes the service location. Please check **only one** box.

☐ Metropolitan ☐ Rural ☐ Urban ☐ Teaching (Hospitals only)

3. List all owners and officers of the business entity

Please list the name, title, and address of each individual who owns five percent or more of the provider entity. If the entity is a corporation or not-for-profit, list the name, title, and address of each officer. Attach additional pages as necessary to list all officers and owners.

Name	Title	Address

4. Background Information

State the name and position within the provider entity of any agent, managing employee, or owner of the provider entity who has been excluded from or convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs:

Schedule C.1 – Physicians	
Physicians must complete the following question	
1. In accordance with Section 4752 OBRA 1990, effective January 1, 1995, physician enrollment in, and reimbursement from, the Indiana Health Coverage Programs is contingent upon satisfying at least one of the following criteria. Please indicate with an "X" the category that describes your practice	
☐	Your practice is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for Family Practice or Obstetrics;
☐	You are employed by, or affiliated with, a Federally Qualified Health Center as defined in 1905(1)(2)(B) of the Social Security Act;
☐	You hold admitting privileges at a hospital participating in an approved state Medicaid plan;
☐	You are a member of the National Health Service Corps;
☐	You can document a current, formal consultation and referral arrangement for purposes of specialized treatment and admission to a hospital with a pediatrician or family practitioner who is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for Family Practice or Obstetrics, or;
☐	You have been certified by the Secretary of Health and Human Services as qualified to provide physician services to pregnant women and children under 21 years of age.
Note: Failure to check at least one of the criteria will result in EDS returning this application for incomplete information.	
Note: Providers must notify the IHCP of any changes in the above information to remain eligible for reimbursement.	

Schedule C.2 Institutional Providers

Enrollment of Institutional providers surveyed and licensed by the Indiana State Department of Health (ISDH) is dependent upon EDS receiving a completed Certificate and Transmittal from the ISDH. The ISDH ensures that an institutional provider meets all federal and state qualifications to participate in the IHCP

1. Have you completed the ISDH survey process? ☐ **Yes** ☐ **No**

If you answered No, you must contact ISDH to complete the survey process prior to enrolling in the IHCP.

Section A – Hospitals

1. If the provider is a hospital, are the requirements of *42 USC Section 1395ww(d)(5)(D)(iii)* met for the hospital to qualify as a sole community hospital?

If you satisfy the requirements of 42 USC Section 1395ww(d)(5)(D)(iii) to qualify as a sole community hospital, please check Yes. Otherwise, please check No.

☐ Yes ☐ No

Section B – Long Term Care Facilities

1. Are you enrolling in Medicaid **solely** to be reimbursed for services provided to Qualified Medicare Beneficiaries (QMB) in long term care facilities?

☐ Yes ☐ No

Schedule C.3 – Transportation Providers

1. Type of Service (indicate all that apply)

Please check all of the services provided by this location. You may select more than one box.

☐	Common Carrier (Ambulatory)	☐	Ambulance	☐	Taxicab
☐	Common Carrier (Non-ambulatory)	☐	Air Ambulance	☐	Bus
☐	Family Member/Volunteer Transportation				

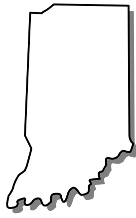
2. Please Attach All That Apply

For each box checked in number 1 above, please include all of the attachments shown below

	Attachment included?	
Ambulance or Air Ambulance:	Yes	No
Emergency Medical Services Commission (EMS) Certification	☐	☐
Bus		
Motor Carrier Services (MCS) Certification	☐	☐
Common Carrier Ambulatory or Non-Ambulatory (for profit):		
Motor Carrier Services (MCS) Certification	☐	☐
Common Carrier Ambulatory or Non-Ambulatory (not-for-profit):		
Certification of not-for-profit status from the IRS	☐	☐
Proof of insurance ($500,000 combined single limit commercial automobile liability insurance is required)	☐	☐
Taxicabs:		
Operating agreement from local governing body	☐	☐
Proof of insurance as indicated by local ordinances (if unspecified by local ordinance, a minimum of $25,000/$50,000 public livery insurance covering all vehicles used in the business)	☐	☐
Family Member/Volunteer Transportation:		
Proof of insurance as specified by Indiana state law	☐	☐
Appropriate and valid driver's licenses as specified by Indiana state law	☐	☐
Certification from the County Welfare Office for the IHCP member	☐	☐

Note: Failure to attach the necessary attachments will result in EDS returning this application for incomplete information.

Provider-Authorized Signature – All Schedules
The owner or an authorized officer of the business entity must complete this section.
I certify, under penalty of law, that the information stated in Schedules A, B, C.1, and C.2 is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make all necessary verifications concerning me and my medical practice, and further authorize and request each education institution, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Indiana Health Coverage Programs and the Indiana Children's Health Insurance Programs. Provider DBA Name ______________________ Tax ID __________ Officer Name ______________________ Title __________ Signature ______________________ Date __________
Note: Failure to complete this section will result in EDS returning the application for incomplete information.



MEDICAID/CHILDREN'S HEALTH INSURANCE PROGRAM PROVIDER AGREEMENT

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs. As an enrolled provider in the Indiana Health Coverage Programs, the undersigned entity agrees to provide Medicaid-covered and Children's Health Insurance Program (CHIP)-covered services and/or supplies to Indiana Medicaid and Indiana CHIP members. As a condition of enrollment, 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 ("IFSSA").
2. To comply with all federal and state statutes and regulations pertaining to the Medicaid Program or CHIP, 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 IFSSA 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 Medicaid-covered and CHIP-covered services and/or supplies for which federal financial participation is available for Medicaid and CHIP members pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about Medicaid and CHIP 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 Medicaid and CHIP members only to the IFSSA 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 Medicaid-covered and CHIP-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. Provider also agrees 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 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-MR, 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 Medicaid-covered and CHIP-covered services rendered pursuant to this Agreement.

11. To comply, if a hospital, nursing facility, provider of home health care and personal care services, hospice, or HMO; with advance directive requirements as required by *42 Code of Federal Regulations, parts 489, subpart I, and 417.436*.

12. To abide by the *Indiana Health Coverage Programs Provider Manual*, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the provider manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its fiscal agent.

13. To submit timely billing on Medicaid and CHIP approved claim forms, as outlined in the *Indiana Health Coverage Programs Provider Manual*, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

14. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. 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/or state law.

15. To submit claim(s) for Medicaid or CHIP reimbursement only after first exhausting all other sources of reimbursement as required by the *Indiana Health Coverage Programs Provider Manual*, bulletins, and banner pages.

16. To submit claim(s) for Medicaid or CHIP reimbursement utilizing the appropriate claim forms and codes as specified in the provider manual, 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 payment as payment in full the amounts determined by IFSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid or CHIP covered services provided to Medicaid or CHIP members (recipients.) Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any co-payment permitted by law.

19. To refund within fifteen (15) days of receipt, to IFSSA or its fiscal agent any duplicate or erroneous payment received.

20. To make repayments to IFSSA or its fiscal agent, or arrange to have future payments from the Medicaid program and CHIP withheld, within sixty (60) days of receipt of notice from IFSSA 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. A hospital licensed under *IC 16-21* has one hundred eighty (180) days to repay.

21. To pay interest on overpayments in accordance with *IC 12-15-13-3, IC 12-15-21-3*, and *IC 12-15-23-3*.

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

23. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.

24. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid and CHIP payments made to Provider, to assure the proper administration of the Medicaid Program and CHIP, and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 IAC 1-5* and in the *Indiana Health Coverage Programs Provider Manual*, and shall include, without being limited to, the following:
    - a. medical records as specified by *Section 1902(a)(27)* of Title XIX of the Social Security Act, 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 IFSSA 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 Indiana Medicaid program or Indiana CHIP;
- d. documentation in each patient's record that will enable the IFSSA 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 IFSSA 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 IFSSA.

25. To cease any conduct that IFSSA or its representative deems to be abusive of the Medicaid program or CHIP.

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

27. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
    - a. the petitioner is a person to whom the order is specifically directed;
    - b. the petitioner is aggrieved or adversely affected by the order;
    - c. the petitioner is entitled to review under the law.

28. 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 IFSSA from which Provider is appealing;
    - b. with respect to each finding, action or determination, all statutes or rules supporting Provider's contentions of error.

29. Time limits for filing an appeal and the statement of issues are as follows:
    - a. A hospital licensed under *IC16-21* must file an appeal of any of the following actions within one hundred eighty (180) days of receipt of IFSSA's determination:
    - (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
    - (2) A notice of overpayment.
    - (3)The statement if issues must be filed with the request for appeal.
    - b. Other providers must file an appeal of determination that an overpayment has occurred within 60 days of receipt of IFSSA's determination. The statement of issues must be filed within 60 days of receipt of IFSSA's determination.
    - c. All appeals of actions not described in (a) or (b) must be filed within 15 days of receipt of IFSSA's determination. The statement of issues must be filed within 45 days of receipt of IFSSA's determination.

30. To cooperate with IFSSA 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.

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 a Medicaid-covered or CHIP-covered service.

32. To comply with *42 Code of Federal Regulations, part 455, subpart B* pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to IFSSA, or its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, "pay to," "mail to,",or home office), federal tax identification number(s), or change in the Provider's direct or indirect ownership interest or controlling interest. Pursuant to *42 Code of Federal Regulations, part 455.104(c),* OMPP must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.

33. To furnish to IFSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in Schedules A through D to this Agreement, which are incorporated here by reference, and to update this information as it may be necessary.

34. That subject to item 32, this Agreement shall be effective as of the date set out in the provider notification letter.

35. That this Agreement may be terminated as follows:

- a. By IFSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by IFSSA; or
- b. By IFSSA or its fiscal agent, or by Provider, upon 60 days written notice.

36. That this Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider.

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, HEREBY AGREES, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID OR CHIP RELATED OFFENSE AS SET OUT IN *42 USC 1320a-7b* MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

Provider-Authorized Signature – All Schedules			
The owner or an authorized officer of the business entity must complete this section.			
I certify, under penalty of law, that the information stated in Schedules A, B, C.1, and C.2 is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified, I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each education institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Health Coverage Programs and the Indiana Children's Health Insurance Programs.			
Provider DBA Name		Tax ID	
Officer Name		Title	
Signature		Date	
Telephone Number			
NOTE: Failure to complete this section will result in EDS returning the application for incomplete information.			

Group Member Authorized Signature			
Providers being enrolled as a group must complete this section.			
Group Member's Signature		Date	
Provider Entity Name (Doing Business As)			
Name of Authorized Representative (printed)			
(Must be an authorized officer, owner, or partner)			
Signature		Date	
Title		Telephone Number	

ENROLLMENT APPLICATION CHECKLIST

The following checklist contains the most common reasons Indiana Health Coverage Programs (IHCP) enrollment applications are returned. Please use this checklist to review enrollment applications before sending to the IHCP.

Did you remember to…

- ☐ Include a copy of your professional license, if applicable
- ☐ Sign the provider agreement
- ☐ Include a copy of your DEA certificate for prescription referral or billing
- ☐ Include a copy of your CLIA certificate for laboratory services
- ☐ Complete Schedules A, B, and as appropriate, Schedule C
- ☐ Indicate *only one* provider type on Schedule A
- ☐ Indicate *one primary* provider specialty and secondary specialties as applicable
- ☐ Include a list of practice locations for all new group members
- ☐ Include a list of all members for new group enrollments
- ☐ Include a copy of W-9 form for tax identification purposes
- ☐ Include a copy of your Medicare Assignment Letter.

Thank you for your participation in the IHCP.