



**G R O U P M E M B E R E N R O L L M E N T
A P P L I C A T I O N I N S T R U C T I O N S**

(FOR INDIVIDUAL PRACTITIONERS RENDERING SERVICES AS A MEMBER OF A GROUP)

Please Read Carefully

Dear Group Provider,

On behalf of EDS and the Office of Medicaid Policy and Planning, thank you for your interest in enrolling a practitioner as a new member of your group in the Indiana Health Coverage Programs (IHCP).

This application must be used only for enrolling a practitioner who has never previously enrolled in the IHCP. You must use the *Group Member Update* form to add a previously enrolled practitioner to your group location.

Enclosed are instructions and an application for the enrollment of a group member (also called rendering provider) as an IHCP provider. Please refer to the instructions when completing the application.

When should the Group Member Enrollment Application be used?

A *Group Member Enrollment Application* must be used when **all** of the following statements regarding the practice apply.

- The practice has two or more practitioners practicing under a single tax identification number
- The practice has an IHCP group provider number or is submitting the *Group Member Enrollment Application* along with a *Billing Provider Enrollment Application* for a group provider number
- The practitioner being enrolled as a member of your group has never previously enrolled in the IHCP

Note: Complete a separate application for each group member being enrolled.

Completing the Application

Please carefully read the instructions prior to completing the application. The instructions are numbered to correspond with the field number on the application. You must complete the **entire** application and enclose **all requested attachments** before sending the application to the IHCP Provider Enrollment. Incomplete applications will be returned to the provider and will delay enrollment.

Group Provider Information

1. Enter your group (also called “billing”) provider number. If your group has not yet been assigned a provider number, this field may be left blank and your *Group Member Enrollment Application(s)* must be sent with a *Billing Provider Enrollment Application*.

Note: If you are waiting for confirmation of a billing provider enrollment application previously sent to Provider Enrollment, do not submit the Group Member Enrollment Application until you have received your confirmation letter and group billing provider number.

2. Enter the federal Taxpayer Identification Number (TIN) of the group in the Group Tax ID field.
3. Enter the Doing Business As (DBA) name of your group in the Provider Name field. (Note that if a business uses a name other than its legal name, the DBA name must be on file with the Secretary of State.)
4. Enter a contact name for questions regarding this application.
5. Enter the telephone number for the contact listed in item 4.
6. Enter a return address for the group where the application should be sent if additional information is required for enrollment in the IHCP.

Group Member Information

7. Enter the Social Security Number of the group member (practitioner).
8. Enter the first name of the group member.
9. Enter the middle initial of the group member.
10. Enter the last name of the group member.
11. Enter the Universal Provider Identification Number (UPIN) for the group member, if applicable. If not applicable, please write N/A in this field.
12. Enter the Federal Drug Enforcement Agency Certificate number for the group member. A copy of the certificate must be attached to the application.
13. Enter all appropriate licensing information for each state in which the group member will render services for IHCP members. A copy of each license must be attached to the application.
14. Please refer to Attachment A and list the specialty number(s) in this field that best describes the group member's area(s) of expertise. The primary specialty is listed first with additional specialties listed under the primary.

Service Location Links

15. Enter the alpha suffix for each group service location where this group member will be rendering services. The alpha suffix is the alpha character that follows the nine-digit provider number used in field 33 on the HCFA-1500 form. For example, if you place 303030330B in field 33 of the HCFA-1500 form, then 303030330 is the provider number and B is the service location alpha suffix.
16. Enter the state in which the service location specified in field 15 is located.
17. Enter the group member Medicare number that corresponds to the performing (rendering) Medicare number for the group. This number should be a six-digit number that matches the group's Medicare number followed by one or more alpha characters. You must attach the Medicare number assignment letter to this application or a copy of a remittance advice notice from Medicare with the correct Medicare number for the rendering provider, or a copy of a remittance advice notice from Medicare with the correct Medicare number for the rendering provider. Billing Medicare numbers will not be added to group member provider numbers.
18. Please refer to attachment A and list the specialty number in this field that will be the primary specialty practiced by the group member at the service location specified in field 15.
19. For the service location specified in field 15, enter the effective date of participation for the group member.

Note: Please complete numbers 15-19 for each location where the group member renders services.

20. 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.
21. The group member, rendering practitioner, must sign the application certifying that your group is authorized to bill for the services rendered by the group member. An original signature is required for enrollment.
22. Enter the date the group member signs the application in this field.
23. Print the name of the authorized officer of the group provider entity who is certifying the relationship between the group and the group member.
24. Print the title of the officer listed in field 23.
25. Enter the e-mail address of the officer listed in field 23 or a main e-mail address for the group if applicable.

26. Enter the telephone number of the officer listed in field 23.
27. Enter a fax number for the officer listed in field 23 if applicable.
28. The officer listed in field 23 must sign the application to certify the relationship between the group and the group member. An original signature is required for enrollment.
29. Enter the date the application is signed by the officer listed in field 23.

Medicaid/Children's Health Insurance Program Provider Agreement

The group member and the authorized officer of the group must both sign the Provider Agreement. Applications received without the provider agreement signed by the group member being enrolled and the authorized officer of the group will be returned to the group.

Note: A group member who leaves the group to form a sole proprietorship must contact Provider Enrollment for a Billing Provider Application to continue participation in the IHCP. The group must notify Provider Enrollment whenever a group member leaves the group.

Mailing Instructions

Once you have fully completed the application, signed the provider agreement, and enclosed copies of all required licenses, forms, and certifications, please send the entire packet to:

EDS – Provider Enrollment

P.O. Box 7263

Indianapolis, IN 46207-7263

Once your enrollment application and agreement have been reviewed, EDS will notify you in writing of the status of your enrollment. Please allow 15 business days for mailing and processing time.

Questions

Please visit our Web site at www.indianamedicaid.com or contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 with any questions about this application.