



**M E D I C A I D / C H I L D R E N ' S H E A L T H
I N S U R A N C E P R O G R A M P R O V I D E R
A G R E E M E N T**

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, drug 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 of 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 _____