IHCP Provider Name and Address Maintenance Form

www.indianamedicaid.com

Dear Provider:

Billing, Group, and Dual providers use this form to report name changes (business and personal) and address changes. Submit only the address information that changed. An owner, officer, or delegated administrator must sign the completed form. An original signature is required.

Groups are responsible for submitting rendering provider name changes. Rendering provider name changes do not require a W-9. However, proof of a legal name change must accompany the request. An updated practitioner's license is acceptable in lieu of the name change court document. When the practitioner's license does not show the new name, a legal name change document is presented.

Note: The IHCP does not maintain address information for rendering providers.

Provider Identification [Provider Number (LPI) Alpha Suffix, NPI, and ZIP Code+4]:

Provider profile maintenance is an important part of adhering to your Provider Agreement. Always ensure the IHCP can identify you by providing your specific service location on the form. Use your LPI with the alpha suffix or your reported NPI and ZIP Code + 4.

To request a change using an NPI, the NPI must first be reported to the IHCP. NPIs can be reported through links provided at indianamedicaid.com. You can use this form to change the Home Office, Mail To, or Pay To address for all of your actively enrolled service locations. See the checklist below.

Four addresses types are maintained for each provider service location enrolled in the IHCP.

Address Type	Description
Service Location	**This address must be a physical location. A post office box is not a valid service location address.** Read the detail in the Service Location name and address area on the form.
Home Office	**The address must be a physical location. A post office box is not a valid home office address.** Read the detail in the Legal Name and Home Office address area on the form. If the Home Office name or address change applies to all of the service locations enrolled for the provider business, a checkbox is available to indicate so. When the checkbox is marked, all of the provider's Home Office addresses are changed to the address listed on the submitted Address Maintenance Form.
Mail To	This is the location where the IHCP sends provider bulletins, newsletters, manuals, and general correspondence. A post office box is acceptable for a mailing address. If the same mailing address change applies to all of the service locations enrolled for the provider business, indicate it using the appropriate checkbox. When the checkbox is marked, all of the provider's service locations' mailing addresses are changed to the address listed on the submitted Address Maintenance Form.
Pay To	This is the name that appears on all payments. This is the location where the IHCP mails payments and remittance information. If the same Pay To address change applies to all of the service locations enrolled for the provider business, confirm by using the appropriate checkbox. When the checkbox is marked, all of the provider's service locations' Pay To addresses are changed to the address listed on the submitted Address Maintenance Form.

Web interChange:

Users can connect to Web interChange via the Internet to make inquiries concerning IHCP member eligibility, filed claims, and check payment information. More information is available through Web interChange than is available through Automated Voice Response (AVR) or the Omni swipe card device.

Name and Address Maintenance Processing:

After the Provider Enrollment Unit receives, reviews, and processes a provider maintenance form, the provider receives notification. If the form is incomplete or the required supporting documentation is not present, the form is returned to the provider. An instructional letter stating the reason(s) the address maintenance request was not processed is included with the form. Please allow at least 30 business days for mailing and processing before checking the status of the submitted form.

Name and Address Maintenance Information and Checklist:

The following checklist is designed to assist providers and the IHCP in completing and verifying that information is included on the attached form.

For Provider Use Only	Did you remember to….	For IHCP Use Only
☐	**Supporting documents required for a Home Office or Service Location business name change:** • Submit a new W-9 • Submit registration documentation from the Secretary of State or County Recorder's Office for the business. *Exception: A business name that is a non-registered personal name*.	☐
☐	**Fields 1 – 4.** Document the appropriate **LPI and Alpha Suffix** for the service location, **NPI, taxonomy** and Zip Code + 4 (nine digits).	☐
☐	**Fields 5 – 9.** Complete the Maintenance Request Information Section.	☐
☐	**Fields 10 – 13. Personal Name Change:** Submit documentation showing proof of a personal name change. A provider's updated license or appropriate certification may be presented as proof of a name change. If a provider license does not show the new name, an official document showing the legal name change is required.	☐
☐	**Fields 14 – 24. Service Location Change:** • Give the assumed business name or doing business as (DBA) name for the service location, if applicable. • Give the new physical location, telephone number, and county name for the service location.	☐
☐	**Fields 25 – 33. Home Office Change:** ▪ Give the Legal Business Name for the business ▪ Give the physical location of the home office ▪ If the change applies to the submitted service location only, check **No** in box 21. ▪ If the change applies to all of the business service locations, check **Yes** in box 21.	☐
☐	Provide the tax identification number associated with the service location (box 20).	☐
☐	**Fields 34 – 40. Mail To Address Change:** ▪ If the change applies to the submitted service location only, check **No** in box 28. ▪ If the change applies to all of the business service locations, check **Yes** in box 28.	☐
☐	**Fields 41 – 48. Pay To Address Change:** ▪ If the change applies to the submitted service location only, check **No** in box 36. ▪ If the change applies to all of the business service locations, check **Yes** in box 36.	☐
☐	**Fields 49 – 53. Contact Information:** This is the person who the IHCP should contact with questions about the submitted form. Answer Web interChange and additional contact method questions.	☐
☐	**Fields 54 – 59. Signatures.** Include the business and signatory names, business' tax ID, signatory' s original signature and business title, and signature date.	☐

Mailing Instructions:

Please retain a copy of the completed *IHCP Name and Address Maintenance Form* for your records. Mail the original signed form to the following address:

EDS – Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

Available Assistance:

Refer to the IHCP Web site at www.indianamedicaid.com for additional information, or contact Provider Enrollment Customer Assistance at 1-877-707-5750 for information about the field requirements for all IHCP provider forms.

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Billing Provider Identification

1. Billing IHCP Provider Number and Service Location Alpha Suffix:	2. National Provider Identifier (NPI) Number for Service Location:
3. Taxonomy:	4. ZIP + 4: **(Nine digits required)** -

Maintenance Request Information

5. Is the address change a result of a **change of ownership**? (If Yes, complete and submit the appropriate IHCP Enrollment Application, W-9, Provider Agreement, appropriate licensure and certifications for the provider type, the *Change of Ownership Addendum*, and a copy of the purchase agreement.) ☐ Yes ☐ No

6. **Rendering Provider Name Change** (Items 8-11 & 47-57)? ☐ Yes ☐ No

7. **Billing Provider Name Change** (Items 12-31 & 47-57)? (Submit registration documentation from the Secretary of State or County Recorder's office showing your filed business name and assumed business name(s) when the name(s) differ from your personal name.) **(Contact Information and Authorized Signatures are required to complete this form.)** ☐ Yes ☐ No

8. Billing Provider Address Change (Complete only those addresses that changed)

Rendering Provider Name Change ☐

To support a Rendering Provider's name change, submit a copy of the provider's updated license from the state(s) where the provider renders services to ICHP members. If a rendering provider's license is not current, submit a legal document showing the name change.

9. Rendering Provider's Current Name:	
10. Rendering Provider's Previous Name:	
11. Rendering Provider's LPI:	12. Rendering Provider's NPI:

Service Location Name and Address Change ☐

The service location name and address is for the site where members obtain services. A service location maintains supporting documentation related to the claim. The service location name must be the Doing Business As (DBA) name registered with the Secretary of State, except for sole proprietors or business owners who must register their Assumed Business Name with the county recorder. Anesthesiologists who provide services at multiple locations should enter their home office as their service location. **The address must be a physical location. A post office box is not a valid service location address.**

13. Current DBA Name:		
14. Previous DBA Name (Use this field when reporting a DBA Name Change Only):		
15. Street Address:		16. Indiana County:
17. City:	18. State:	19. ZIP + 4: **(Nine digits required)** -
20. Telephone:	21. Effective Date of Change:	

22. Is claim documentation kept at this location? ☐ Yes ☐ No

23. Are services provided in Indiana? ☐ Yes ☐ No

Legal Name and Home Office Address Change ☐

The home office is considered to be the legal entity maintaining ownership of the above 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, or filed with the County Recorder as the Assumed Business Name. The legal name and business name must match on the on the W-9. **The address must be a physical location. A post office box is not a valid home office address.**

24. Current Legal Name:		
25. Previous Legal Name (Use this field when reporting a Legal Name Change):		
26. Street Address:		
27. City:	28. State:	29. ZIP + 4: **(Nine digits required)** -
30. Tax ID Number:		

31. Change the **Home Office name** for all of the service locations associated with the identified provider. ☐ Yes ☐ No

32. Change the **Home Office address** for all of the service locations associated with the identified provider. ☐ Yes ☐ No

Mail To Name and Address Change ☐

The mailing address is the location where the IHCP sends provider bulletins, newsletters, manuals, and general correspondence. A post office box is acceptable for a mailing address.

33. Name:		34. Telephone:
35. Street Address:		
36. City:	37. State:	38. ZIP + 4: **(Nine digits required)** -

39. Change the Mail To address for all of the service locations associated with the identified provider. ☐ Yes ☐ No

Pay To Name and Address Change ☐

The pay to address is the location where the IHCP sends checks, remittance advices, and general claims payment information. If this is a billing agent's address, please provide the name, address, and telephone number of the billing agent. The name listed below as the Payee Name will appear as the payee on all checks and remittance. A post office box is acceptable for this address. **Billing agents must furnish proof of authorization to be the billing agent for provider.**

40. Payee Name:		
41. Billing Agent Name:		42. Telephone:
43. Street Address:		
44. City:	45. State:	46. ZIP + 4: **(Nine digits required)** -

47. Change the Pay To address for all of the service locations associated with the identified provider. ☐ Yes ☐ No

Contact Name	
The contact person is the person who answers questions about the information provided in this form.	
48. Contact Name:	49. Telephone:
50. Contact E-mail:	
51. Would you like a Web interChange application sent to your Mail To address? ☐ Yes ☐ No	
52. Are you willing to receive IHCP bulletins, banners, and newsletters via E-mail or the Web? ☐ Yes ☐ No	

Authorized Signature Information	
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 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. ***The owner or an authorized representative of the business entity directly, or ultimately responsible for operating the business enterprise must complete this section to avoid return of the form.***	
53. Legal Business Name (please print):	54. Tax ID:
55. Authorized Official's Name (please print):	56. Title:
57. Authorized Official's Signature:	58. Date:

To the Signatory: Please carefully read and complete the *IHCP Delegated Administrator Addendum* if you are not an owner or authorized official with the group. Owners, officials, and delegated administrators may sign maintenance forms. Provider profile maintenance can be processed only if the appropriate signature is present.