IHCP Enrollment Guide for Child Mental Health Wraparound Providers

Indiana Health Coverage Programs
DXC Technology
June, 2019

Table of Contents

- Overview of CMHW and the Division of Mental Health and Addiction (DMHA) Authorization Process
- Aspects of Indiana Health Coverage Programs (IHCP/Medicaid) Provider Enrollment
- Excluded Entities
- Appendix A – Screen-by-screen examples of **Group** Provider Enrollment application (slides 31-69)
- Appendix B – Screen-by-screen examples of **Rendering** Provider Enrollment application (slides 70-82)
- Appendix C – Linking Rendering Providers to Group (slides 83-92)
- Appendix D – Screen-by-screen examples of **Billing** Provider Enrollment application (slides 93-121)
- Registering on the Provider Healthcare Portal
- Helpful Tools

Caution!

Please review this entire document before beginning your application. This will save time and energy, and improve you chances of successfully submitting your application the first time!

DMHA Authorization of CMHW Providers

Child Mental Health Wraparound (CMHW)

- For information on the authorization process, please review the *Division of Mental Health and Addiction's Child Mental Health Wraparound Services* provider reference module: http://*provider.indianamedicaid.com/media/155601/dmha%20cmhw.pdf*
- Before enrolling as an Indiana Health Coverage Programs (IHCP) provider for the CMHW program, a provider must be authorized by the Family & Social Service Administration's (FSSA) DMHA
- After authorization by the DMHA, providers must enroll with the IHCP to become a Medicaid provider

Aspects of IHCP (Medicaid) Provider Enrollment

Provider classifications

Your DMHA authorization and your IHCP enrollment must match

- If DMHA authorized you as an Individual Provider with your Social Security Number, then you must enroll as an Individual Provider with your Social Security Number with IHCP (Medicaid).
- If DMHA authorized you as an Agency with your EIN number, then you must enroll as an agency with your EIN number with IHCP (Medicaid).

Provider classifications

- If DMHA authorized you as an agency, you **must** enroll as a **Group** with **Rendering** providers linked to the group
  - Group providers will enroll as their company/agency name, and must have a EIN (employer identification number)
  - All authorized CMHW staff are rendering providers
  - CMHW group providers are subject to an application fee: ($586 for 2019)
- If DMHA authorized you as an individual, you **must** enroll as a **Billing** provider with your individual name and social security number.
- **EIN=Group; SSN=Billing**

Caution!

- CMHW providers are not permitted by DMHA to enroll as agency and as a billing provider.
- Other programs may allow agencies, such as an LLC, to enroll as a billing provider. This is not allowed by DMHA for CMHW providers.

Provider Classifications

Example 1: Individual Provider

DMHA authorized individual provider, Jane Doe

Jane Doe will enroll as a individual billing provider using her social security number as her tax ID.

Provider Classifications

Example 2: Agency with three CMHW authorized provider staff, one of whom is the owner

DMHA authorized provider agency, ABC Agency

DMHA authorized ABC Agency staff includes:

- Rendering authorized staff 1 (staff)
- Rendering authorized staff 2 (staff)
- Rendering authorized staff 3 (staff)

ABC Agency will enroll as a GROUP

ABC Agency's authorized staff will each enroll as RENDERING providers

Provider Type & Specialty

- All Medicaid providers (group, rendering and billing) are assigned a provider type and specialty
- **CMHW** providers are:
  - **Provider Type 11- Mental Health**
  - **Provider Specialty 611- Child Mental Health Wraparound**
- CMHW providers should select this provider type and specialty when completing the provider enrollment application

National Provider Identifier (NPI)

- National Provider Identifier (NPI) is a unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS)
- **NPI's must be obtained for the group, billing, and rendering providers**
- Providers obtain an NPI from the National Plan and Provider Enumeration System (NPPES) https://nppes.cms.hhs.gov
- Providers will indicate their NPI on the Medicaid enrollment application

NPPES
National Plan & Provider Enumeration System

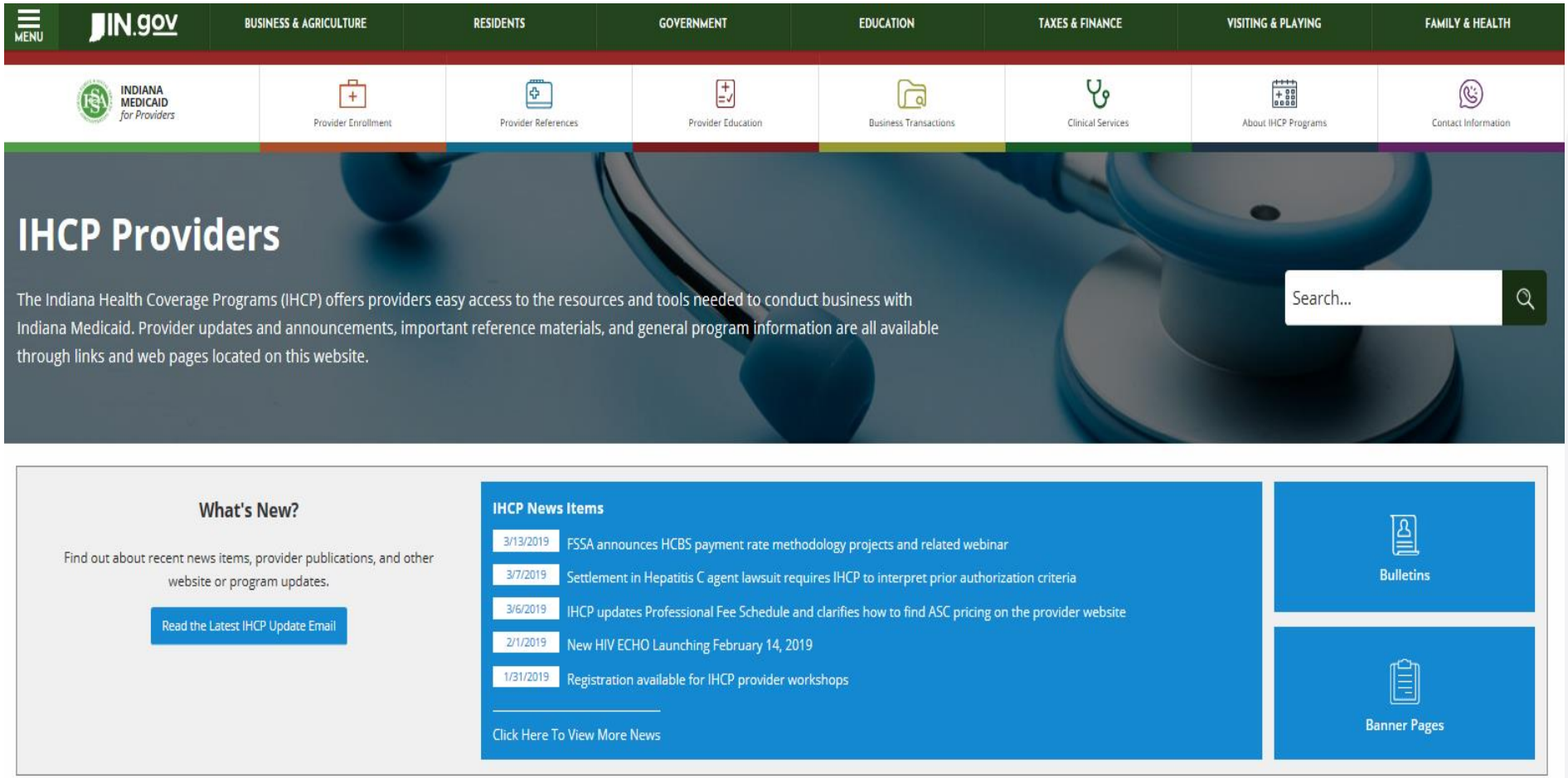
INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION FSSA

Taxonomy Codes

- Providers must choose taxonomy codes when obtaining an NPI from the NPPES (*choose it*)
- Taxonomy codes are administrative codes set for identifying the provider type and area of specialization for health care providers
- Each taxonomy code is a unique 10 character alphanumeric code that enables providers to identify their specialty at the claim level
- Providers must indicate their taxonomy codes during the Medicaid application process (*Use it)*
- Information on taxonomy codes is available at www.cms.gov
- Taxonomy code examples:
  - 193400000X – Single Specialty Group
  - 104100000X – Social Worker
  - 101YM0800X – Mental Health Counselor

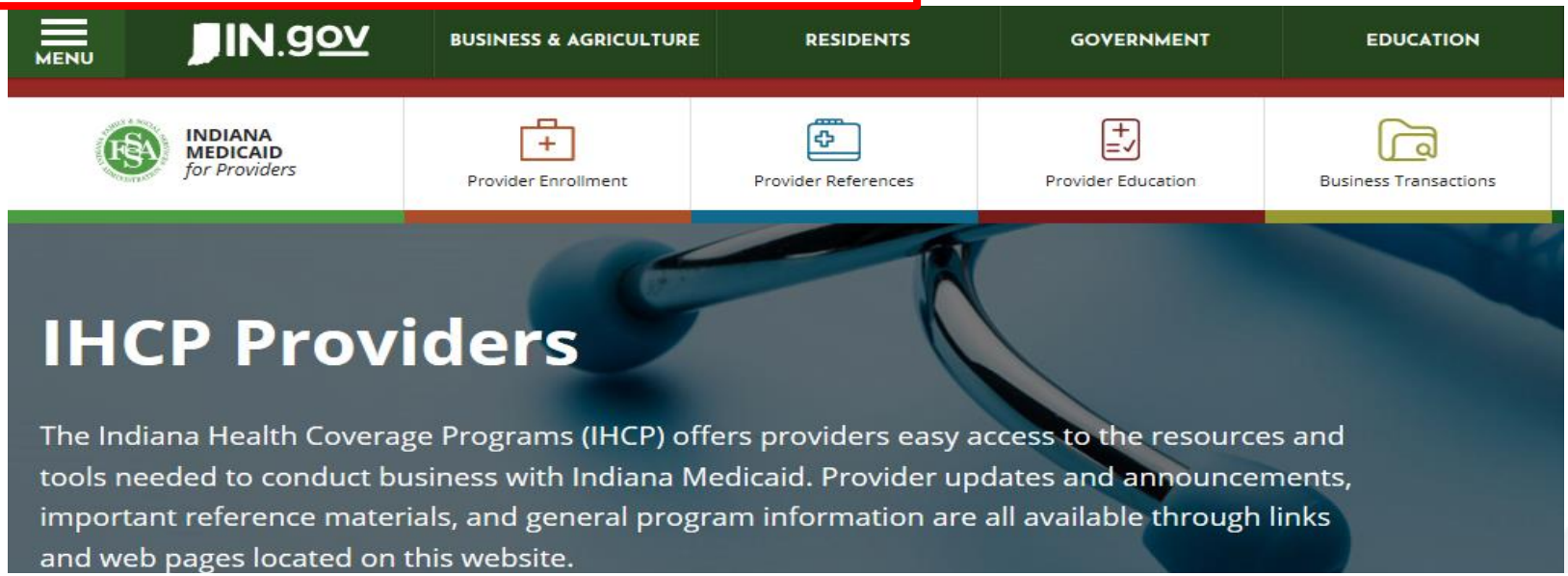
Enrolling in Medicaid

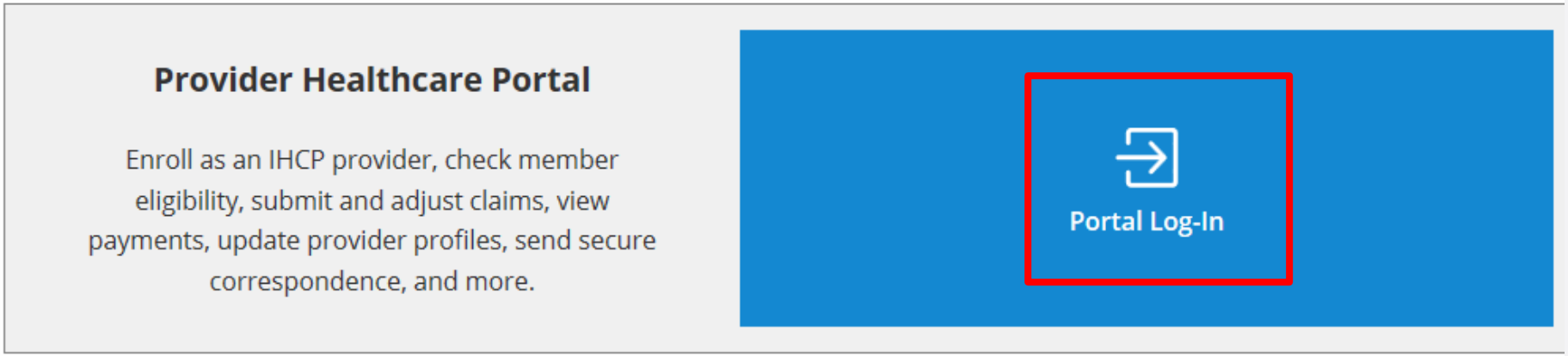
- Information about becoming a Medicaid provider is available at https://www.in.gov/medicaid/providers/index.html



Enroll from Provider Healthcare Portal

- Scroll down and click on Portal Log-In





Enroll on Provider Healthcare Portal

Login

*User ID

Log In

Forgot User ID?

Register Now

Where do I enter my password?

Protect Your Privacy!
Always log off and close all of your browser windows

Would you like to enroll as a Provider?

Provider Enrollment

Drug Resources

View Drug Formulary

Fee Schedule

Search Fee Schedule

WHAT CAN YOU DO IN THE PROVIDER HEALTHCARE PORTAL?

Through the Indiana Health Coverage Programs (IHCP) secure and easy-to-use internet portal, healthcare providers can:

- Submit claims
- Check on the status of their claims
- Inquire on a patient's eligibility
- View their Remittance Advices
- Request prior authorization

Managed Care Entities can:

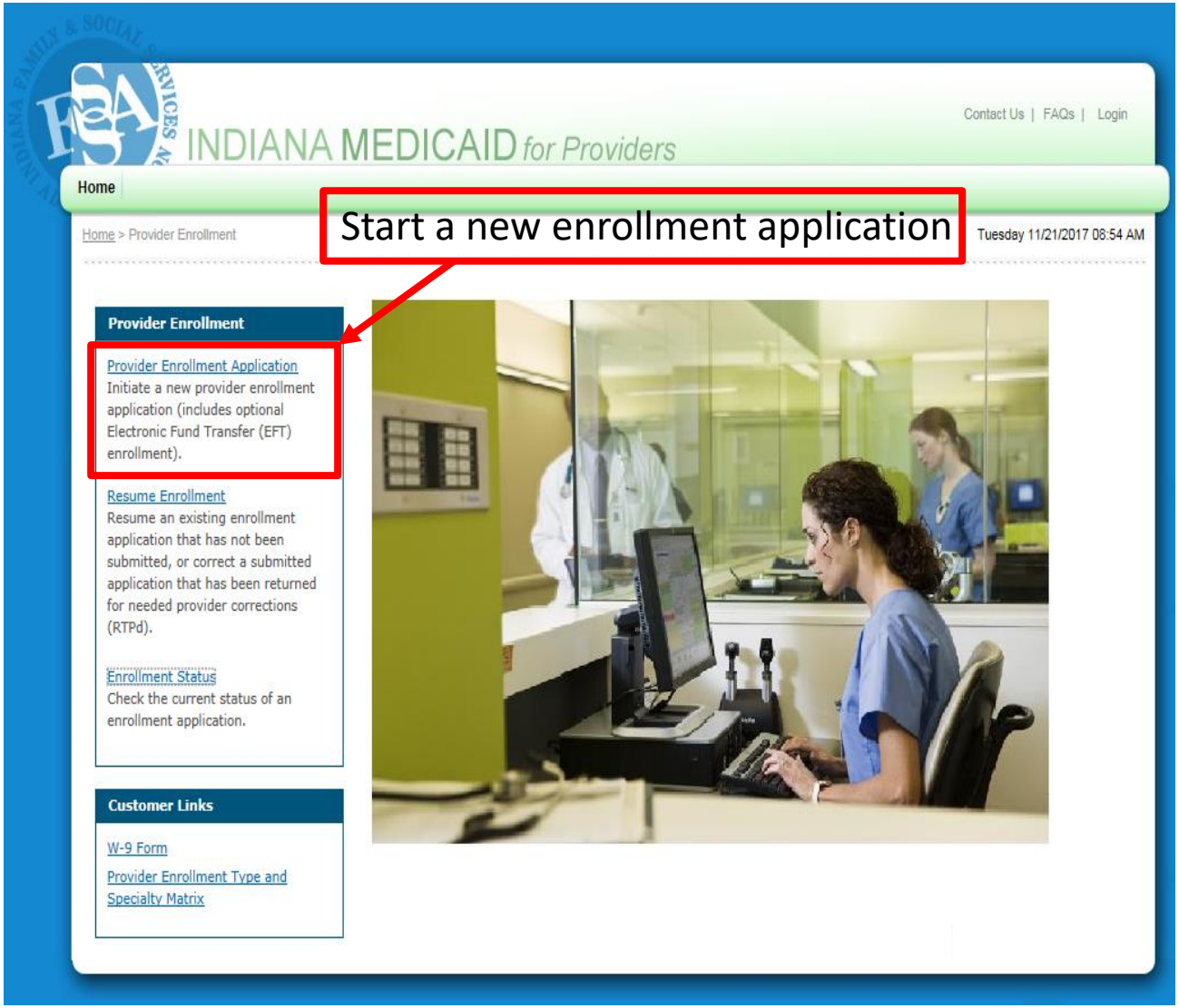
- Enroll, disenroll, and update primary medical providers
- Review their encounter claims
- Inquire on a managed care member's eligibility

In addition, the Portal provides access to a wide variety of IHCP information and resources.

On-line enrollment is accessed from the Portal Login screen

Using the Portal for Your Enrollment

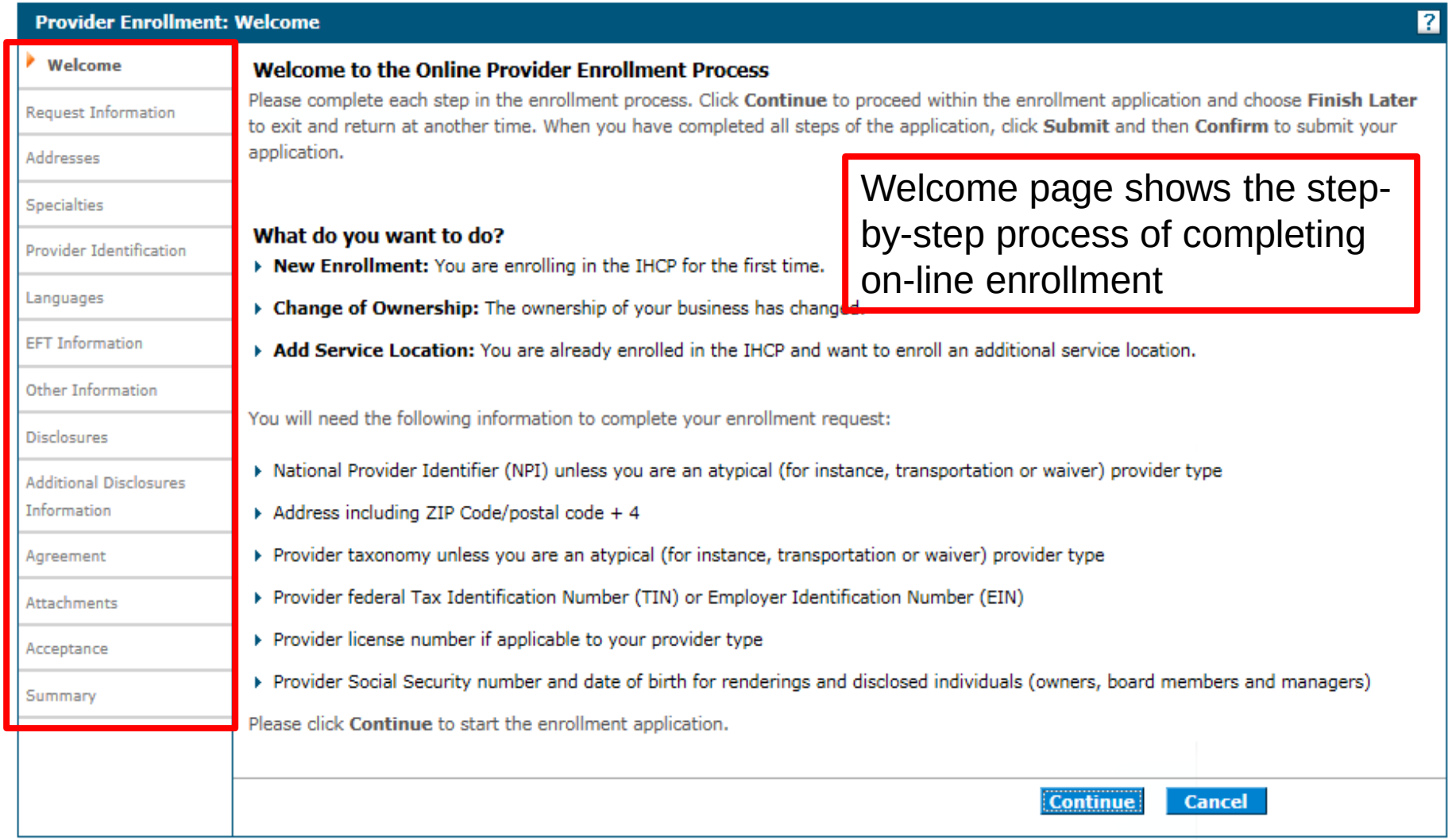
- The Portal's on-line provider enrollment feature is an easy-to-use option for providers enrolling for the first time, as well as for current providers who need to enroll a new service location or add rendering providers to their group. Providers can also make other updates to their profile or revalidate their enrollment.



Using the Portal for Your Enrollment

- Online transactions are more efficient and convenient
- Systematic checks help verify that information is complete, reducing inadvertent submission errors and the need for corrections
- Enrollment applications can be easily saved and edited, as needed, during the process
- Supporting enrollment documentation can be uploaded electronically and submitted with the transaction
- Providers can monitor the status of submitted transactions in real time

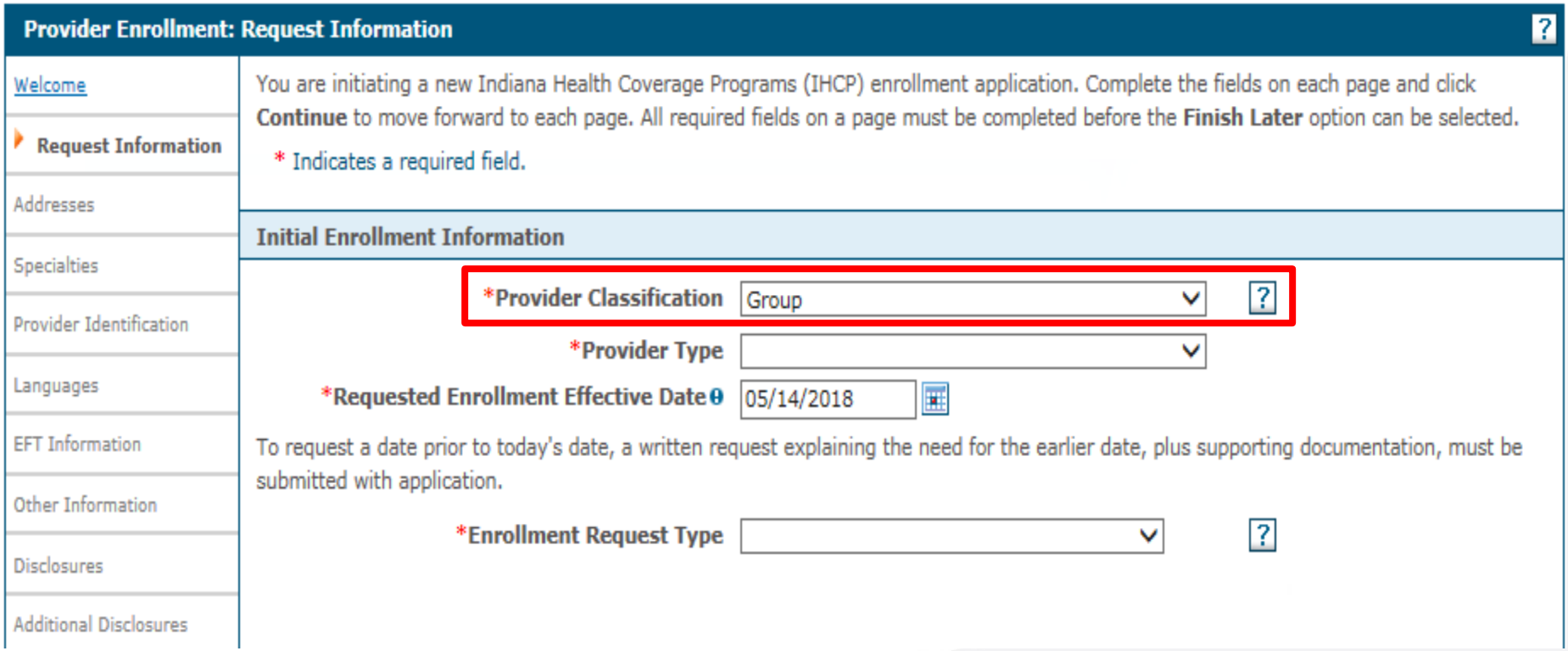
On-line Provider Enrollment: Welcome



Welcome page shows the step-by-step process of completing on-line enrollment

Enrolling the Group

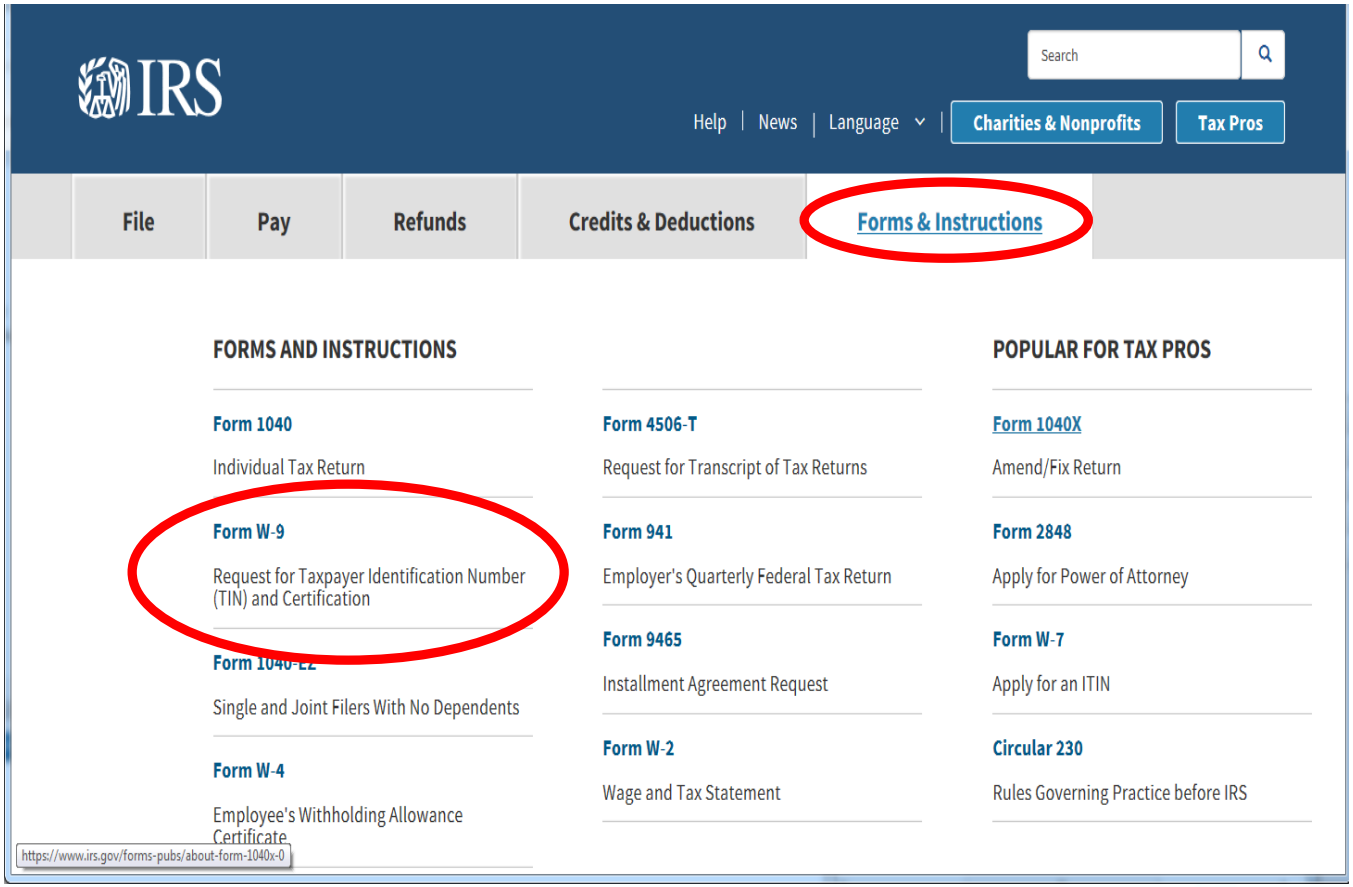
- If you are a group, enroll the group first, then enroll the rendering provider(s) to be linked to the group
  - Group application must be completed, or in process with an application tracking number (ATN), prior to beginning the rendering application



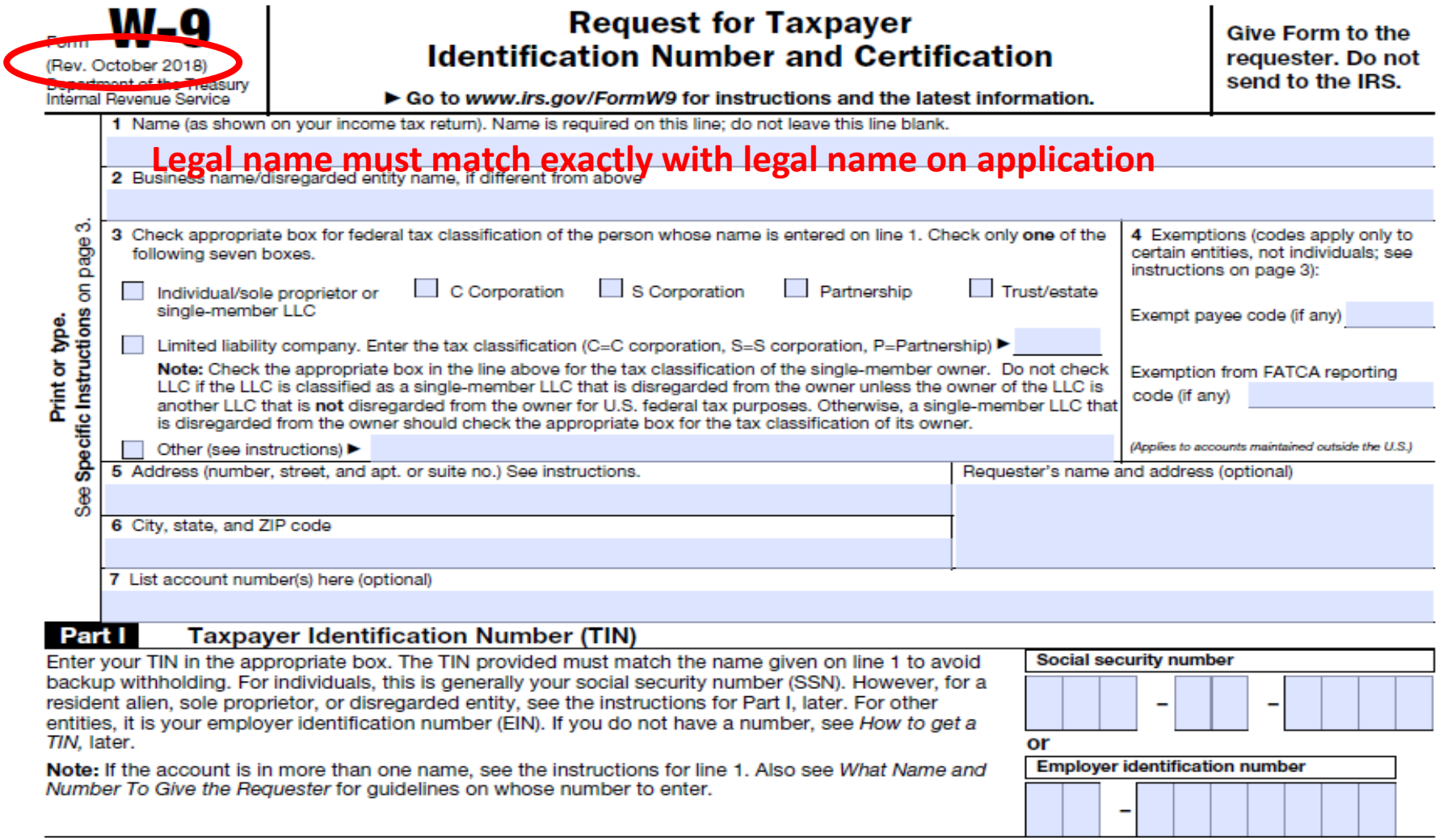
Form *W-9*

A *W-9* form must be included with each group enrollment

- The *W-9* must be the most recent version of the *W-9* from the irs.gov website
- Go to **Forms & Instructions**



Form W-9



Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Legal name must match exactly with legal name on application

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ►

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from FATCA reporting code (if any)

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Print or type. See Specific Instructions on page 3.

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

– –

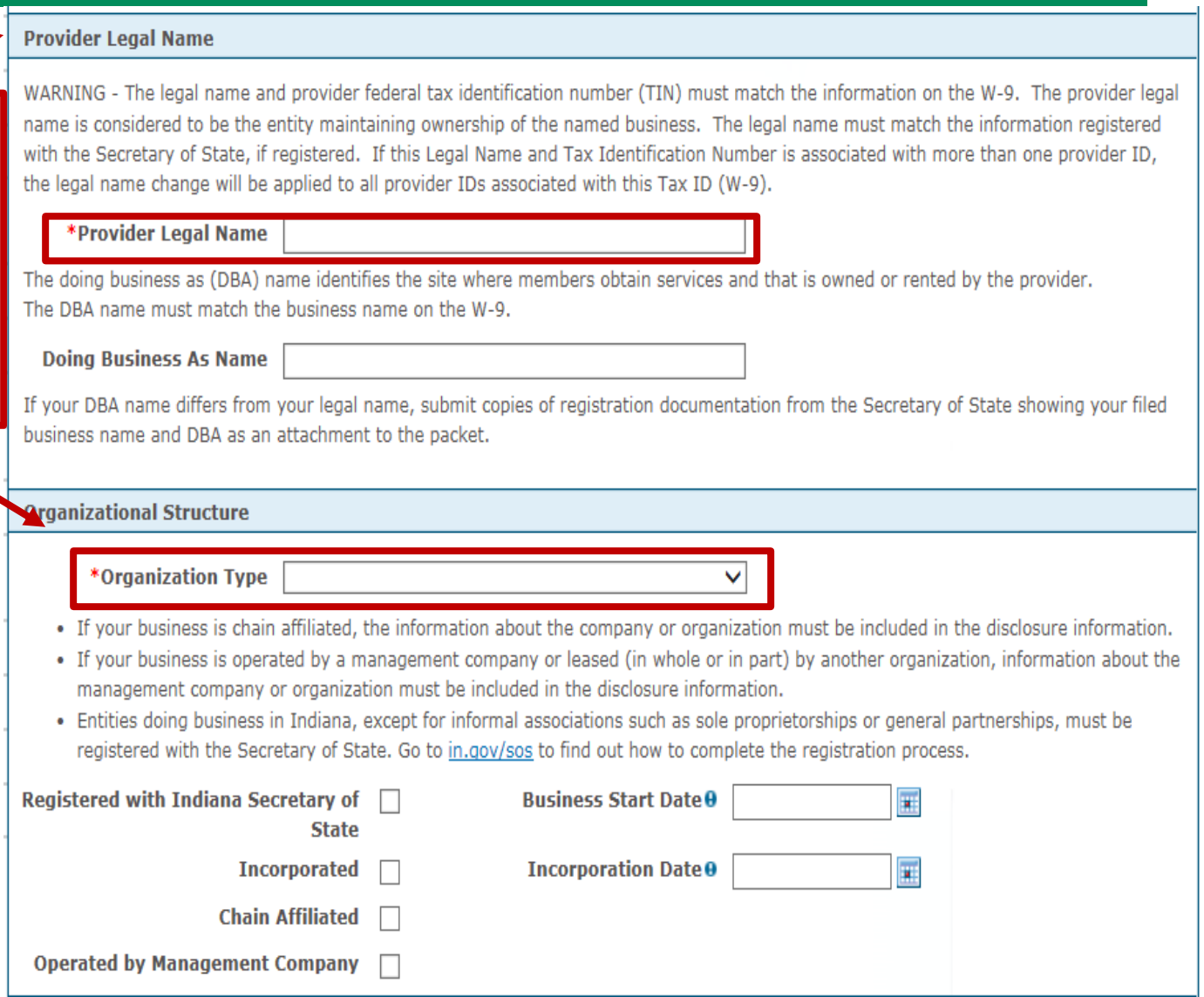
or

Employer identification number

–

Application Process – Legal Name and Organizational Structure

The legal name, doing business as (DBA), and organizational structure entered MUST match the *W-9* information submitted EXACTLY



Provider Legal Name

WARNING - The legal name and provider federal tax identification number (TIN) must match the information on the W-9. The provider legal name is considered to be the entity maintaining ownership of the named business. The legal name must match the information registered with the Secretary of State, if registered. If this Legal Name and Tax Identification Number is associated with more than one provider ID, the legal name change will be applied to all provider IDs associated with this Tax ID (W-9).

*Provider Legal Name

The doing business as (DBA) name identifies the site where members obtain services and that is owned or rented by the provider. The DBA name must match the business name on the W-9.

Doing Business As Name

If your DBA name differs from your legal name, submit copies of registration documentation from the Secretary of State showing your filed business name and DBA as an attachment to the packet.

Organizational Structure

*Organization Type

- If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.
- 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.
- 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 in.gov/sos to find out how to complete the registration process.

Registered with Indiana Secretary of State

Business Start Date

Incorporated

Incorporation Date

Chain Affiliated

Operated by Management Company

Appendix A, B, D

For screen-by-screen examples of the provider enrollment applications, refer to

- Appendix A for the **Group** application
  - (slides 31-69)
- Appendix B for the **Rendering** application
  - (slides 70-82)
- Appendix D for the **Billing** application
  - (slides 93-121)

Revalidation

- The CMS requires state Medicaid programs, such as IHCP, to *revalidate* provider enrollments at intervals not to exceed every five years
- This means you will have to complete a new enrollment with IHCP every five (5) years.
- This is separate from the CMHW reauthorization you are required to do with DMHA.
- IHCP will send reminders with instructions 90 and 60 days in advance of the revalidation due date to the “mail to” address on file

Excluded Entities

Obligation to Screen for Excluded Individuals/Entities

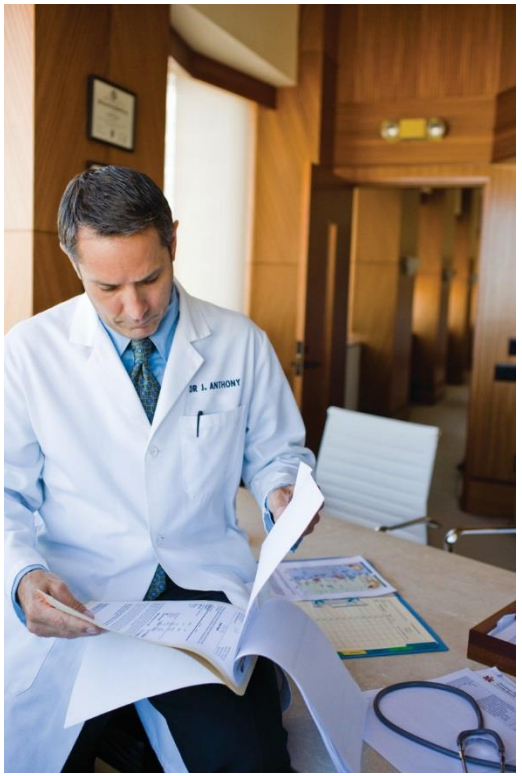
- The U.S. Health and Human Services Office of Inspector General (HHS-OIG) can exclude individuals and entities from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and all federal healthcare programs
- **Providers are obligated to screen employees and contractors for excluded individuals and entities before hiring or contracting as well as on a periodic basis**
- See IHCP provider bulletin *BT201731* for additional details

Obligation to Screen for Excluded Individuals/Entities

- As a condition of enrollment, all current IHCP providers, and providers applying to participate in the IHCP, are required to take actions to determine whether their employees and contractors are excluded individuals or entities
  - Screen all employees and contractors to determine if any have been excluded
  - Providers can access the List of Excluded Individuals/Entities (LEIE) database on the HHS-OIG website at oig.hhs.gov and search by the name of any individual or entity
  - Search the HHS-OIG website periodically to capture exclusions and reinstatements that have occurred since the last search
  - Report to the State any exclusion information discovered by contacting the Provider and Member Concern Line toll-free at 1-800-457-4515

Welcome Letter/DMHA Activation

- After approval of the application, the IHCP issues a “welcome letter” to the provider
- Providers will be assigned a 9-digit Provider ID, also referred to as “Medicaid Provider Number” and/or “Legacy Provider Identifier (LPI)”
  - Currently, the Provider ID begins with 3000
- Providers must send a copy of the entire welcome letter to the DMHA for the group as well as each rendering, and billing
- The DMHA sets the provider’s status to “Active”
- The provider is then fully enrolled, and will begin to appear on the pick list



Appendix A

*Screen-by-screen examples of **GROUP** Provider Enrollment application*

Do Group application first

Provider Enrollment: Request Information

Welcome
Request Information
Addresses
Specialties
Provider Identification
Languages
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Attachments
Acceptance
Summary

You are initiating a new Indiana Health Coverage Programs (IHCP) enrollment application. Complete the fields on each page and click **Continue** to move forward to each page. All required fields on a page must be completed before the **Finish Later** option can be selected.

* Indicates a required field.

Initial Enrollment Information

*Provider Classification: Group

*Provider Type: 11 : Mental Health Provider

*Requested Enrollment Effective Date: 04/08/2019

To request a date prior to today's date, a written request explaining the need for the earlier date, plus supporting documentation, must be submitted with application.

*Enrollment Request Type: New Enrollment

The effective date of the application will be the date it is submitted, unless you request a prior date. A copy of a claim must be attached to support the prior date

Provider Identification

A Social Security number or Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

Provider Identification

A Social Security number or Federal Tax Identification Number, also known as an Employer
business entity.

Enter group/agency EIN consistent with your DMHA application

*Federal Tax ID: *****3333

*Tax ID Type: (•) EIN ( ) SSN

*Are you currently enrolled as an IHCP provider? ( ) Yes (•) No

*Were you previously enrolled as an IHCP provider? (•) Yes ( ) No

*Previous IHCP Provider ID: 123456789

If not previously enrolled, check No

Contact Information

The contact person may be contacted to answer any questions regarding the information provided in this enrollment application. Email addresses will be used for IHCP business only.

Enter contact information

*Last Name: YOUR LAST NAME

*First Name: YOUR FIRST NAME

Title:

*Telephone Number: 1234567890

Telephone Number Extension:

Fax Number:

*Contact Email: your.email.address@yahoo.com

*Confirm Email Address: your.email.address@yahoo.com

Preferred Method of Communication: Email

Delegated Administrator Information

Not applicable unless you want to authorize someone to have "signing authority"

*Address Type: Service Location

*Service Location (DBA) Name: NAME OF YOUR GROUP

*Street: 950 N MERIDIAN ST

NULL

*City: INDIANAPOLIS

*County: MARION

*State: Indiana

*ZIP Code: 46204-1077

Enter the "service location" address (the actual physical location of the provider office); must be a street address with zip+4

This address information must be verified each time that it is changed. Please click the **Verify Address** button below each time the addre is changed. The address cannot be saved until it has been verified.

Verify Address

Click "verify address"; system verifies it is a valid address with postal service

Email Address:

Confirm Email Address:

*Telephone Number: 1234567890

Telephone Number Extension:

Fax Number:

Fax Extension:

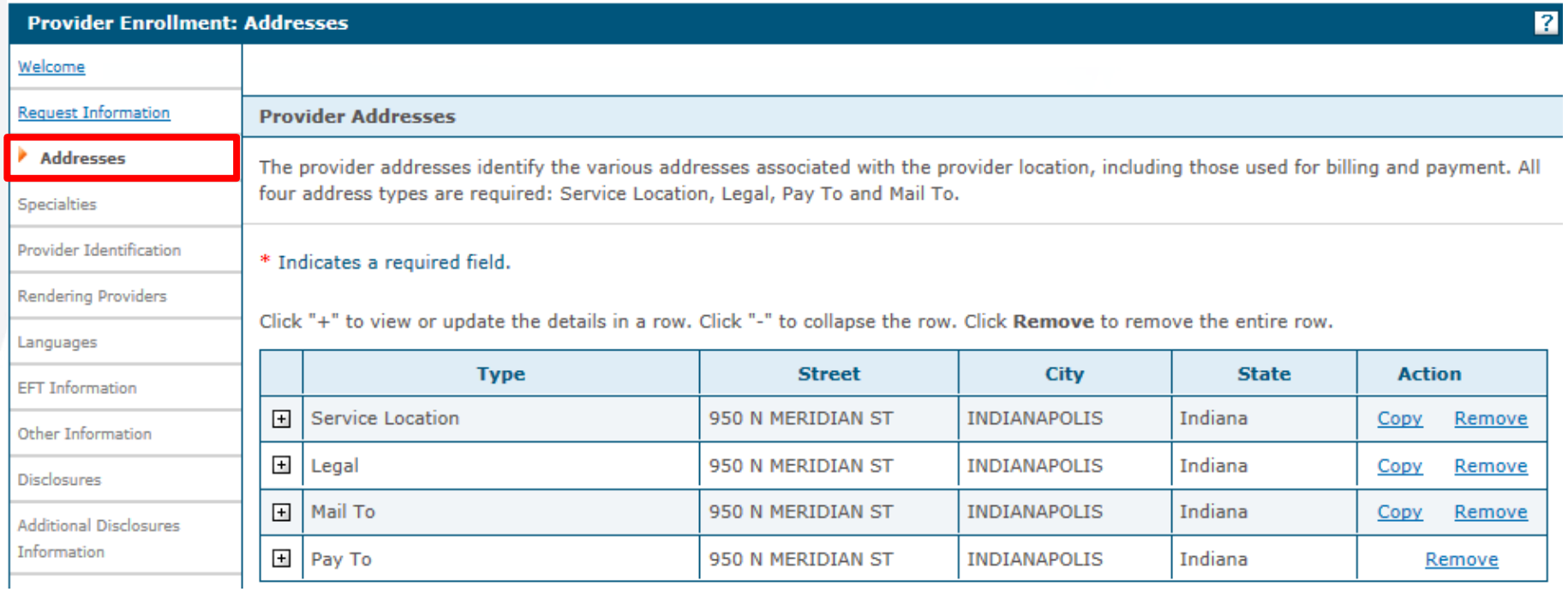
Service Address Information

If **Address Type** is changed from "Service Location", any information entered in the **Service Address Information** section will be lost upon **Add** or **Save** of address.

Claim Documentation Kept Here: ☑

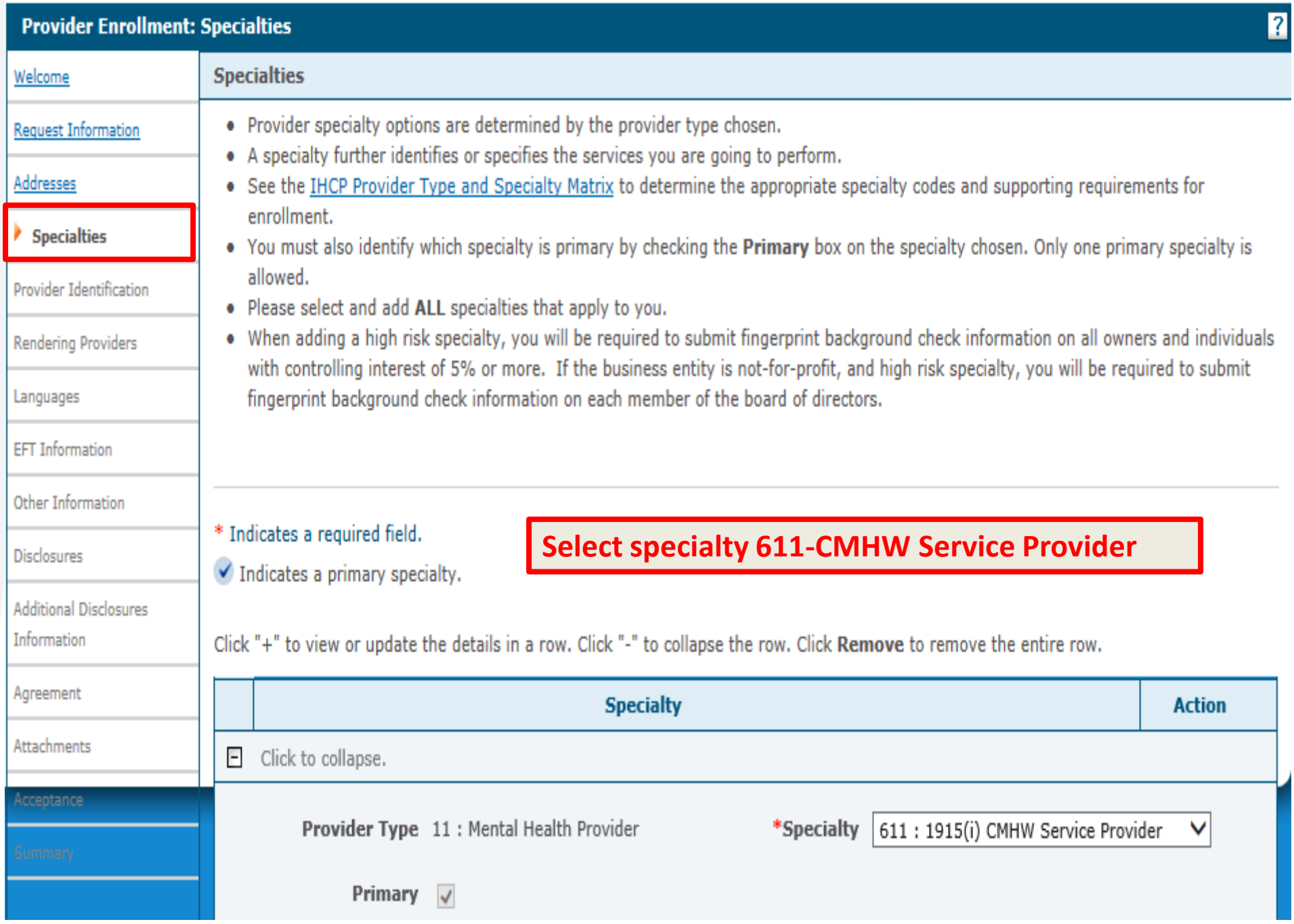
Check this box to confirm that claim documentation is maintained at this address

Four addresses required



After "service location" address is entered, us the Copy button to add "legal", "mail to" and "pay to" addresses. The legal address must match EXACTLY with address put on the W-9 form

"Mail to" is where general correspondence from the IHCP is mailed
"Pay to" is where your check will be mailed if you do not elect direct deposit


Provider Enrollment: Specialties
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Other Information
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Additional Disclosures Information
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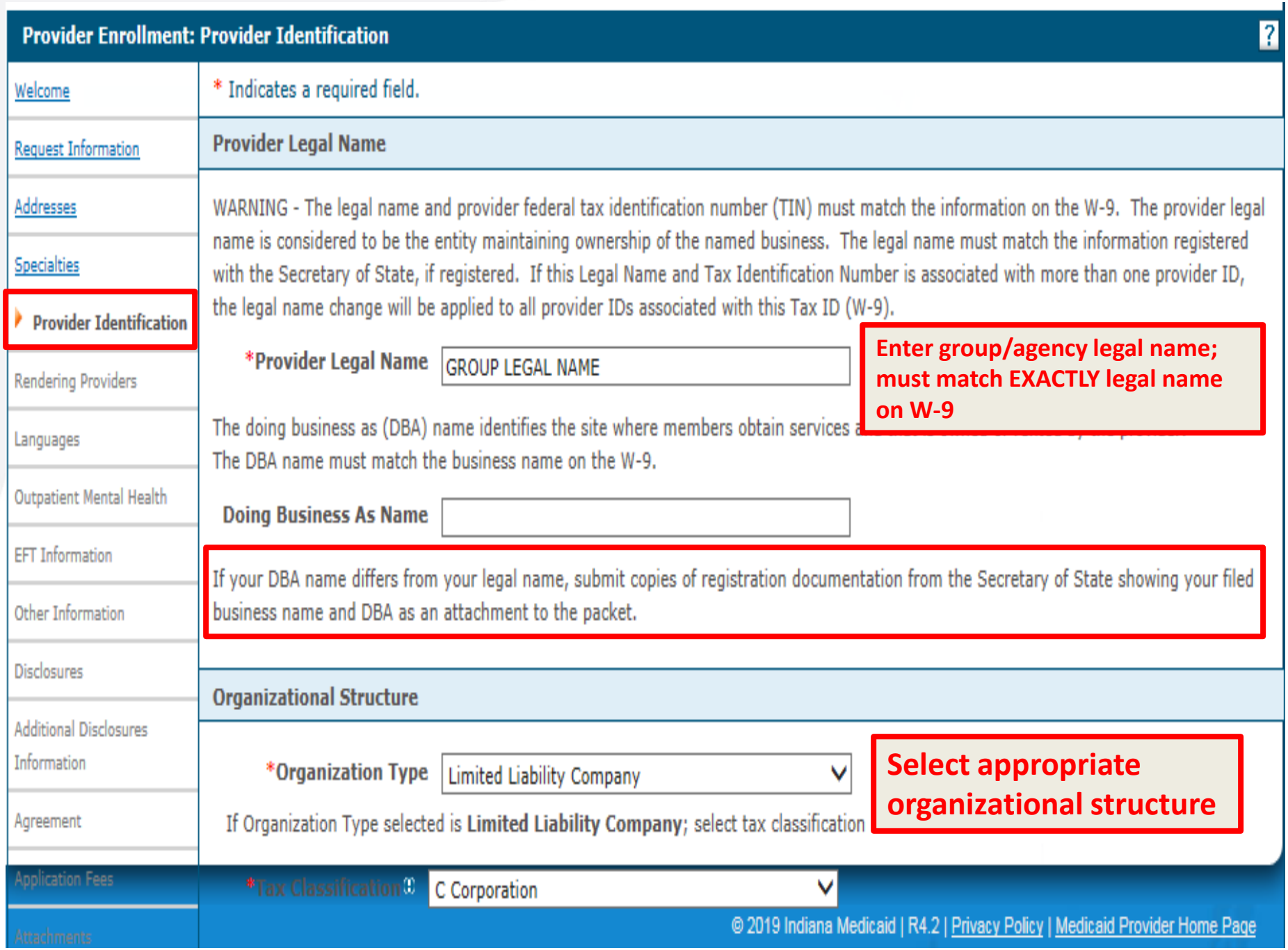
Summary
Specialties
Provider specialty options are determined by the provider type chosen.
A specialty further identifies or specifies the services you are going to perform.
See the IHCP Provider Type and Specialty Matrix to determine the appropriate specialty codes and supporting requirements for enrollment.
You must also identify which specialty is primary by checking the Primary box on the specialty chosen. Only one primary specialty is allowed.
Please select and add ALL specialties that apply to you.
When adding a high risk specialty, you will be required to submit fingerprint background check information on all owners and individuals with controlling interest of 5% or more. If the business entity is not-for-profit, and high risk specialty, you will be required to submit fingerprint background check information on each member of the board of directors.
* Indicates a required field.
Indicates a primary specialty.
Select specialty 611-CMHW Service Provider
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click Remove to remove the entire row.
Specialty
Action
Click to collapse.
Provider Type 11 : Mental Health Provider
*Specialty 611 : 1915(i) CMHW Service Provider
Primary


Provider Enrollment: Provider Identification
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Application Fees
Attachments
* Indicates a required field.
Provider Legal Name
WARNING - The legal name and provider federal tax identification number (TIN) must match the information on the W-9. The provider legal name is considered to be the entity maintaining ownership of the named business. The legal name must match the information registered with the Secretary of State, if registered. If this Legal Name and Tax Identification Number is associated with more than one provider ID, the legal name change will be applied to all provider IDs associated with this Tax ID (W-9).
*Provider Legal Name
GROUP LEGAL NAME
Enter group/agency legal name; must match EXACTLY legal name on W-9
The doing business as (DBA) name identifies the site where members obtain services a
The DBA name must match the business name on the W-9.
Doing Business As Name
If your DBA name differs from your legal name, submit copies of registration documentation from the Secretary of State showing your filed business name and DBA as an attachment to the packet.
Organizational Structure
*Organization Type
Limited Liability Company
Select appropriate organizational structure
If Organization Type selected is Limited Liability Company; select tax classification
*Tax Classification
C Corporation
© 2019 Indiana Medicaid | R4.2 | Privacy Policy | Medicaid Provider Home Page

*Tax Classification: C Corporation

- If your business is chain affiliated, the information about the company or organization must be included in the disclosure information.
- 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.
- 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 in.gov/sos to find out how to complete the registration process.

*Registered with Indiana Secretary of State: ☑

*Business Start Date: 04/08/2019

Incorporated: ☑

Incorporation Date: 04/08/2019

Chain Affiliated: ☐

Operated by Management Company: ☐

National Provider Identifier

National Provider Identifier (NPI) is a unique identification number for healthcare providers.

.... NPI subpart information

Enter your GROUP/agency NPI

*NPI: 123456789

Taxonomy Information

A taxonomy code identifies a healthcare provider type and specialty; it is not a unique physician identification number (UPIN), a Medicare provider number, or an IHCP provider number. The full taxonomy code set can be found at wpc-edi.com under *Reference*. The taxonomy requested is the taxonomy associated with the provider's NPI.

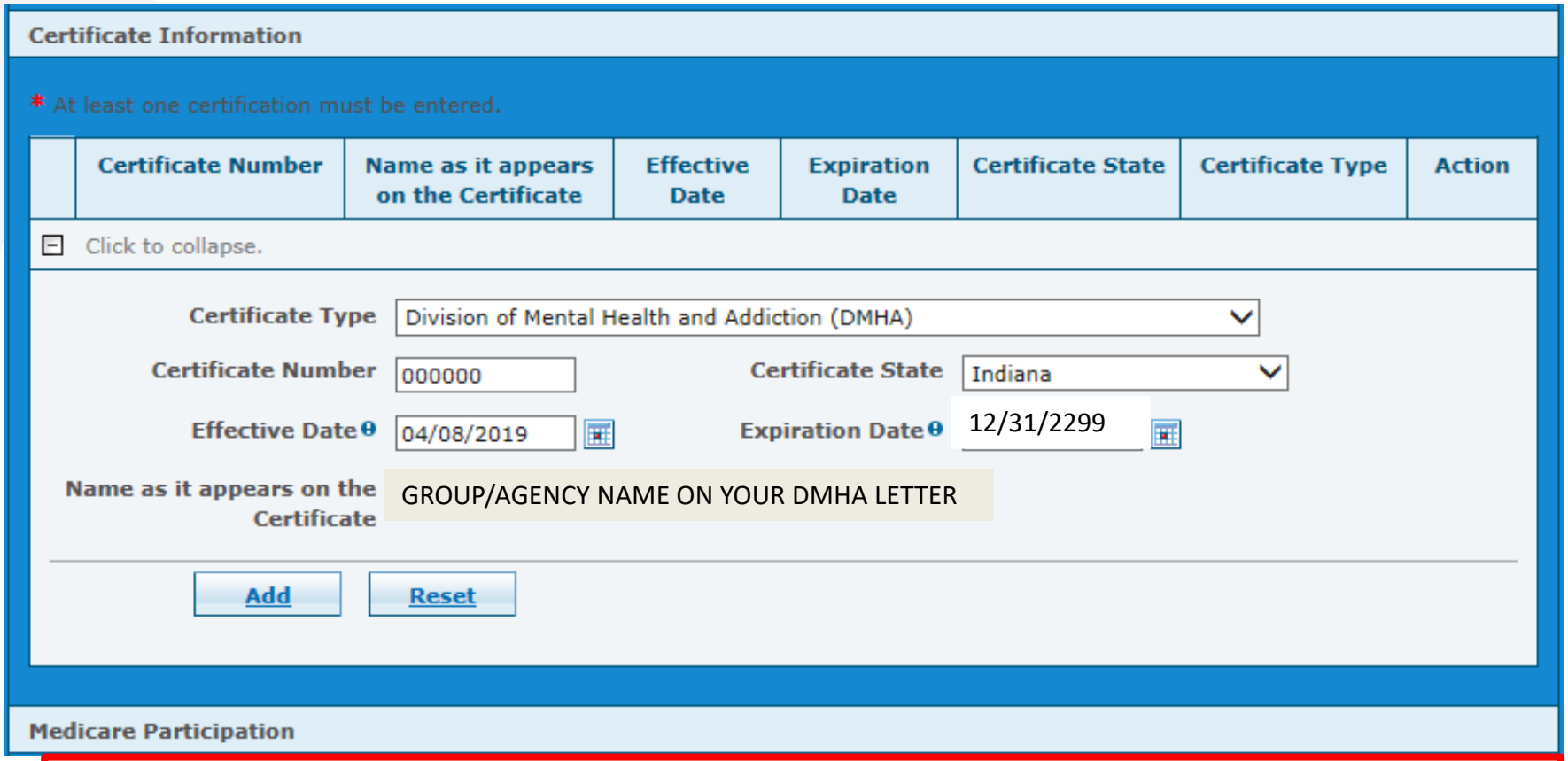
Please include all taxonomy codes that reflect the services to be provided at this service location.

* At least one taxonomy code must be entered.

Enter taxonomy code(s)

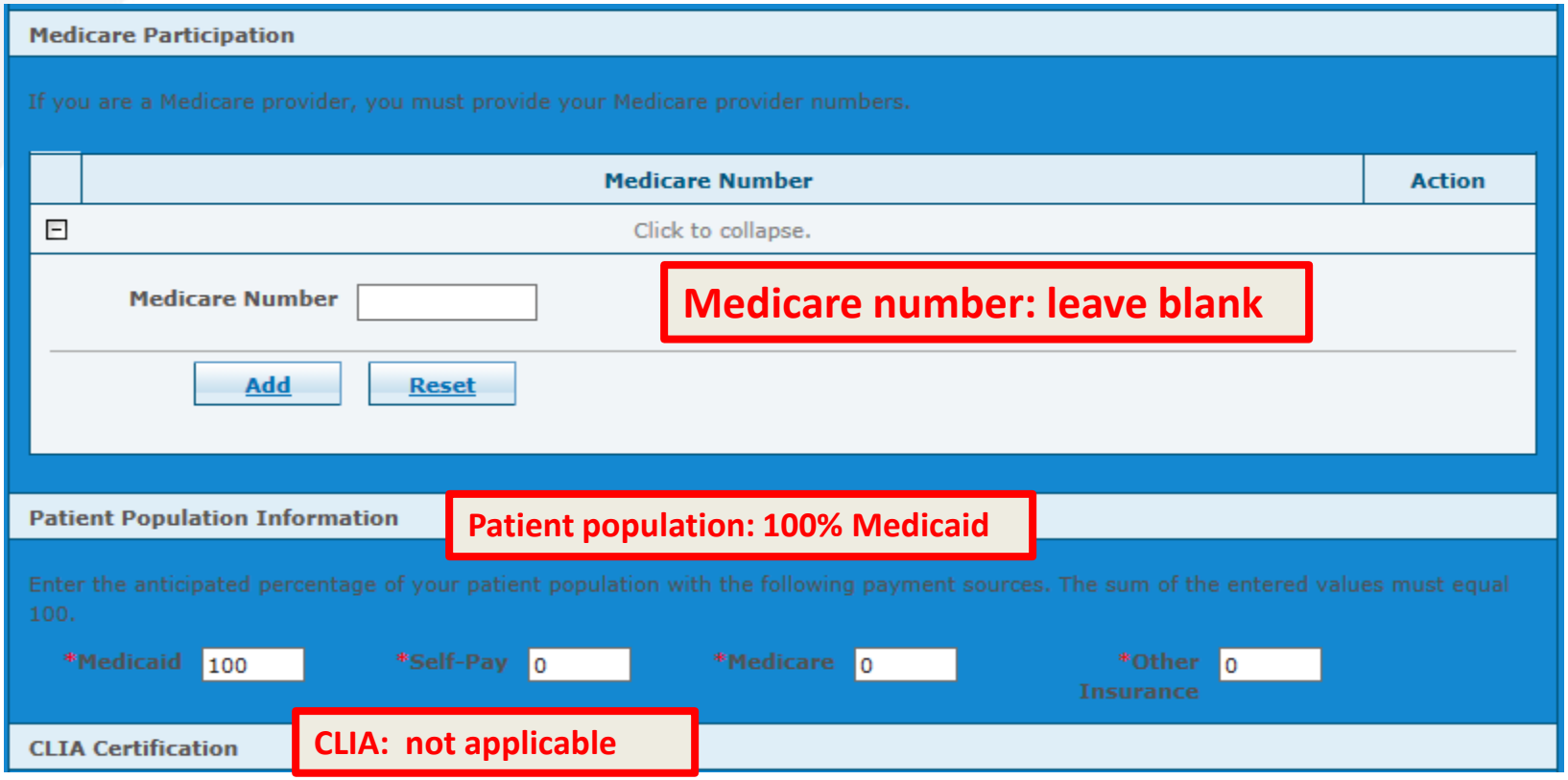
	Taxonomy	Action
	193200000X-Multi-Specialty	Remove
⊞	Click to add taxonomy.	

Certificate information

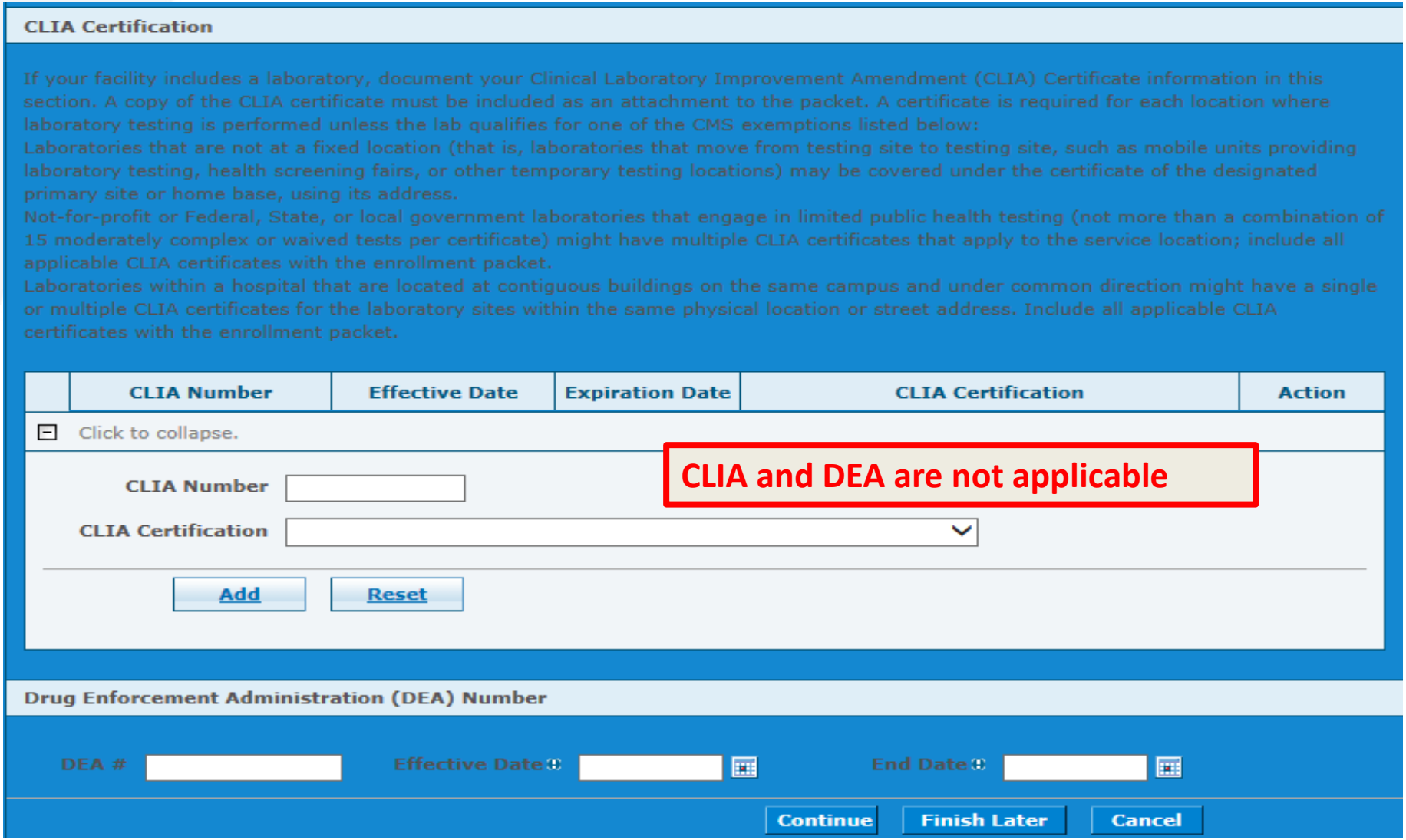


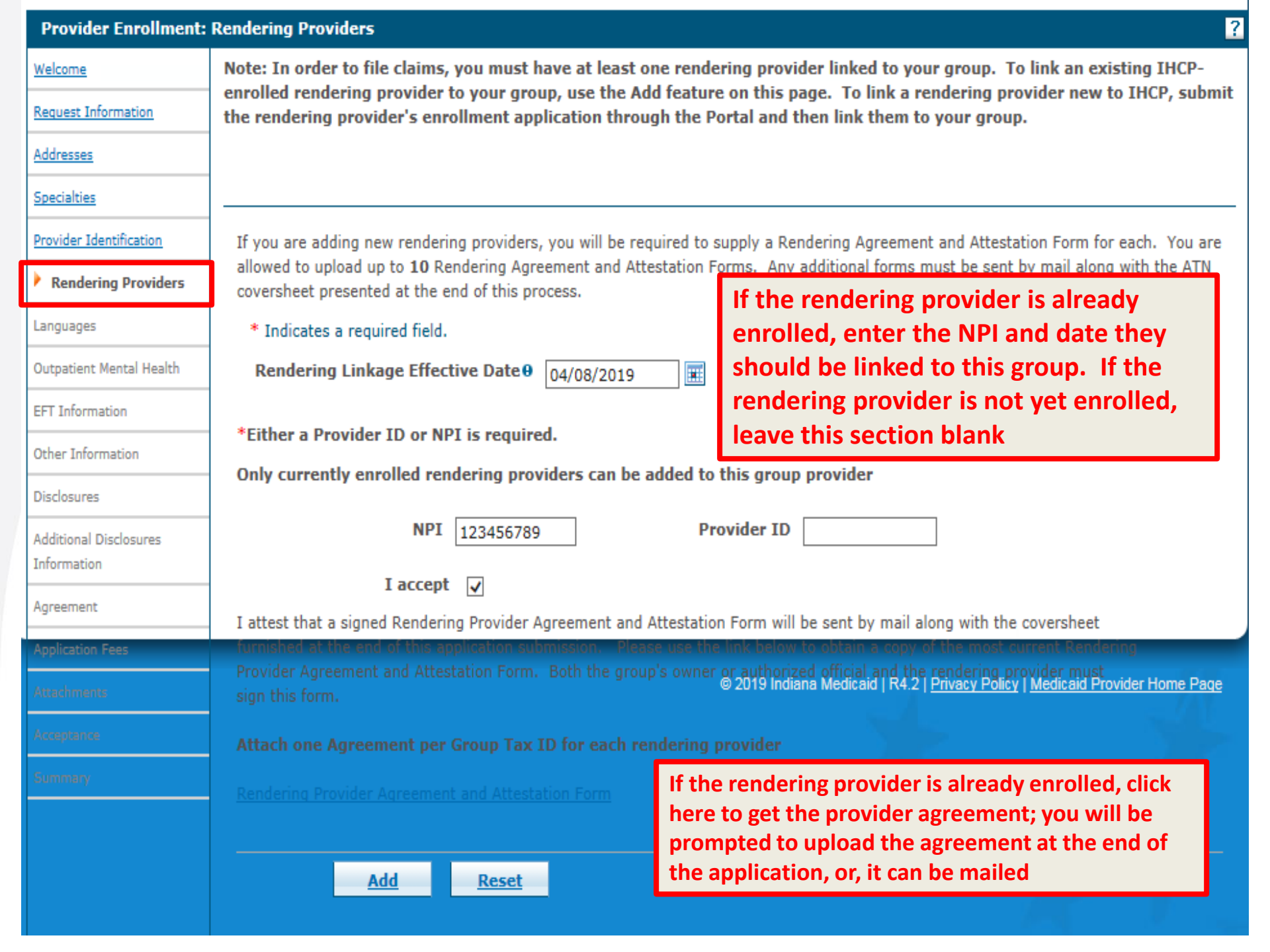
Select DMHA certificate type from drop down arrow; six zeros for certificate number; the effective date from your DMHA approval letter, the "infinity date" for expiration date, and the group name on your DMHA letter

Medicare, patient population, CLIA info



CLIA, DEA


CLIA Certification
If your facility includes a laboratory, document your Clinical Laboratory Improvement Amendment (CLIA) Certificate information in this section. A copy of the CLIA certificate must be included as an attachment to the packet. A certificate is required for each location where laboratory testing is performed unless the lab qualifies for one of the CMS exemptions listed below:
Laboratories that are not at a fixed location (that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations) may be covered under the certificate of the designated primary site or home base, using its address.
Not-for-profit or Federal, State, or local government laboratories that engage in limited public health testing (not more than a combination of 15 moderately complex or waived tests per certificate) might have multiple CLIA certificates that apply to the service location; include all applicable CLIA certificates with the enrollment packet.
Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction might have a single or multiple CLIA certificates for the laboratory sites within the same physical location or street address. Include all applicable CLIA certificates with the enrollment packet.
CLIA Number
Effective Date
Expiration Date
CLIA Certification
Action
Click to collapse.
CLIA Number
CLIA Certification
CLIA and DEA are not applicable
Add
Reset
Drug Enforcement Administration (DEA) Number
DEA #
Effective Date
End Date
Continue
Finish Later
Cancel


Provider Enrollment: Rendering Providers
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Application Fees
Attachments
Acceptance
Summary
Note: In order to file claims, you must have at least one rendering provider linked to your group. To link an existing IHCP-enrolled rendering provider to your group, use the Add feature on this page. To link a rendering provider new to IHCP, submit the rendering provider's enrollment application through the Portal and then link them to your group.
If you are adding new rendering providers, you will be required to supply a Rendering Agreement and Attestation Form for each. You are allowed to upload up to 10 Rendering Agreement and Attestation Forms. Any additional forms must be sent by mail along with the ATN coversheet presented at the end of this process.
* Indicates a required field.
Rendering Linkage Effective Date
04/08/2019
If the rendering provider is already enrolled, enter the NPI and date they should be linked to this group. If the rendering provider is not yet enrolled, leave this section blank
*Either a Provider ID or NPI is required.
Only currently enrolled rendering providers can be added to this group provider
NPI
123456789
Provider ID
I accept
I attest that a signed Rendering Provider Agreement and Attestation Form will be sent by mail along with the coversheet furnished at the end of this application submission. Please use the link below to obtain a copy of the most current Rendering Provider Agreement and Attestation Form. Both the group's owner or authorized official and the rendering provider must sign this form.
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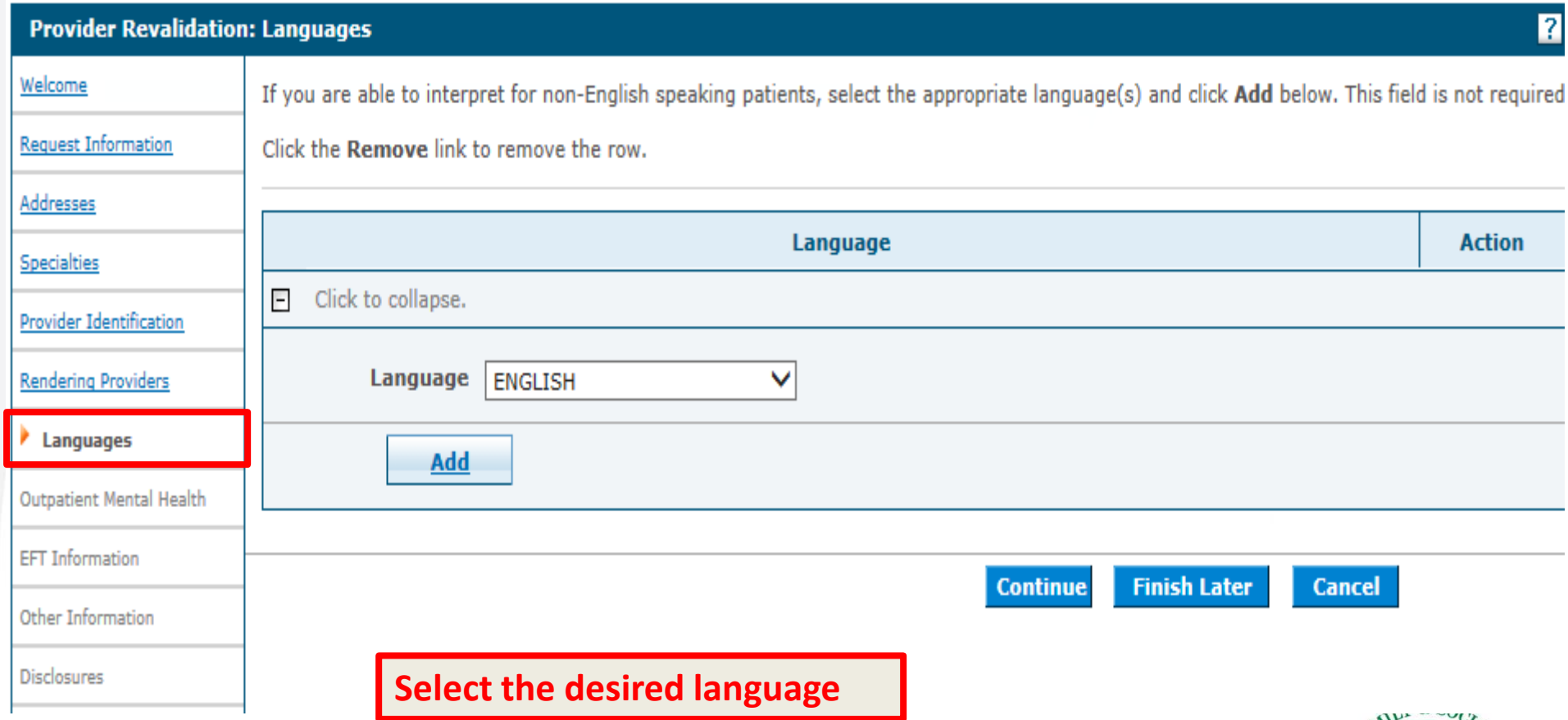
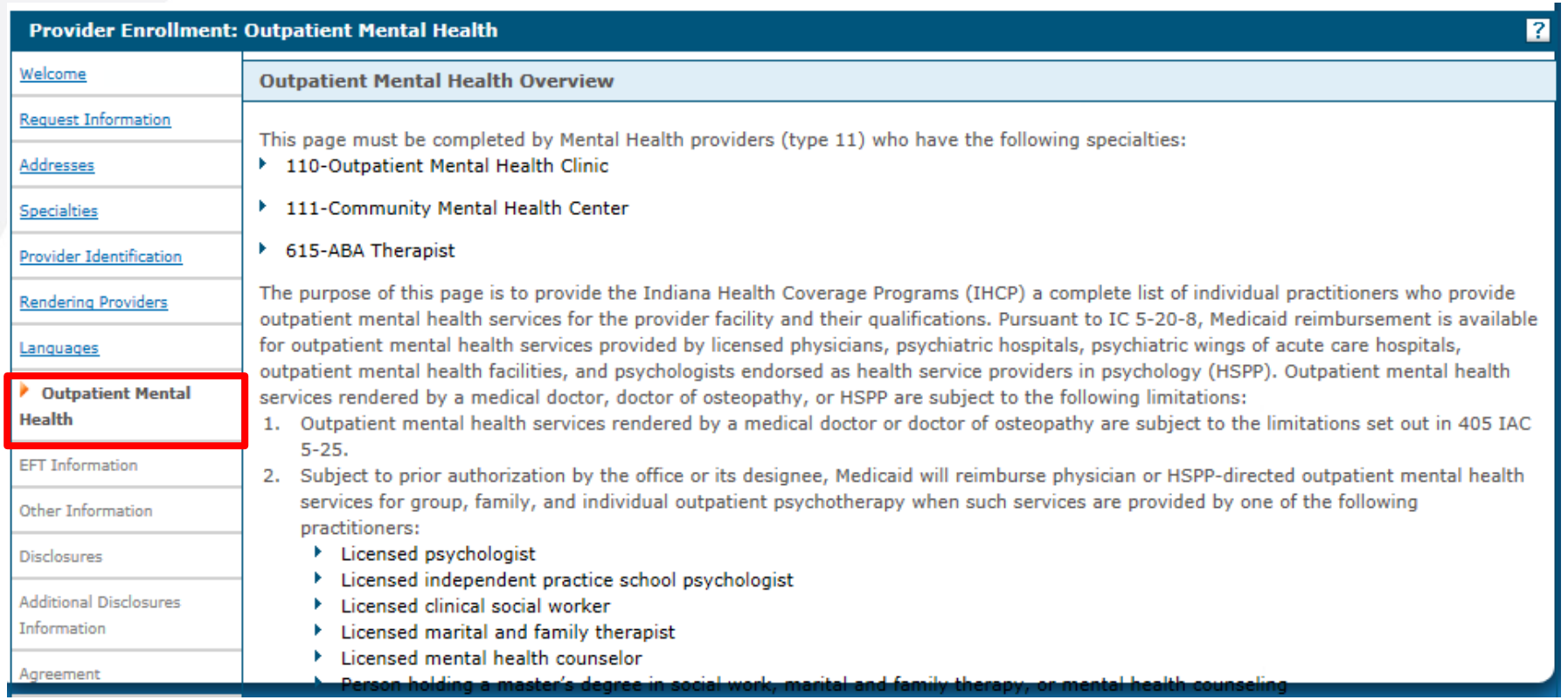
Attach one Agreement per Group Tax ID for each rendering provider
Rendering Provider Agreement and Attestation Form
If the rendering provider is already enrolled, click here to get the provider agreement; you will be prompted to upload the agreement at the end of the application, or, it can be mailed
Add
Reset

Language



Select the desired language

Outpatient Mental Health



This section is not applicable to CMHW providers; however, at this time, this section must be completed. Complete as directed on next three slides

Supervising Physician/HSPP

Supervising Physician or HSPP

Clearly identify the supervising pratictioner's name, IHCP Legacy Provider Identifier (Provider ID), and National Provider Identifier (NPI). The supervising physician or HSPP must provide a copy of his or her license as an attachment.

*Supervising Physician or HSPP Name: NOT APPLICABLE

* You must enter either a National Provider identifier (NPI), an existing IHCP Provider ID, or both.

Provider ID: NA

NPI:

*Supervising Physician or HSPP is a: ○ Contractor ◉ Employee

*License Number: 000000

*Issuing State: Indiana

I certify that I have read and understand the above text regarding Outpatient Mental Health. I further certify that I am an employee or contractor of this clinic and supervise all plans of treatment as required by law and outlined in the text.

*Electronic Signature of Supervising Physician or HSPP: YOUR INDIVIDUAL NAME

Date: 04/08/2019

Employees (RBT and BCaBA Therapists) or Contracting Practitioners

Enter NOT APPLICABLE, NA, six zeros for license number, Indiana, and your individual name

Employees (RBT and BCaBA Therapists) or Contracting Practitioners

	Practitioner's Name	NPI / Provider ID (if available)	Specialty	Qualifications - License Number	License/Certificate Issuing State	Action

Click to collapse.

This section is not applicable; leave blank

Practitioner's Name

NPI

Provider ID

Specialty

License Number

License/Certificate Issuing State

Add Reset

Outpatient Signature Section

Outpatient Signature Section

An authorized official or owner of the provider entity or a delegated administrator must complete the Signature Section of this page.

I have read and understand the above text related to outpatient mental health. I further certify that each practitioner listed on this list is an employee or contractor of our facility, each of these practitioners has been informed of the IHCP policy for reimbursement of outpatient mental health services, and each practitioner, whether employed or contracted, understands that he or she will be reimbursed for services by our facility. I further certify that all information provided is accurate to the best of my knowledge.

Legal Name of Outpatient Mental Health Clinic/Community Mental Health Center: GROUP LEGAL NAME

Taxpayer Identification Number (TIN): *****3333

Clinic NPI:

NPI ZIP + 4: 46204-1077

Taxonomy: 193200000X

Enter NOT APPLICABLE

*Authorized Official's Electronic Signature: NOT APPLICABLE

Title:

Date: 04/08/2019

Continue | Finish Later | Cancel

Provider Enrollment: EFT Information

- Welcome
- Request Information
- Addresses
- Specialties
- Provider Identification
- Rendering Providers
- Languages
- Outpatient Mental Health
- **EFT Information**
- Other Information
- Disclosures
- Additional Disclosures Information
- Agreement
- Application Fees
- Attachments
- Acceptance
- Summary

Providers that would like to have their claim payments deposited into a bank account should enter their relevant information below.

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.

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 will be mailed to the *Pay To* address documented. When your EFT account becomes active, direct deposits begin.

* Indicates a required field.

Would you like to have your payments electronically deposited? (•) Yes ( ) No

EFT (direct deposit) is highly recommended. If you select YES, enter your banking information. If you select NO, you will receive checks mailed to your "Pay To" address

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) *****3333

Provider National Provider Identifier (NPI)

Provider Agent Information

Provider agent Information is optional. If you wish to include provider agent information with your application, please click the checkbox and enter the required information. If you uncheck the checkbox, any data entered will be removed.

☐ **Does account belong to a provider agent (billing agent)?**

Financial Institution Information

***Financial Institution Routing Number**

***Type of Account at Financial Institution**

***Provider's Account Number with Financial Institution**

Provider Enrollment: Other Information

- Welcome
- Request Information
- Addresses
- Specialties
- Provider Identification
- Rendering Providers
- Languages
- Outpatient Mental Health
- EFT Information
- **Other Information**
- Disclosures
- Additional Disclosures Information
- Agreement
- Application Fees
- Attachments
- Acceptance
- Summary

Additional information is requested for each enrollment, for all billing, group, and rendering providers.

* Indicates a required field.

Managed Care Program Provider

After enrolling as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's Managed Care Program, you must apply directly with one or more of the managed care entities (MCEs). Please see the *Hoosier Healthwise MCEs* and *Healthy Indiana Plan MCEs* sections of the IHCP Quick Reference Guide at indianamedicaid.com for contact information.

Other IHCP Program Participation

This enrollment is to serve Medicaid members and is the first step in the process of enrollment to serve members in the managed care programs. There is also the option to have this enrollment considered as an 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 offsite facilities to individuals who reside in State institutions.

Select NO for 590 Program; Select NONE for Medical Review Program

***Participate in the 590 Program?** ○ Yes ◉ No

The **Medical Review Program** provides determination of 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 submit the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT is responsible for establishing 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 to DXC Technology 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 that elect to enroll as an IHCP provider and choose to provide MRT assessment services.
Medical Review Program Only – Providers that do not elect to enroll in the IHCP but choose to provide MRT assessment services only.
Medical Review Program – Medical Records Only – Providers that have been requested to supply MRT medical records only and want to bill for only those services.

***Medical Review Program Participation:** NONE

*Medical Review Program Participation: None

340B Participation

Section 340B of the *Veteran's Health Care Act* of 1992 limits the cost of covered outpatient drugs to entities such as certain federal grantees. Federally Qualified Health Centers (FQHCs), FQHC look-alikes, and qualified disproportionate share hospitals, enabling these entities to purchase drugs at discounted rates and stretch scarce federal resources. Indiana Health Coverage Programs (IHCP) policy regarding the 340B Program is as follows:

Federal law allows eligible entities to decide if they do or do not want to service Medicaid members using 340B stock. This decision is wholly at the discretion of the entity. However, once an eligible entity makes a decision to service or not service Medicaid members with the 340B stock, the entity is "locked" into that decision and not permitted to dispense a mix of 340B and non-340B drugs to Medicaid members.

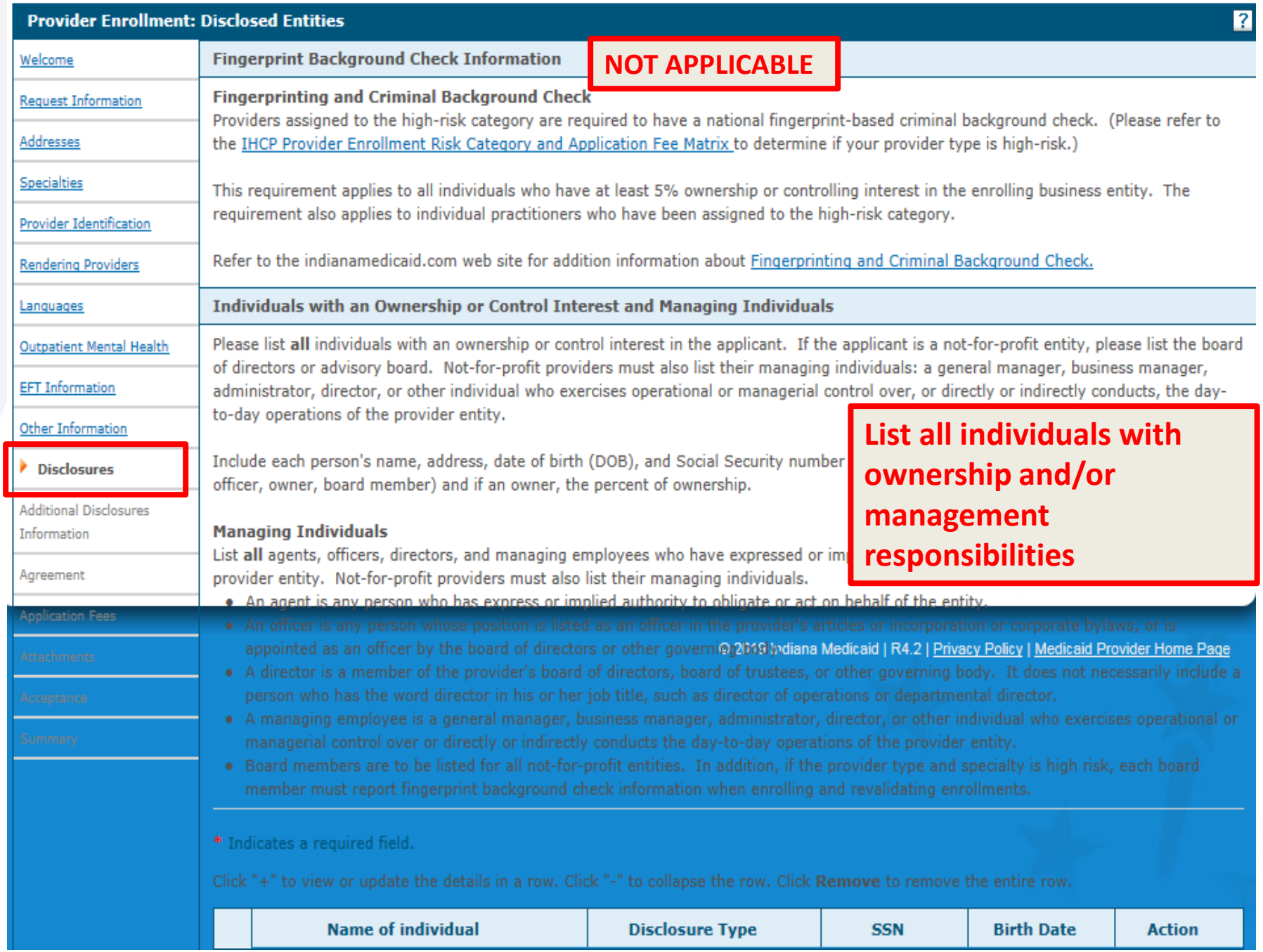
*340B Participation

- ○ The entity wishes to serve Medicaid members using 340B stock. It will only dispense 340B stock and bill the program accordingly at its acquisition cost of the drug, plus the Medicaid dispensing fee (carve-in).
- ◉ The entity wishes to serve Medicaid members using a separate non-340B stock. It will not use 340B stock at any time. The entity will bill the program at its usual and customary (U&C) charges to Medicaid (carve-out).

This section is not applicable; select either box

Federal law prohibits the entity from buying at 340B acquisition cost, providing 340B purchased stock to Medicaid members, and billing Medicaid at U&C rates.

Continue | Finish Later | Cancel


Provider Enrollment: Disclosed Entities
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Application Fees
Attachments
Acceptance
Summary
Fingerprint Background Check Information
NOT APPLICABLE
Fingerprinting and Criminal Background Check
Providers assigned to the high-risk category are required to have a national fingerprint-based criminal background check. (Please refer to the IHCP Provider Enrollment Risk Category and Application Fee Matrix to determine if your provider type is high-risk.)
This requirement applies to all individuals who have at least 5% ownership or controlling interest in the enrolling business entity. The requirement also applies to individual practitioners who have been assigned to the high-risk category.
Refer to the indianamedicaid.com web site for addition information about Fingerprinting and Criminal Background Check.
Individuals with an Ownership or Control Interest and Managing Individuals
Please list all individuals with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers must also list their managing individuals: 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.
Include each person's name, address, date of birth (DOB), and Social Security number
officer, owner, board member) and if an owner, the percent of ownership.
List all individuals with ownership and/or management responsibilities
Managing Individuals
List all agents, officers, directors, and managing employees who have expressed or im
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 or incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing
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.
Board members are to be listed for all not-for-profit entities. In addition, if the provider type and specialty is high risk, each board member must report fingerprint background check information when enrolling and revalidating enrollments.
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* Indicates a required field.
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click Remove to remove the entire row.
Name of individual
Disclosure Type
SSN
Birth Date
Action

	Name of individual	Disclosure Type	SSN	Birth Date	Action
⊟	YOUR LAST NAME, YOUR FIRST NAME	Ownership and Control, Managing Individuals	*****3333	7/1/1980	Remove

Fingerprint Background Check Information **NOT APPLICABLE**

Disclosure Type
- [x] Ownership and Control
- [x] Managing Individuals
- [ ] Board of Directors

Confirmation Number

Confirmation Source

Date Fingerprint Obtained

*Last Name: YOUR LAST NAME

*First Name: YOUR FIRST NAME

Middle:

Title:

% of ownership (if applicable): 100

*Social Security Number: *****3333

*Birth Date: 07/01/1980

*Street: 950 N. MERIDIAN STREET

*City: INDIANAPOLIS

*State: Indiana

*ZIP Code: 462041077

Enter name, social security number, address, birth date and percent ownership for all owners. Check disclosure type(s)

Save | Reset | Cancel

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **Remove** to remove the entire row.

	Name of Corporation	TIN	Action
⊟	Click to collapse.		

*Name of Corporation: NAME OF YOUR GROUP/AGENCY

*TIN: *****3333

% of Ownership: 100

Primary Business Address

*Street: 950 N. MERIDIAN STREET

*City: INDIANAPOLIS

*State: Indiana

*ZIP Code: 462041077

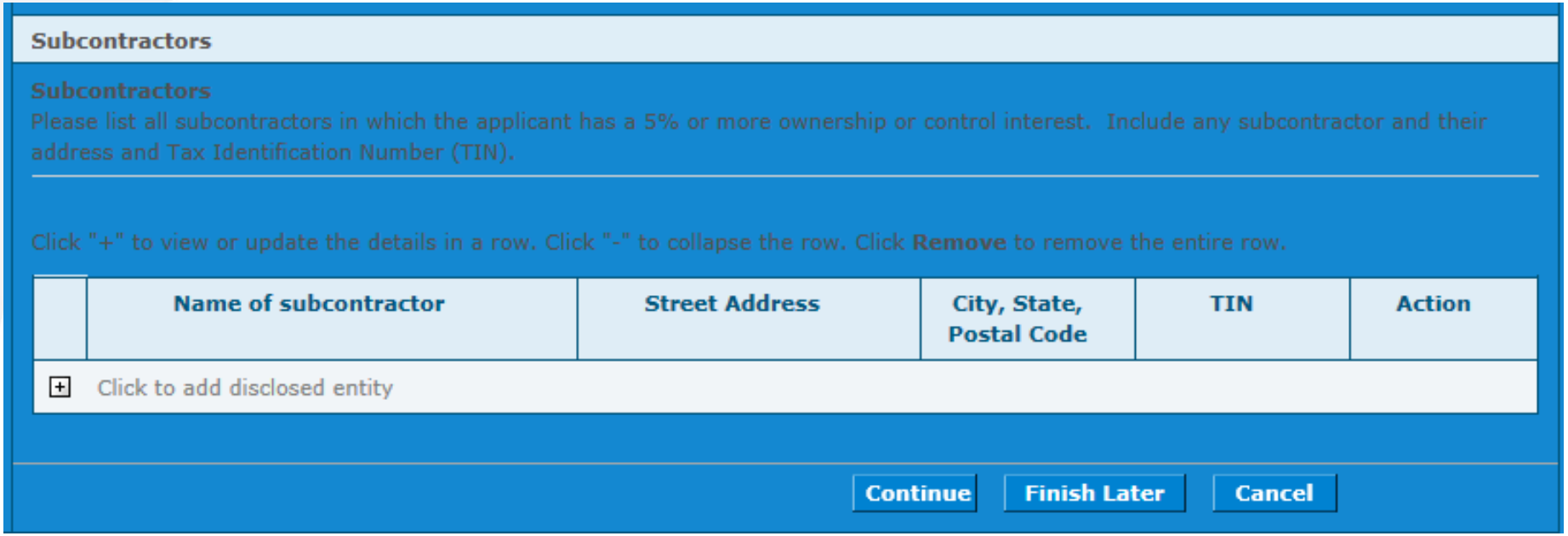
Enter information for any corporation that has ownership control

	Street Address	City, State, Postal Code	Action
⊞	Click to add address.		

Save Reset

Subcontractors

Subcontractors



Enter information on any subcontractor you have a 5% ownership control interest

Provider Enrollment: Disclosures

- Welcome
- Request Information
- Addresses
- Specialties
- Provider Identification
- Rendering Providers
- Languages
- Outpatient Mental Health
- EFT Information
- Other Information
- Disclosures
- **Additional Disclosures Information**
- Agreement
- Application Fees
- Attachments
- Acceptance
- Summary

*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 — ○ Yes ◉ No

*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? — ○ Yes ◉ No

*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? — ○ Yes ◉ No

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, XVII, 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.

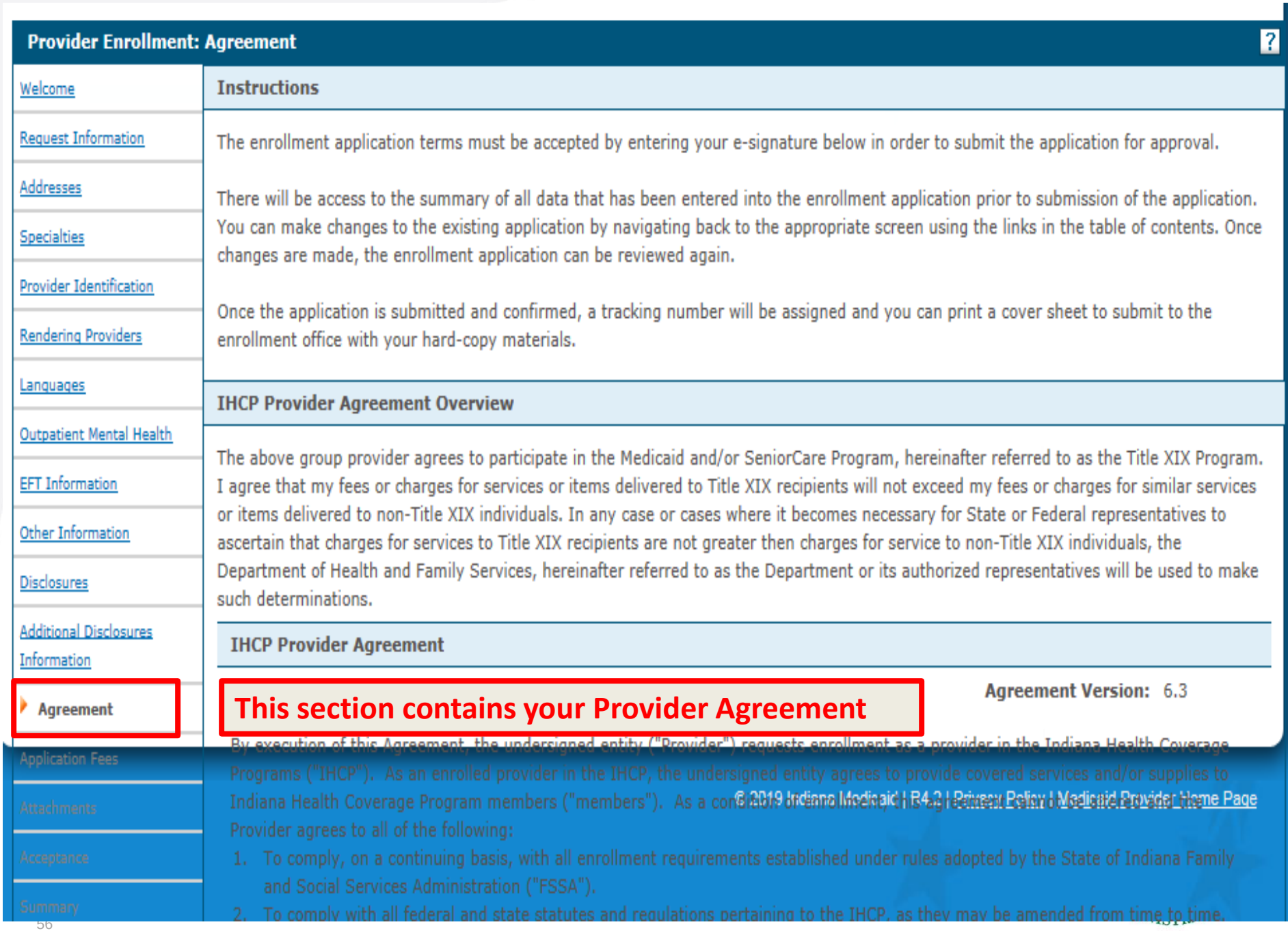
Whereas "disclosing entity" is limited to Medicaid providers, "other disclosing entity" can include entities that are not enrolled in Medicaid.

*Are there any disclosed parties with an ownership or control [illegible] 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? — ○ Yes ◉ No

*Are there any former agents, officers, directors, partners, or managing employees who have 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? — ○ Yes ◉ No

Read each section carefully and answer Yes or No

C.1 refers to "owners" listed on previous slide: C.3 refers to "management" listed on previous slide


Provider Enrollment: Agreement
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Application Fees
Attachments
Acceptance
Summary
Instructions
The enrollment application terms must be accepted by entering your e-signature below in order to submit the application for approval.
There will be access to the summary of all data that has been entered into the enrollment application prior to submission of the application. You can make changes to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.
Once the application is submitted and confirmed, a tracking number will be assigned and you can print a cover sheet to submit to the enrollment office with your hard-copy materials.
IHCP Provider Agreement Overview
The above group provider agrees to participate in the Medicaid and/or SeniorCare Program, hereinafter referred to as the Title XIX Program. I agree that my fees or charges for services or items delivered to Title XIX recipients will not exceed my fees or charges for similar services or items delivered to non-Title XIX individuals. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to Title XIX recipients are not greater then charges for service to non-Title XIX individuals, the Department of Health and Family Services, hereinafter referred to as the Department or its authorized representatives will be used to make such determinations.
IHCP Provider Agreement
Agreement Version: 6.3
This section contains your Provider Agreement
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 between the State and Provider
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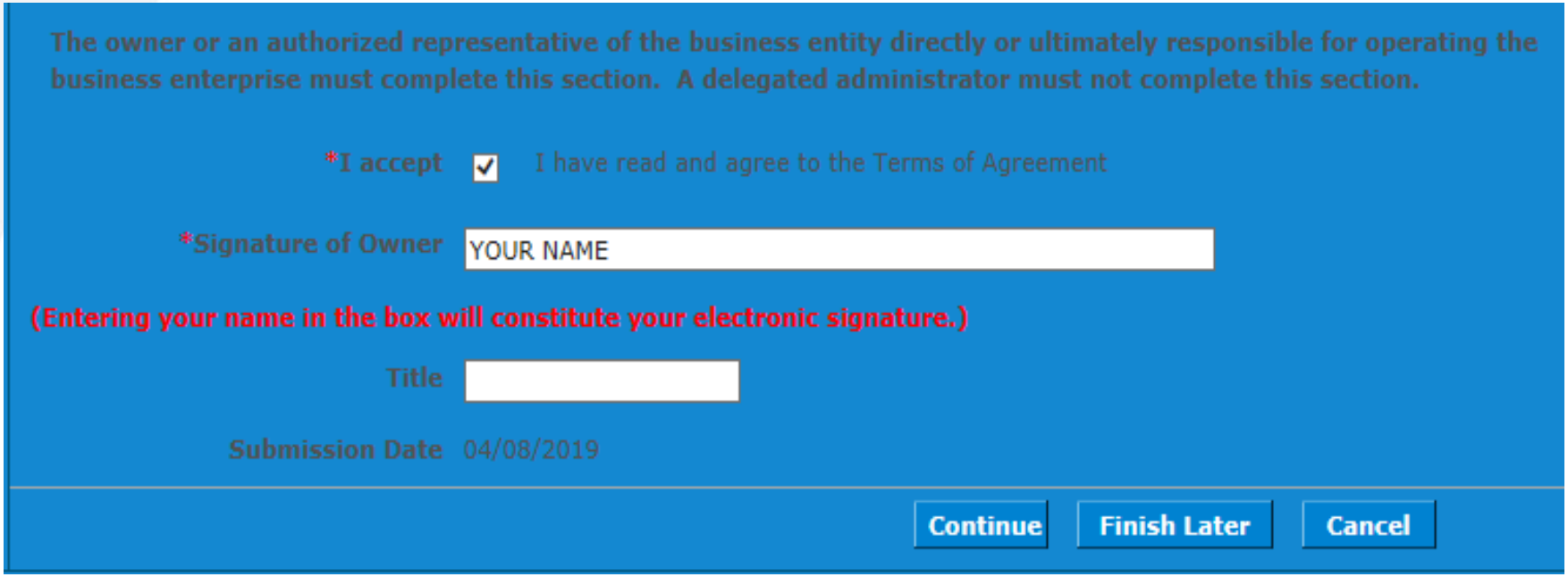
Provider agrees to all of the following:
1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("FSSA").
2. To comply with all federal and state statutes and regulations pertaining to the IHCP, as they may be amended from time to time.

Provider Agreement



After carefully reviewing your Provider Agreement type in your name, which serves as an electronic signature

Provider Enrollment: Application Fees

- Welcome
- Request Information
- Addresses
- Specialties
- Provider Identification
- Rendering Providers
- Languages
- Outpatient Mental Health
- EFT Information
- Other Information
- Disclosures
- Additional Disclosures Information
- Agreement
- Application Fees
- Attachments
- Acceptance
- Summary

Application Fee

Federal regulation requires 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 and change of ownership, as required, and is assessed in full for each service location enrolled in the IHCP. See the Provider Enrollment Application Fee page at indianamedicaid.com for more information and payment options.

Answer each question

If the service location is enrolled in Medicare, a fee payment is not required.

***Is this location enrolled in Medicare?** ○ Yes ◉ No

If yes, make certain all Medicare information is provided. A fee payment is not required to the IHCP for this service location.

If an application fee is paid to another state's Medicaid program for a specific service location, then a fee payment is not required.

***Have you paid an application fee to another state's Medicaid program for this location?** ○ Yes ◉ No

If yes, please submit proof of payment as an attachment. A fee payment is not required to IHCP for this service location.

***Have you received a waiver of the application fee from Medicare or another state's Medicaid program because of financial hardship?** ○ Yes ◉ No

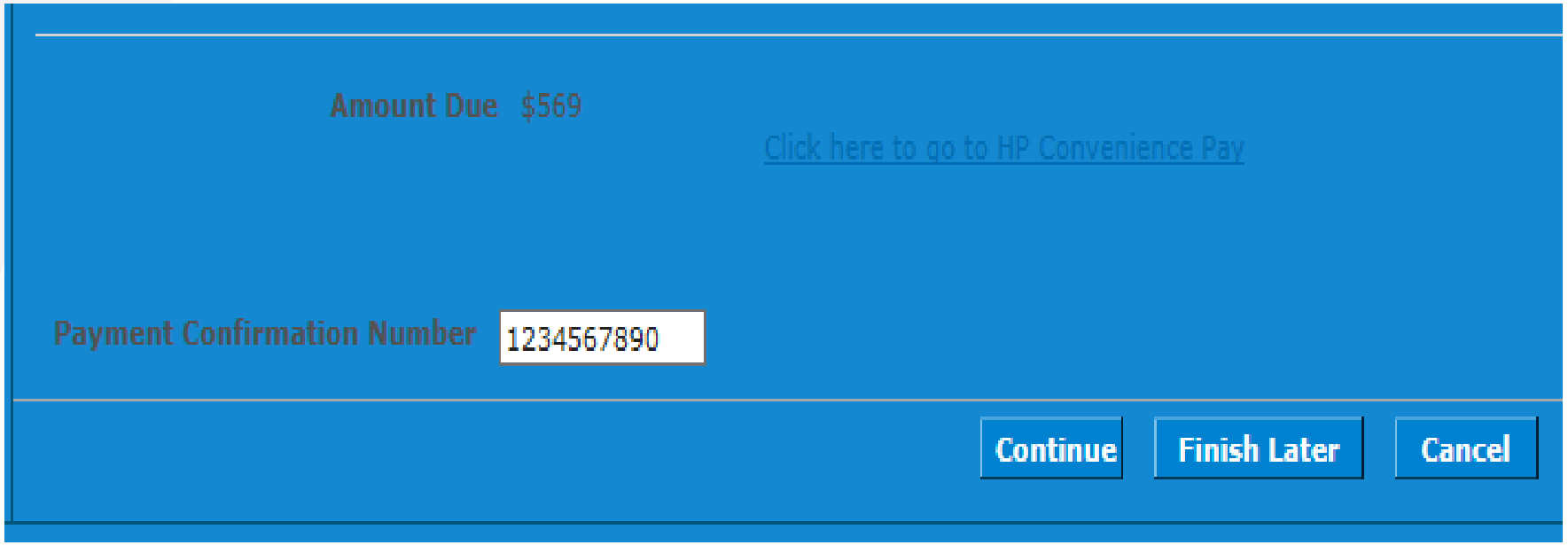
If yes, please submit a copy of the waiver letter. An application fee is not required to IHCP for this service location.

Providers can apply for a hardship exception to the application fee, based on a case-by-base basis, based on circumstances that are appropriate to the provider's situation.

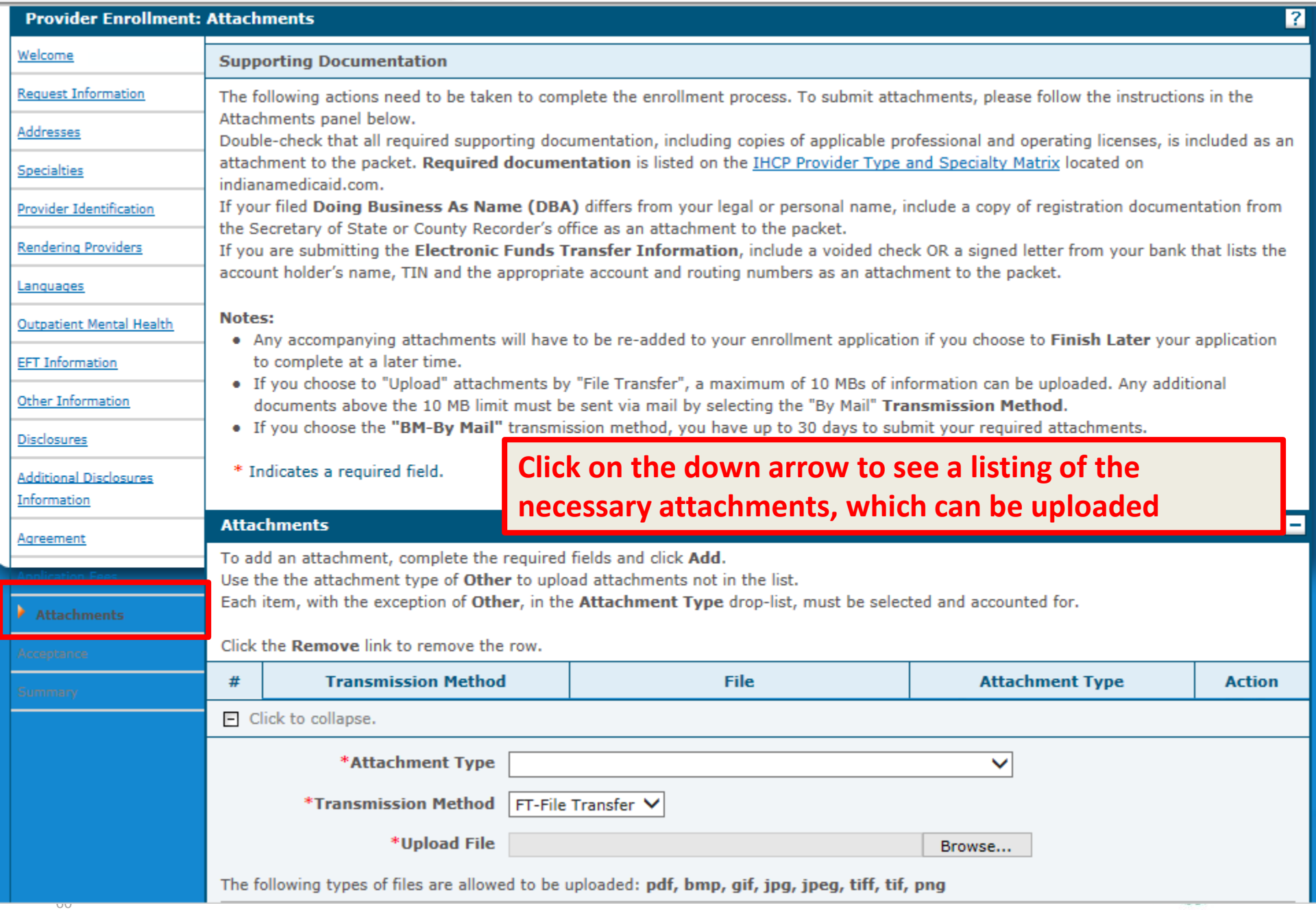
***Are you requesting a waiver of the application fee because of financial hardship?** ○ Yes ◉ No

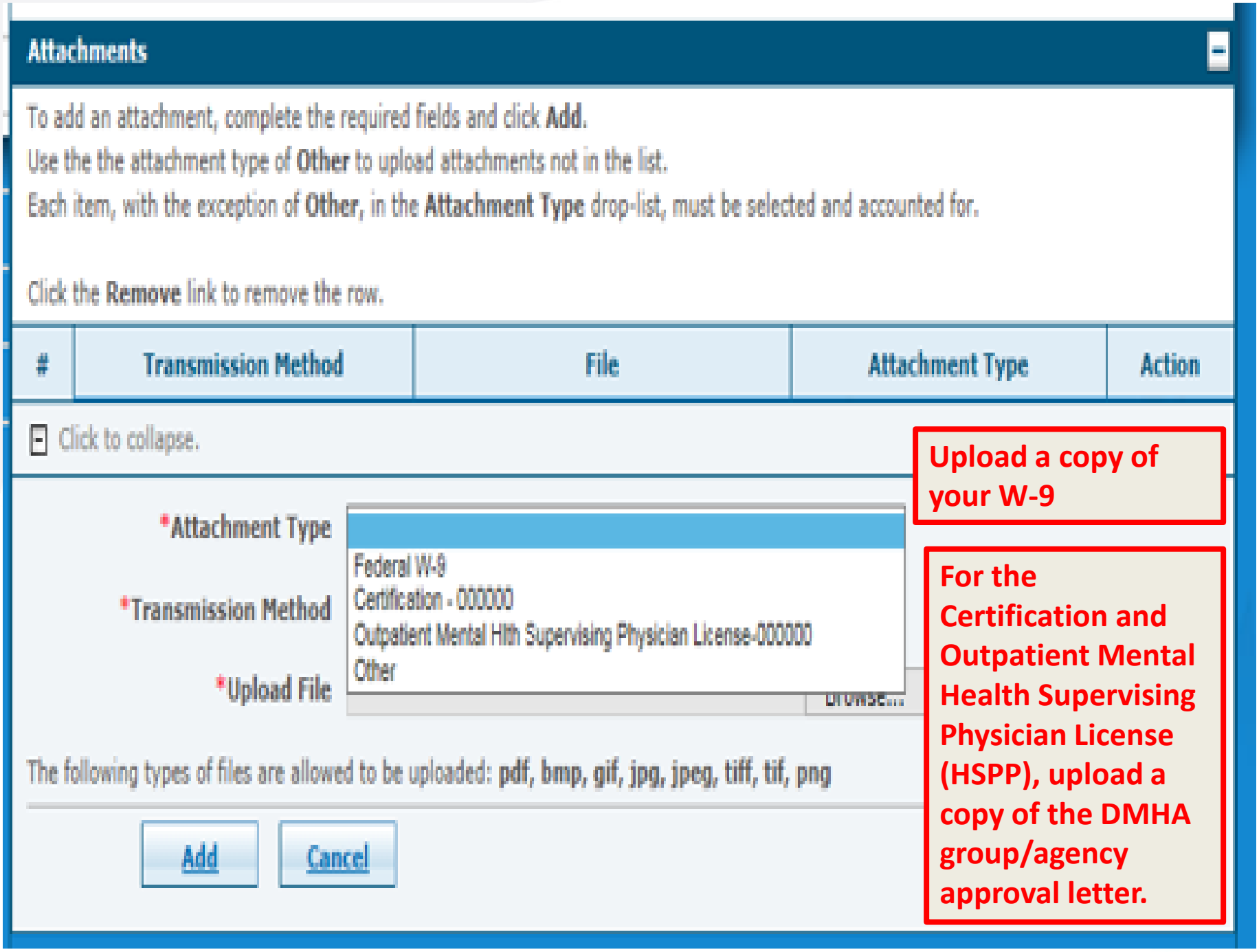
If yes, please submit a letter explaining the financial hardship, including proof of inability to pay and a list of all attempts made to raise the required fee from outside sources, such as loan denial.

Application fee



Click on the link to pay the application fee


Provider Enrollment: Attachments
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Attachments
Acceptance
Summary
Supporting Documentation
The following actions need to be taken to complete the enrollment process. To submit attachments, please follow the instructions in the Attachments panel below.
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 Type and Specialty Matrix located on indianamedicaid.com.
If your filed Doing Business As Name (DBA) differs from your legal or personal name, include a copy of registration documentation from the Secretary of State or County Recorder's office as an attachment to the packet.
If you are submitting the Electronic Funds Transfer Information, include a voided check OR a signed letter from your bank that lists the account holder's name, TIN and the appropriate account and routing numbers as an attachment to the packet.
Notes:
Any accompanying attachments will have to be re-added to your enrollment application if you choose to Finish Later your application to complete at a later time.
If you choose to "Upload" attachments by "File Transfer", a maximum of 10 MBs of information can be uploaded. Any additional documents above the 10 MB limit must be sent via mail by selecting the "By Mail" Transmission Method.
If you choose the "BM-By Mail" transmission method, you have up to 30 days to submit your required attachments.
* Indicates a required field.
Click on the down arrow to see a listing of the necessary attachments, which can be uploaded
Attachments
To add an attachment, complete the required fields and click Add.
Use the the attachment type of Other to upload attachments not in the list.
Each item, with the exception of Other, in the Attachment Type drop-list, must be selected and accounted for.
Click the Remove link to remove the row.
Transmission Method File Attachment Type Action
Click to collapse.
*Attachment Type
*Transmission Method
FT-File Transfer
*Upload File
Browse...
The following types of files are allowed to be uploaded: pdf, bmp, gif, jpg, jpeg, tiff, tif, png


Attachments
To add an attachment, complete the required fields and click Add.
Use the the attachment type of Other to upload attachments not in the list.
Each item, with the exception of Other, in the Attachment Type drop-list, must be selected and accounted for.
Click the Remove link to remove the row.
#
Transmission Method
File
Attachment Type
Action
Click to collapse.
*Attachment Type
*Transmission Method
*Upload File
Federal W-9
Certification - 000000
Outpatient Mental Hlth Supervising Physician License-000000
Other
Browse...
The following types of files are allowed to be uploaded: pdf, bmp, gif, jpg, jpeg, tiff, tif, png
Add
Cancel
Upload a copy of your W-9
For the Certification and Outpatient Mental Health Supervising Physician License (HSPP), upload a copy of the DMHA group/agency approval letter.

Attachments

To add an attachment, complete the required fields and click **Add**.
Use the the attachment type of **Other** to upload attachments not in the list.
Each item, with the exception of **Other**, in the **Attachment Type** drop-list, must be selected and accounted for.

Click the **Remove** link to remove the row.

#	Transmission Method	File	Attachment Type	Action
1	FT-File Transfer	CMHW TEST.pdf (85K)	Federal W-9	Remove
2	FT-File Transfer	CMHW TEST 2.pdf (86K)	Certification - 000000	Remove
3	FT-File Transfer	CMHW TEST 3.pdf (86K)	Outpatient Mental Hlth Supervising Physician License-000000	Remove

Click to collapse.

*Attachment Type

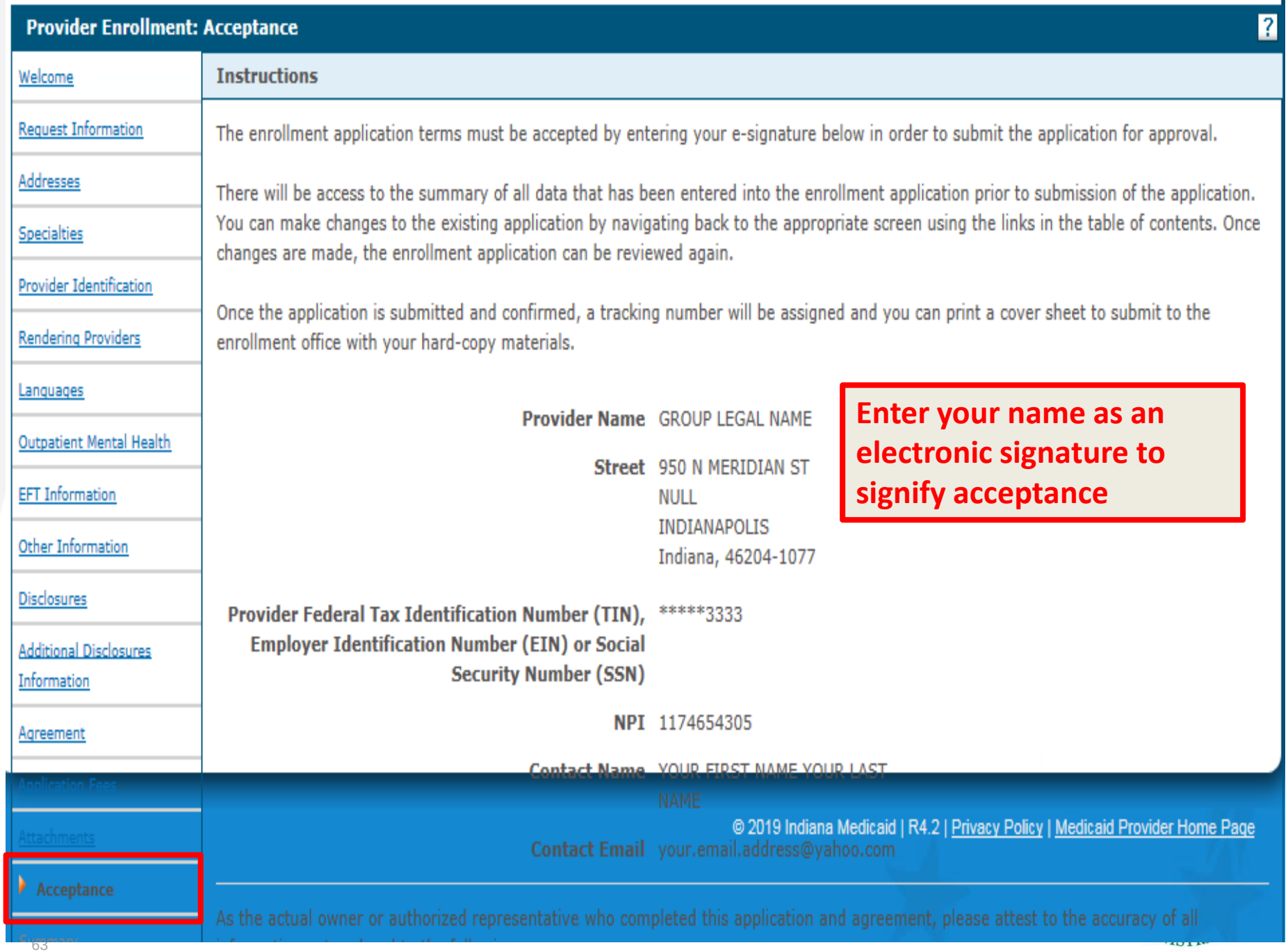
*Transmission Method FT-File Transfer

*Upload File Browse...

After uploading your attachments you will get a screen showing the uploaded files

The following types of files are allowed to be uploaded: **pdf, bmp, gif, jpg, jpeg, tiff, tif, png**

Add Cancel


Provider Enrollment: Acceptance
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Application Fees
Attachments
Acceptance
Summary
Instructions
The enrollment application terms must be accepted by entering your e-signature below in order to submit the application for approval.
There will be access to the summary of all data that has been entered into the enrollment application prior to submission of the application. You can make changes to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.
Once the application is submitted and confirmed, a tracking number will be assigned and you can print a cover sheet to submit to the enrollment office with your hard-copy materials.
Provider Name GROUP LEGAL NAME
Street 950 N MERIDIAN ST
NULL
INDIANAPOLIS
Indiana, 46204-1077
Provider Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) *****3333
NPI 1174654305
Contact Name YOUR FIRST NAME YOUR LAST NAME
Contact Email your.email.address@yahoo.com
Enter your name as an electronic signature to signify acceptance
© 2019 Indiana Medicaid | R4.2 | Privacy Policy | Medicaid Provider Home Page
As the actual owner or authorized representative who completed this application and agreement, please attest to the accuracy of all

I further acknowledge my agreement to and acceptance of all terms and conditions of the Electronic Funds Transfer Request, if applicable, pursuant to my completion of the EFT Information section of this application and agreement.

I hereby confirm my understanding that I am the owner or authorized representative of this business entity, that my electronic signature is equivalent to my written signature, and that my electronic signature below confirms my acceptance of all stipulations, conditions, terms, and attestations herein. All provider information and supporting documentation submitted with this application and attestation is true, complete and correct.

*Your Signature YOUR NAME

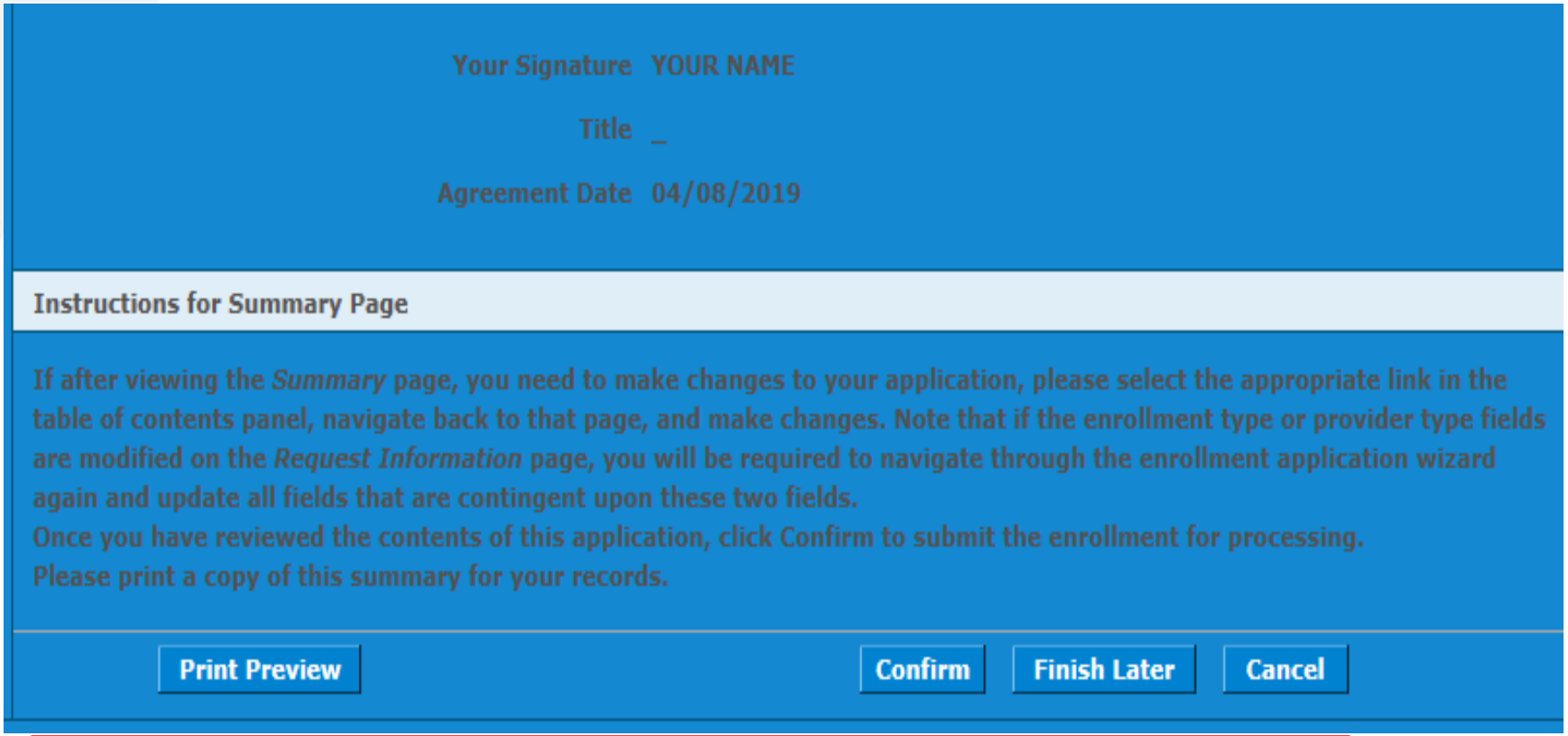
(Entering your name in the box will constitute your electronic signature.)

Title

Submission Date 04/08/2019

Continue Finish Later Cancel

Summary



After acceptance you will receive a summary of all of the information entered on the application. You can review the summary for accuracy and make any corrections, if necessary. Then you will click on "Confirm" to submit the application.

Provider Enrollment: Credentials

Your enrollment application will be submitted for processing.

Once submitted, you will not be able to return to the application to review or make modifications. To check the status of this application, from the Healthcare Portal home page, click on the **Provider Enrollment** link to be taken to the Provider Enrollment page, then click on the **Enrollment Status** link.

Please provide the following information. The credentials you create will be required to revise your application at a later date. Your password must be between 8 and 20 alphanumeric characters. Your Tax Identification Number (TIN) is provided below.

Once all required information is entered, click on the Submit button to submit your application. An application tracking number will be provided. Please keep this number in a safe place. You must have the tracking number to check the status of the application as well as to make corrections/updates necessary to complete the processing of your application. Additionally, you must have your Tax Identification Number (TIN) and the password you will create below.

Along with the ATN, you will also need the password you create when submitting this application. Please make sure to keep a record of the password. Passwords cannot be reset or retrieved by the IHCP. If the password is lost or forgotten, you will need to resubmit the application in full should corrections be needed.

* Indicates a required field.

Enter this information which will be necessary if you need to check the status of your application at a later date

Provider Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) *****3333

***Password** ••••••••••

***Confirm Password** ••••••••••

Below, please enter the email address where you would like your confirmation email sent.

***Email Address** your.email.address@yahoo.com

***Confirm Email Address** your.email.address@yahoo.com

Submit Cancel

Tracking Information

After the application is submitted you will receive an ATN (application tracking number)

Print Preview

To print tracking information click "Print Preview"

Provider Enrollment: Tracking Information

Your application has been submitted for processing and assigned tracking number **3089**.

Please keep this number in a safe place. You must have the tracking number to check the status of the application as well as to make corrections/updates necessary to complete the processing of your application. Additionally, you must have your tax identification number (TIN) and the password you created when you started this application. The tracking number and application password are not stored in our system; therefore, they cannot be retrieved or reset should you misplace them.

To check the status of this application, from the Healthcare Portal home page, click on the **Provider Enrollment** link to be taken to the Provider Enrollment page, then click on the **Enrollment Status** link.

A confirmation email has also been sent to the contact person's email, provided in the application: your.email.address@yahoo.com.

Important Note for Mailing Attachments: If you have indicated that your required attachments will be submitted by mail, you MUST print the cover sheet and mail it, along with any required documentation to the address listed on the cover sheet.

To Print the Coversheet Click Here.

If you need to mail any attachments print the cover sheet to send with the attachments

Exit

DXC.technology

Monday 04/08/2019 02:57 PM

Print

Provider Enrollment: Cover Sheet

This is a barcode image representing the Tracking ID.

Date 4/8/2019

Tracking Number 3089

DXC Technology Provider Enrollment
P. O. Box 7263
Indianapolis, IN 46207-7263

Enrollment form for the following provider:

GROUP/AGENCY LEGAL NAME

950 N MERIDIAN ST

NULL

INDIANAPOLIS, Indiana 46204-1077

If you choose to mail in attachments, instead of uploading, mail them with this cover sheet

Listed below is the complete list of documents necessary to successfully complete your enrollment as an IHCP provider.

All of the attachments listed below must be sent to the address above. Please include ALL attachments in a single mailing and include this letter as your cover sheet.

Attachments

Print Close

Provider Enrollment - Status

Back to Home

Enter your assigned Tracking number and Federal Tax Indentification Number (TIN or EIN) that you used for your enrollment to verify the current status of your enrollment application. For any further queries, please contact Provider enrollment at 1-800-457-4584.

* Indicates a required field.

*Tracking Number 3089

*Provider Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) ⓘ *****3333

Search Cancel

Provider Enrollment - Summary

Below is the status of your provider enrollment application. For any further queries, please contact Provider enrollment at 1-800-457-4584.

Tracking Number 3089

Date Submitted 04/08/2019

Status Completed

Status Date 04/16/2019

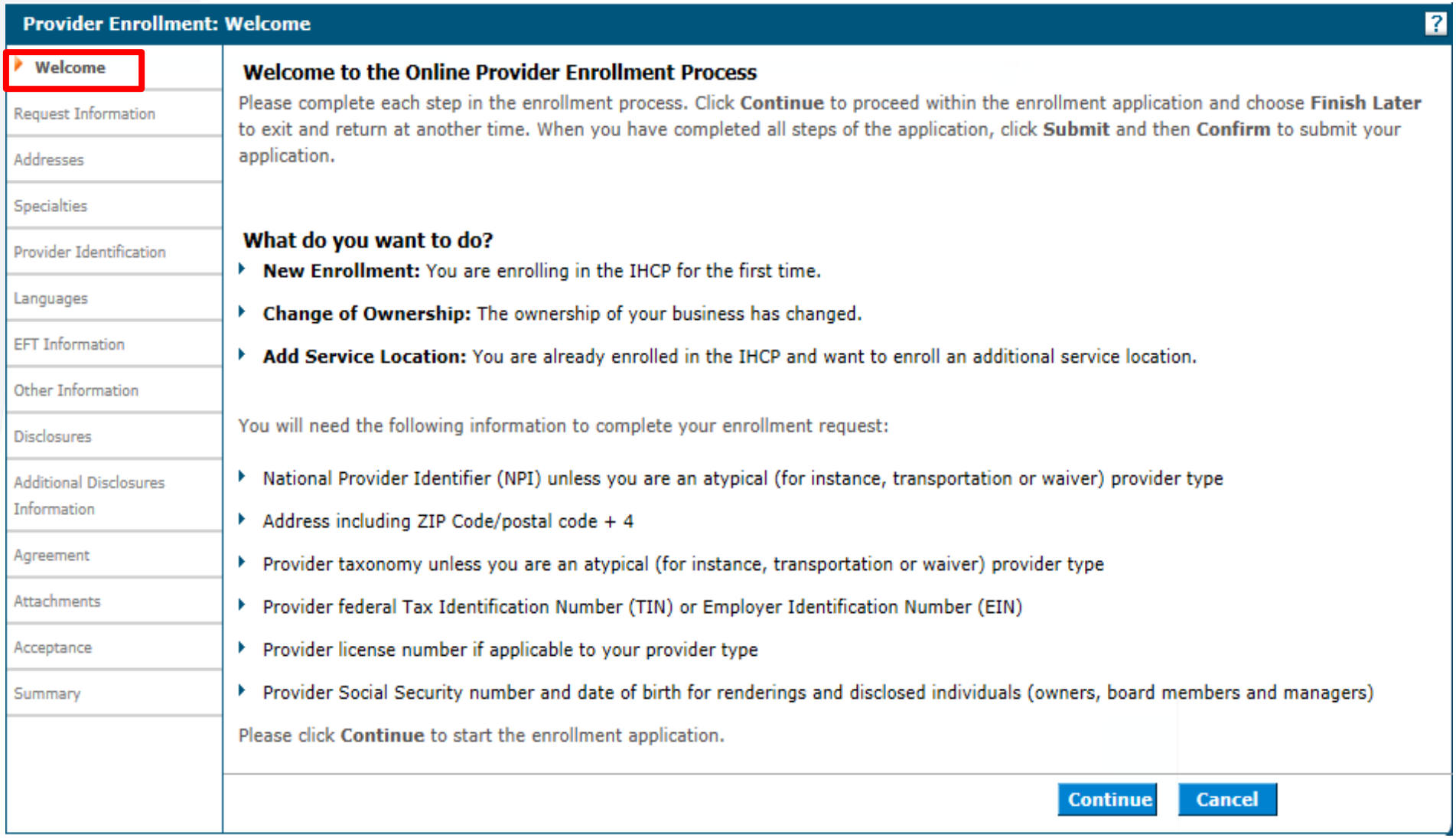
After submitting an application you can check status by entering the ATN (application tracking number)

For a new copy of your enrollment application cover sheet for your records click here.

Appendix B

*Screen-by-screen examples of **RENDERING** Provider*
Enrollment application

Starting the rendering provider application



Provider Enrollment: Request Information

- Welcome
- **Request Information**
- Addresses
- Specialties
- Provider Identification
- Languages
- EFT Information
- Other Information
- Disclosures
- Additional Disclosures Information
- Agreement
- Attachments
- Acceptance
- Summary

You are initiating a new Indiana Health Coverage Programs (IHCP) enrollment application. Complete the fields on each page and click **Continue** to move forward to each page. All required fields on a page must be completed before the **Finish Later** option can be selected.

* Indicates a required field.

Initial Enrollment Information

*Provider Classification: Rendering

*Provider Type: 11 : Mental Health Provider

*Requested Enrollment Effective Date: 04/17/2019

To request a date prior to today's date, a written request explaining the need for the earlier date, plus supporting documentation, must be submitted with application.

*Enrollment Request Type: New Enrollment

Select Rendering, Provider Type 11, and requested enrollment date that is the same as the Group enrollment date

Group Association

When enrolling a rendering provider, you must supply information identifying a group to which this rendering provider will be associated.

If the group is currently enrolled with IHCP, you must enter information to identify the group. If the group is not currently enrolled, then the group must have successfully submitted an enrollment application. You will need to provide the ATN (Application Tracking Number) of the submitted group application.

*Is the group currently enrolled in the IHCP? ○ Yes ◉ No

If the group/agency is already enrolled enter the group NPI. If the group is not yet enrolled enter the ATN (application tracking number) for the pending group application.

*Pending Group Enrollment ATN? 3089

© 2019

ATN (application tracking number) for pending group application

Provider Identification

By entering the rendering provider's Social Security number, you are providi... contractors to use the Social Security number for the sole purpose of verifying initial and continuing eligibility to participate in the Medicaid program with the Office of Inspector General, the Centers for Medicare & Medicaid Services, licensing bodies, and other appropriate state and federal agencies.

Clubhouse providers are required to enter a Federal Employee Identification Number (FEIN). Any other rendering providers are required to enter their Social Security Number (SSN).

*Social Security Number ***6789 *Tax ID Type ○ EIN ● SSN

Enter your social security number

*Are you currently enrolled as an IHCP provider? ○ Yes ● No

*Were you previously enrolled as an IHCP provider? ○ Yes ● No

Contact Information

The contact person may be contacted to answer any questions regarding the information provided in this enrollment application. Email addresses will be used for IHCP business only.

Enter contact information

*Last Name YOUR LAST NAME

*First Name YOUR FIRST NAME

Title

*Telephone Number 1234567890 Telephone Number Extension

Fax Number

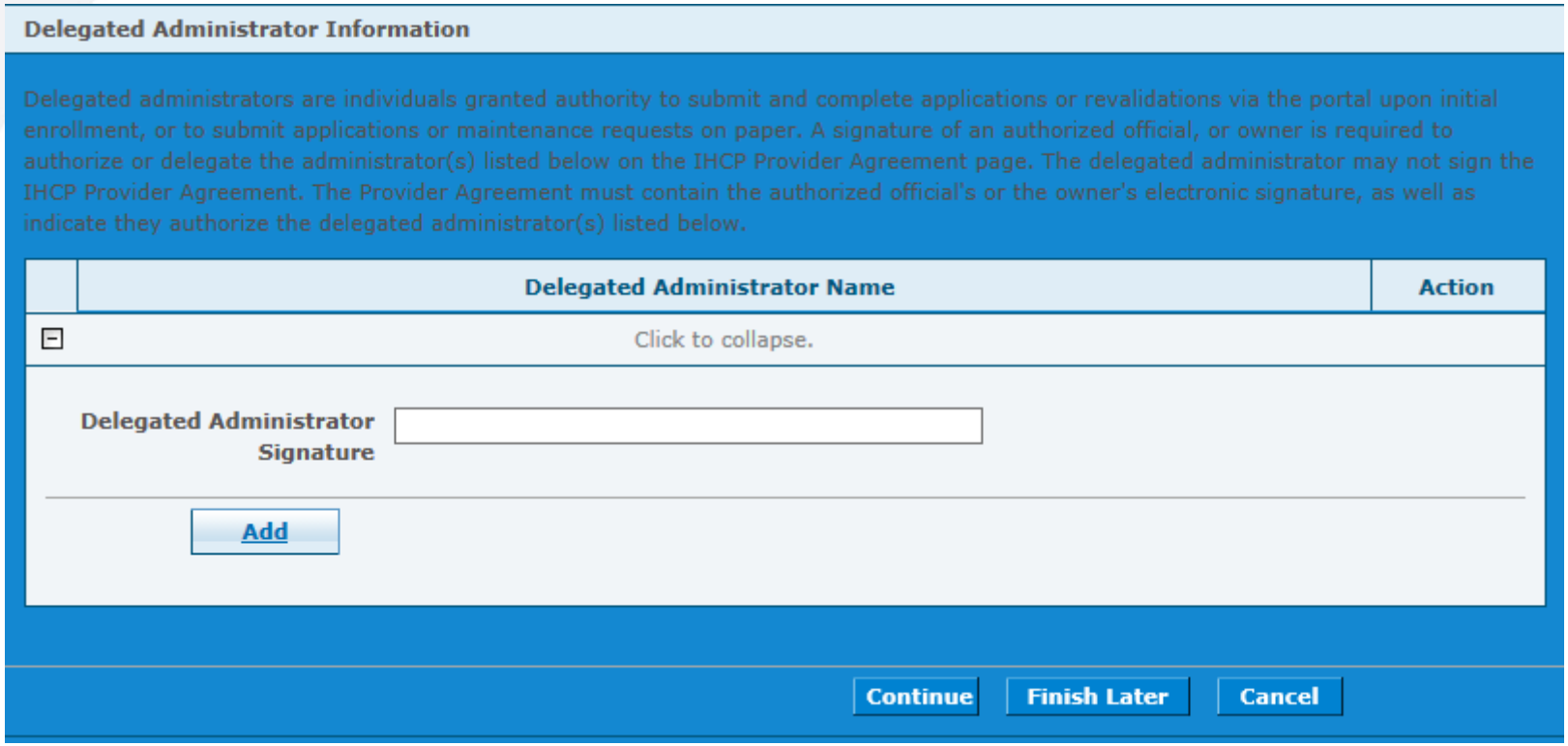
*Contact Email your.emailaddress@gmail.com

*Confirm Email Address your.emailaddress@gmail.com

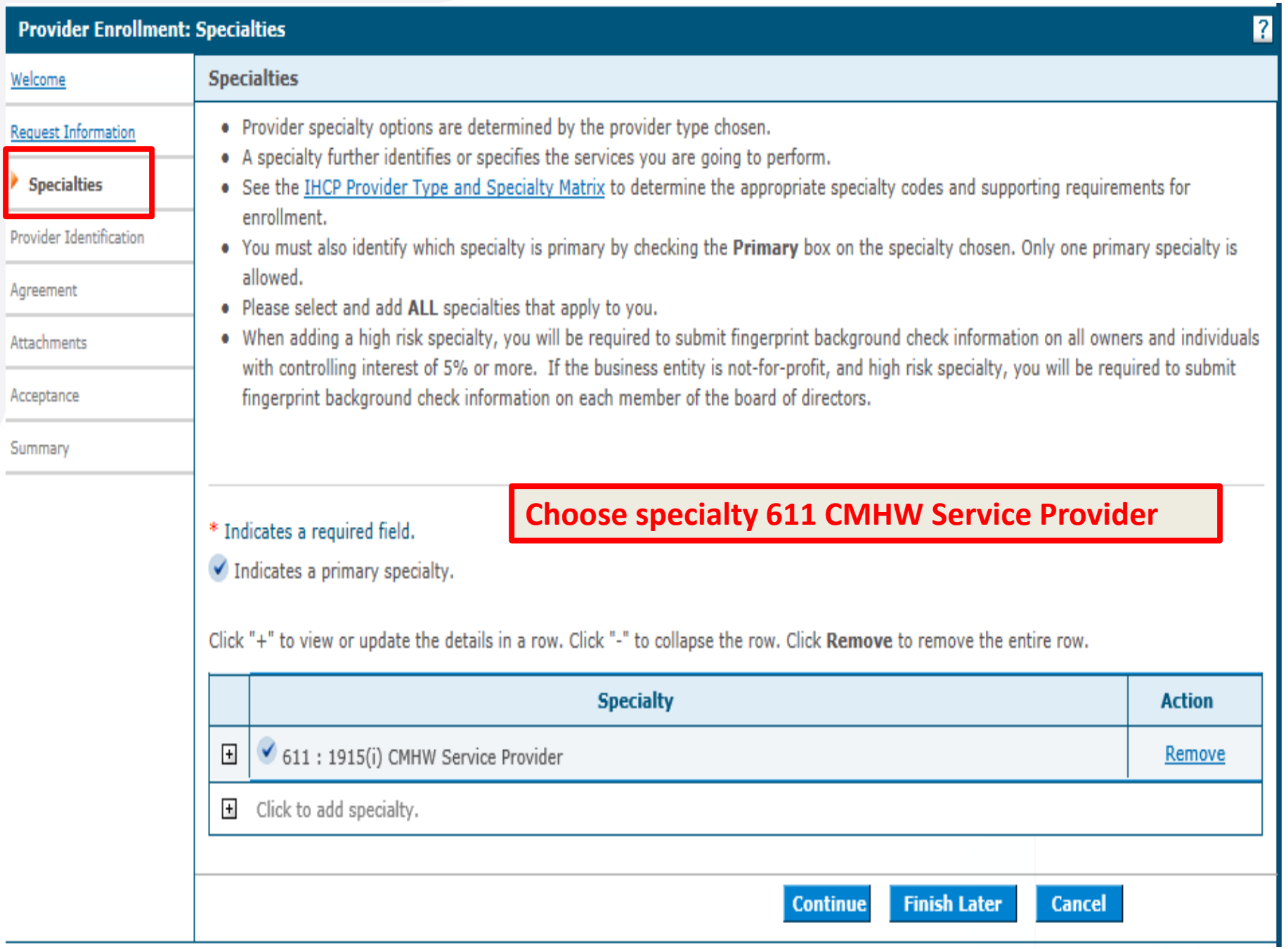
Preferred Method of Communication Email

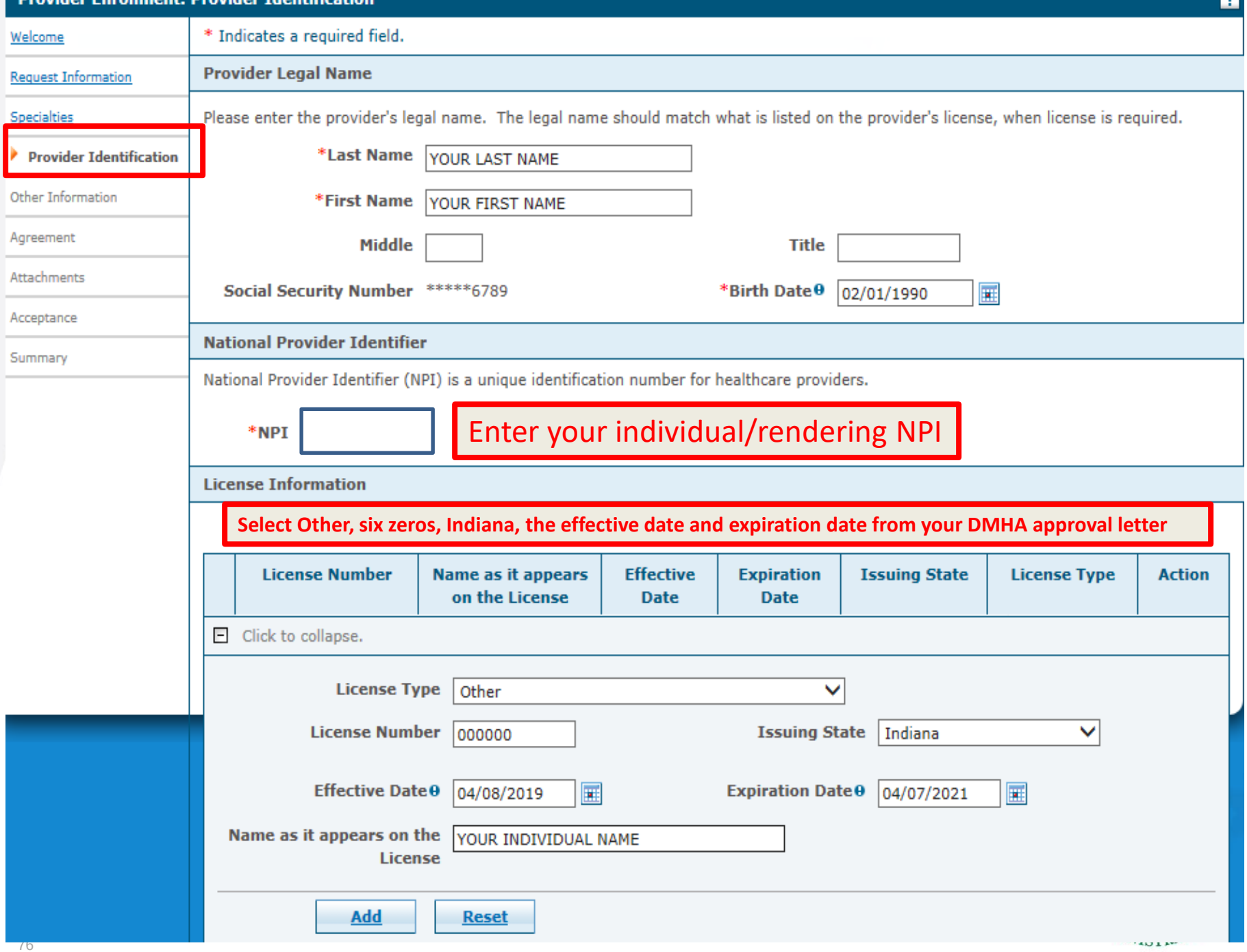
Delegated Administrator Information

Delegated Administrator



Skip this section unless you want to delegate someone other than yourself to be able to submit provider enrollment applications and other documents on your behalf


Provider Enrollment: Specialties
Welcome
Request Information
Specialties
Provider Identification
Agreement
Attachments
Acceptance
Summary
Specialties
Provider specialty options are determined by the provider type chosen.
A specialty further identifies or specifies the services you are going to perform.
See the IHCP Provider Type and Specialty Matrix to determine the appropriate specialty codes and supporting requirements for enrollment.
You must also identify which specialty is primary by checking the Primary box on the specialty chosen. Only one primary specialty is allowed.
Please select and add ALL specialties that apply to you.
When adding a high risk specialty, you will be required to submit fingerprint background check information on all owners and individuals with controlling interest of 5% or more. If the business entity is not-for-profit, and high risk specialty, you will be required to submit fingerprint background check information on each member of the board of directors.
Choose specialty 611 CMHW Service Provider
* Indicates a required field.
Indicates a primary specialty.
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click Remove to remove the entire row.
Specialty
Action
611 : 1915(i) CMHW Service Provider
Remove
Click to add specialty.
Continue
Finish Later
Cancel


Welcome
Request Information
Specialties
Provider Identification
Other Information
Agreement
Attachments
Acceptance
Summary
* Indicates a required field.
Provider Legal Name
Please enter the provider's legal name. The legal name should match what is listed on the provider's license, when license is required.
*Last Name
YOUR LAST NAME
*First Name
YOUR FIRST NAME
Middle
Title
Social Security Number
*****6789
*Birth Date
02/01/1990
National Provider Identifier
National Provider Identifier (NPI) is a unique identification number for healthcare providers.
*NPI
Enter your individual/rendering NPI
License Information
Select Other, six zeros, Indiana, the effective date and expiration date from your DMHA approval letter
License Number
Name as it appears on the License
Effective Date
Expiration Date
Issuing State
License Type
Action
Click to collapse.
License Type
Other
License Number
000000
Issuing State
Indiana
Effective Date
04/08/2019
Expiration Date
04/07/2021
Name as it appears on the License
YOUR INDIVIDUAL NAME
Add
Reset

Certificate Information

* At least one certification must be entered.

	Certificate Number	Name as it appears on the Certificate	Effective Date	Expiration Date	Certificate State	Certificate Type	Action
⊞	000000	YOUR NAME ON CERTIFICTE	04/08/2019	04/07/2021	Indiana	Other	Remove
⊞	Click to add certificate information.						

Medicare Participation

If you are a Medicare provider, you must provide your Medicare provider numbers.

	Medicare Number	Action
⊟	Click to collapse.	

Medicare Number

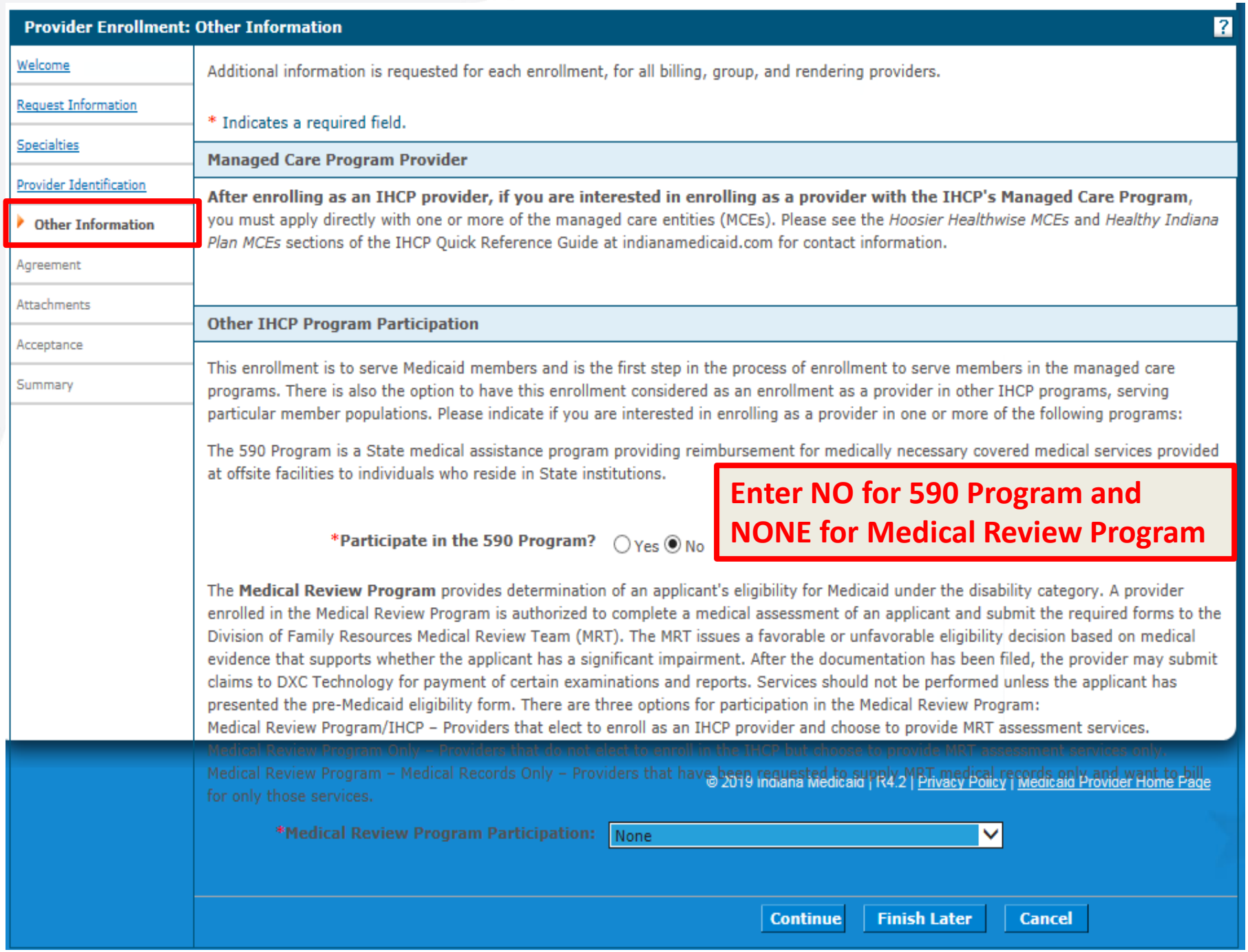
Medicare and DEA information is not applicable

Add Reset

Drug Enforcement Administration (DEA) Number

DEA # Effective Date Ⓘ End Date Ⓘ

Continue Finish Later Cancel


Provider Enrollment: Other Information
Welcome
Request Information
Specialties
Provider Identification
Other Information
Agreement
Attachments
Acceptance
Summary
Additional information is requested for each enrollment, for all billing, group, and rendering providers.
* Indicates a required field.
Managed Care Program Provider
After enrolling as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's Managed Care Program, you must apply directly with one or more of the managed care entities (MCEs). Please see the Hoosier Healthwise MCEs and Healthy Indiana Plan MCEs sections of the IHCP Quick Reference Guide at indianamedicaid.com for contact information.
Other IHCP Program Participation
This enrollment is to serve Medicaid members and is the first step in the process of enrollment to serve members in the managed care programs. There is also the option to have this enrollment considered as an 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 offsite facilities to individuals who reside in State institutions.
Enter NO for 590 Program and
NONE for Medical Review Program
*Participate in the 590 Program? Yes No
The Medical Review Program provides determination of 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 submit the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT issues a favorable or unfavorable eligibility decision based on medical evidence that supports whether the applicant has a significant impairment. After the documentation has been filed, the provider may submit claims to DXC Technology 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 that elect to enroll as an IHCP provider and choose to provide MRT assessment services.
Medical Review Program Only – Providers that do not elect to enroll in the IHCP but choose to provide MRT assessment services only.
Medical Review Program – Medical Records Only – Providers that have been requested to supply MRT medical records only and want to bill for only those services.
© 2019 Indiana Medicaid | R4.2 | Privacy Policy | Medicaid Provider Home Page
*Medical Review Program Participation: None
Continue
Finish Later
Cancel

Provider Enrollment: Agreement

- Welcome
- Request Information
- Specialties
- Provider Identification
- Other Information
- **Agreement**
- Attachments
- Acceptance
- Summary

Instructions

The enrollment application terms must be accepted by entering your e-signature below in order to submit the application for approval.

There will be access to the summary of all data that has been entered into the enrollment application prior to submission of the application. You can make changes to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.

Once the application is submitted and confirmed, a tracking number will be assigned and you can print a cover sheet to submit to the enrollment office with your hard-copy materials.

Carefully review your provider agreement

IHCP Rendering Provider Agreement Overview

The Rendering Provider Agreement details the requirements for participation in the IHCP. Included are provider responsibilities regarding updating provider information, protecting patient health information, requriements for claims processing, overpayments and record retention. In addition, the Agreement details obligations regarding the appeals process, civil rights regulation compliance, utilization, control, and disclosure rules. The entire Agreement must be read, signed, and returned with the application. A signed copy must be retained by the provider.

IHCP Rendering Provider Agreement

Agreement Version: 6.4

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 the 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.

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 complete this section.

*I accept ☑ I have read and agree to the Terms of Agreement

*Signature of Owner YOUR INDIVIDUAL NAME

(Entering your name in the box will constitute your electronic signature.)

Title OWNER

Submission Date 04/17/2019

IHCP Rendering Provider Agreement and Attestation Form

*I accept ☑

I attest that a signed Rendering Provider Agreement and Attestation Form will be uploaded or sent by mail along with the coversheet furnished at the end of this application submission. Please use the link below to obtain a copy of the most current Rendering Provider Agreement and Attestation Form. Both the group's owner or authorized official and the rendering provider must sign this form.

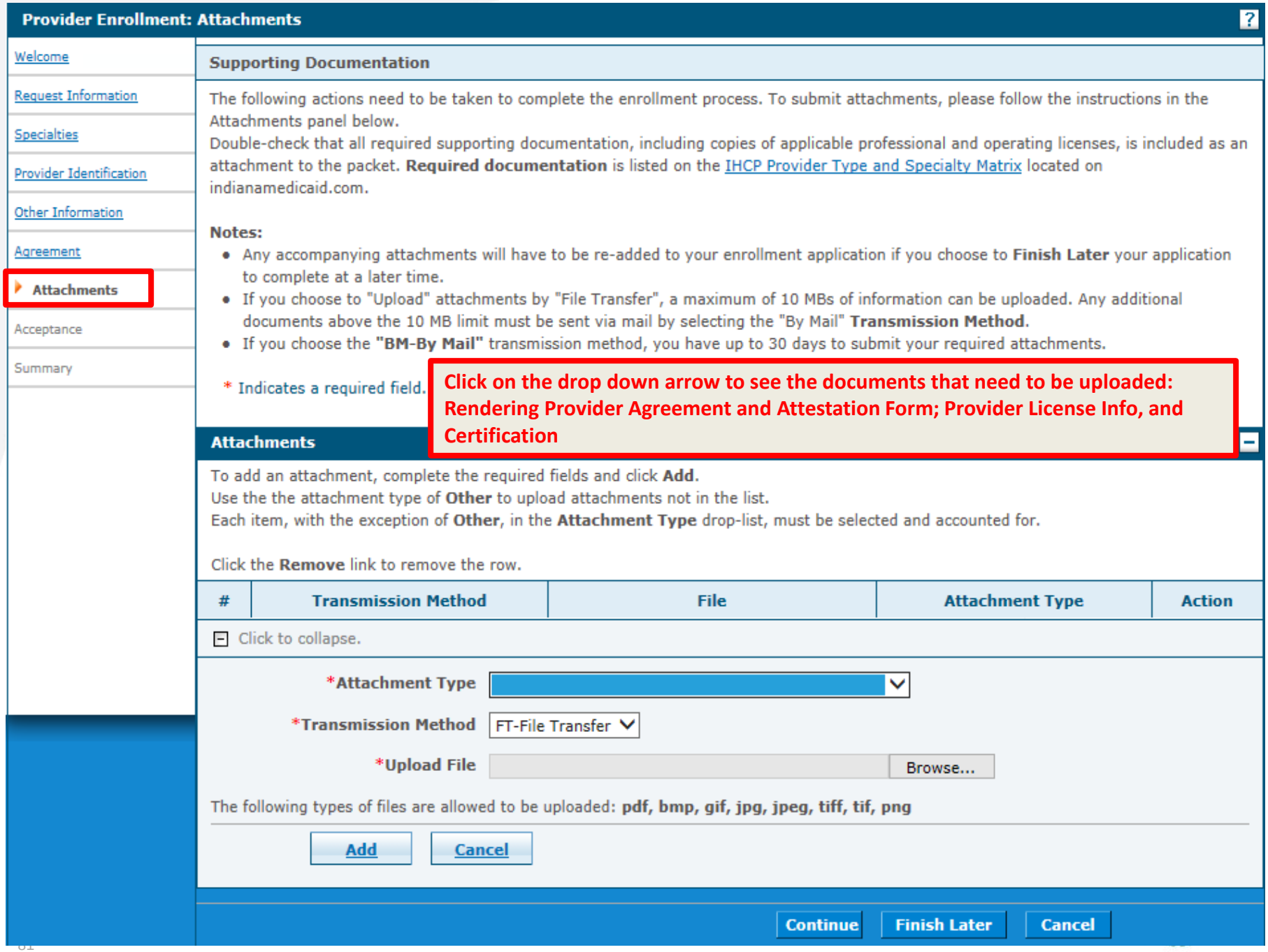
Attach one Agreement per Group Tax ID for each rendering provider

Rendering Provider Agreement and Attestation Form

After reading the provider agreement check "I accept"; enter your name as an electronic signature; and attest that you will submit a signed rendering provider agreement and attestation form

NOTE: The above link to the Rendering Provider Agreement and Attestation Form will open a PDF in a new browser window. PDF Files require Adobe©Acrobat©Reader©

Continue Finish Later Cancel


Provider Enrollment: Attachments
Welcome
Request Information
Specialties
Provider Identification
Other Information
Agreement
Attachments
Acceptance
Summary
Supporting Documentation
The following actions need to be taken to complete the enrollment process. To submit attachments, please follow the instructions in the Attachments panel below.
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 Type and Specialty Matrix located on indianamedicaid.com.
Notes:
Any accompanying attachments will have to be re-added to your enrollment application if you choose to Finish Later your application to complete at a later time.
If you choose to "Upload" attachments by "File Transfer", a maximum of 10 MBs of information can be uploaded. Any additional documents above the 10 MB limit must be sent via mail by selecting the "By Mail" Transmission Method.
If you choose the "BM-By Mail" transmission method, you have up to 30 days to submit your required attachments.
* Indicates a required field.
Click on the drop down arrow to see the documents that need to be uploaded: Rendering Provider Agreement and Attestation Form; Provider License Info, and Certification
Attachments
To add an attachment, complete the required fields and click Add.
Use the the attachment type of Other to upload attachments not in the list.
Each item, with the exception of Other, in the Attachment Type drop-list, must be selected and accounted for.
Click the Remove link to remove the row.
Transmission Method File Attachment Type Action
Click to collapse.
*Attachment Type
*Transmission Method
FT-File Transfer
*Upload File
Browse...
The following types of files are allowed to be uploaded: pdf, bmp, gif, jpg, jpeg, tiff, tif, png
Add
Cancel
Continue
Finish Later
Cancel

Acceptance and Summary

- Refer to the Group application in Appendix A for the “Acceptance and Summary” information, as it will be the same for the Rendering application (slides 63 to 65)

Appendix C

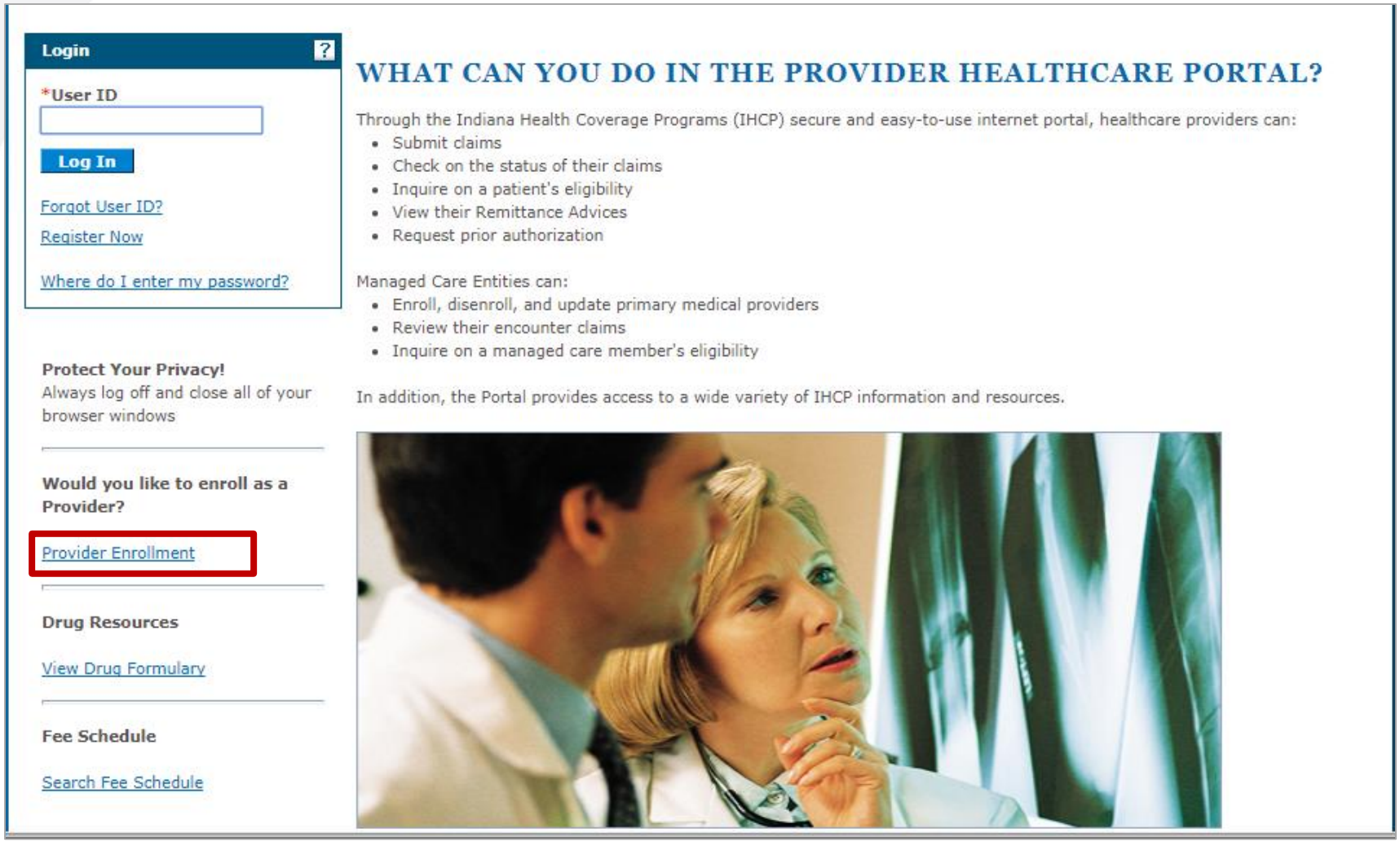
Linking Rendering Providers to Group

Linking Rendering Providers

- Linking rendering provider/s to the group is done after the group and rendering applications have been submitted. See Appendix A and B for step-by-step instructions.
- Individual/billing providers will not link rendering providers to their billing enrollment.

Rendering Linkage

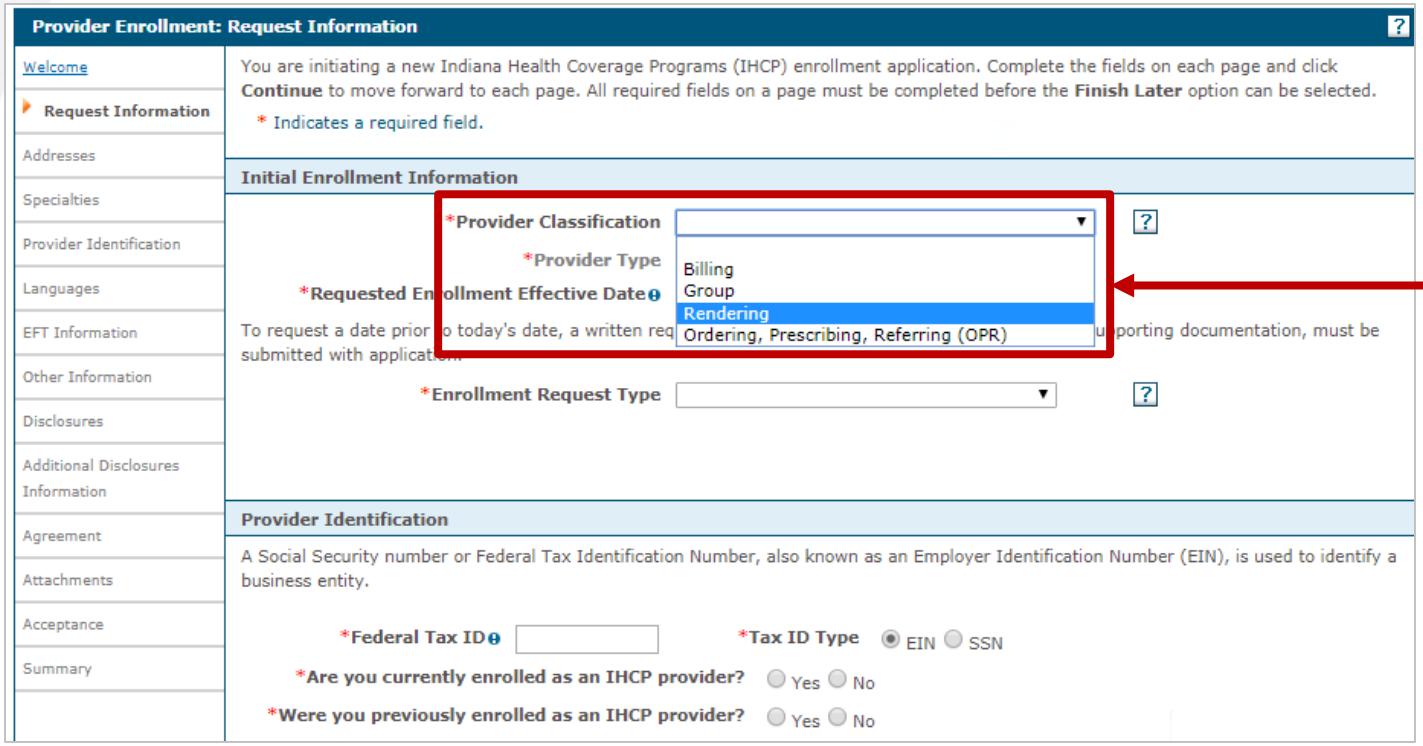
Rendering provider *NOT* currently enrolled in the IHCP



Rendering Linkage

Rendering provider *NOT* currently enrolled in the IHCP

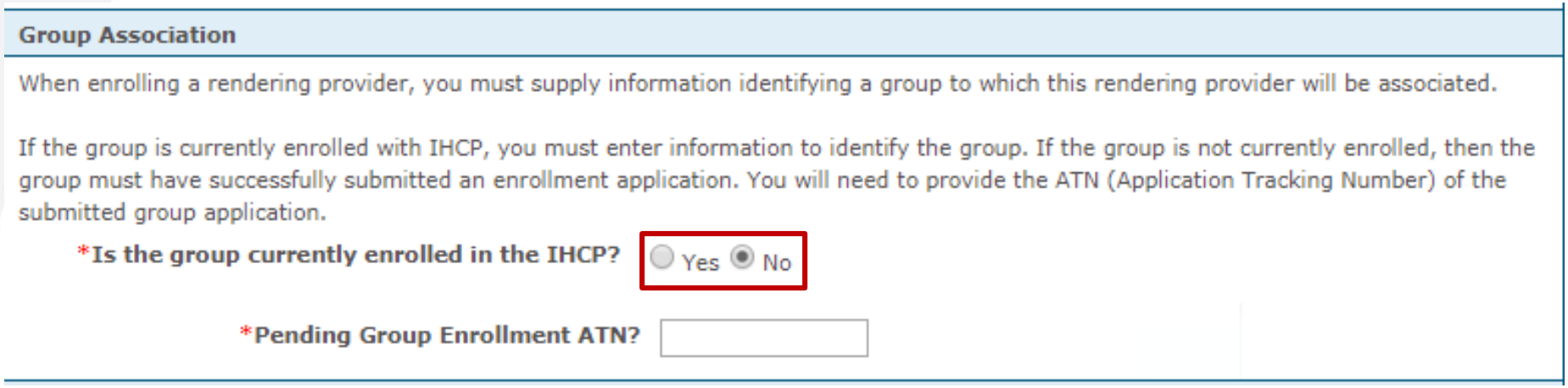
Choose ***Provider Enrollment Application***



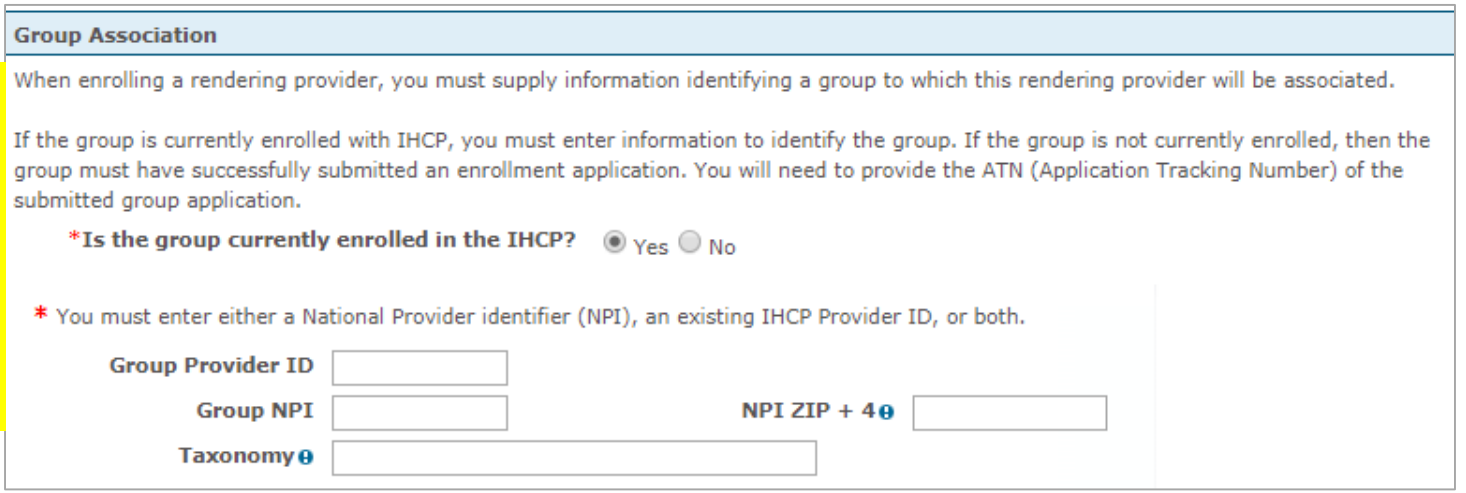
Provider classification is *Rendering*

Rendering Linkage

Rendering provider *NOT* currently enrolled in the IHCP

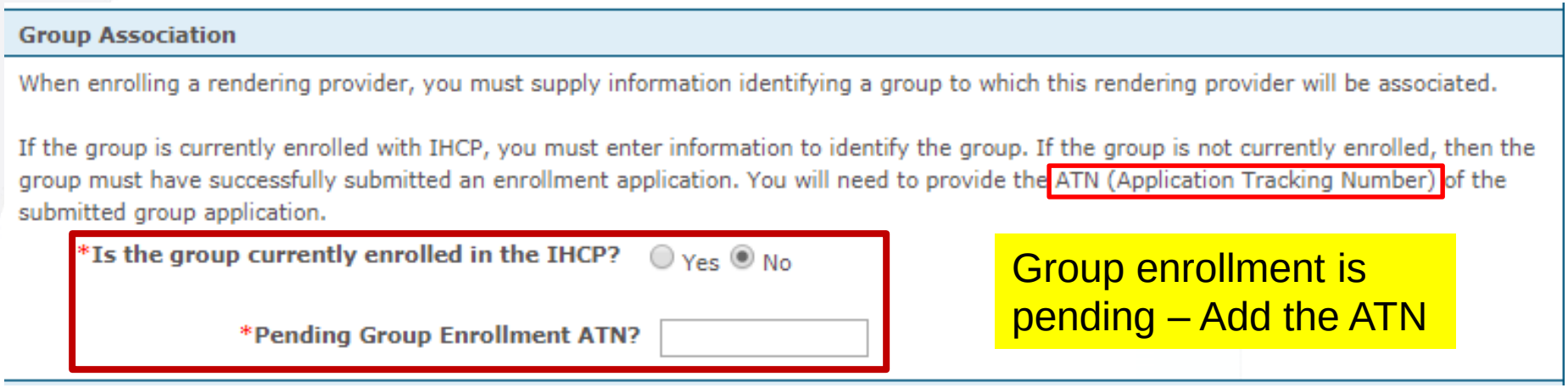


Group is enrolled – Add NPI, ***ZIP+4***, and taxonomy for ***service location*** where rendering is being linked



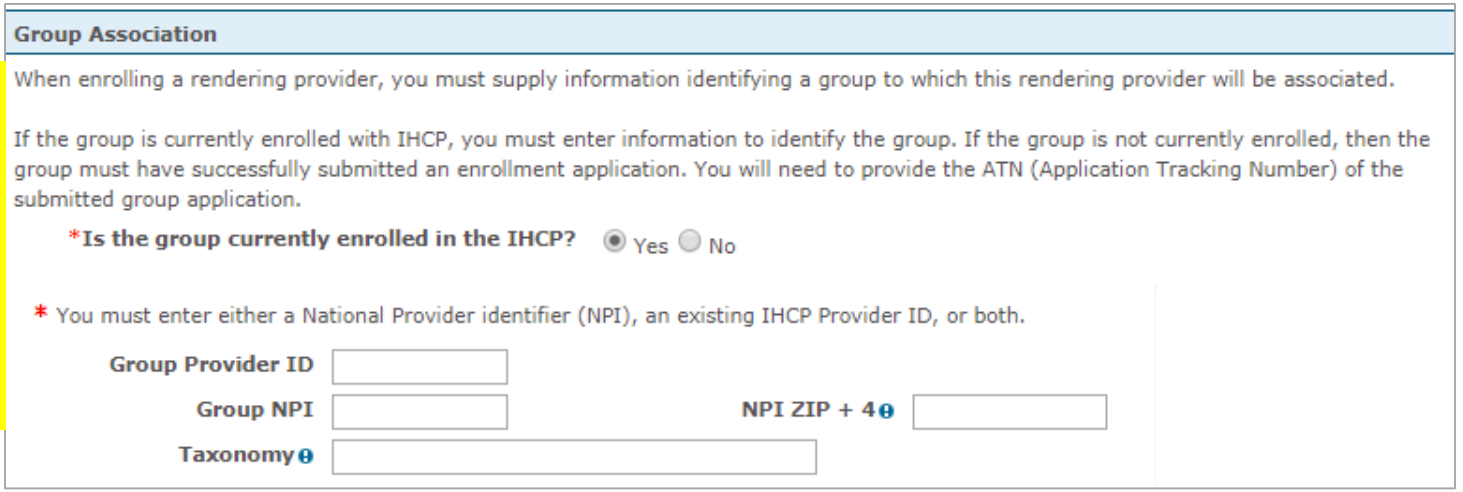
Rendering Linkage

Rendering provider *NOT* currently enrolled in the IHCP



Group enrollment is pending – Add the ATN

Group is enrolled – Add NPI, ***ZIP+4***, and taxonomy for ***service location*** where rendering is being linked



Rendering Linkage

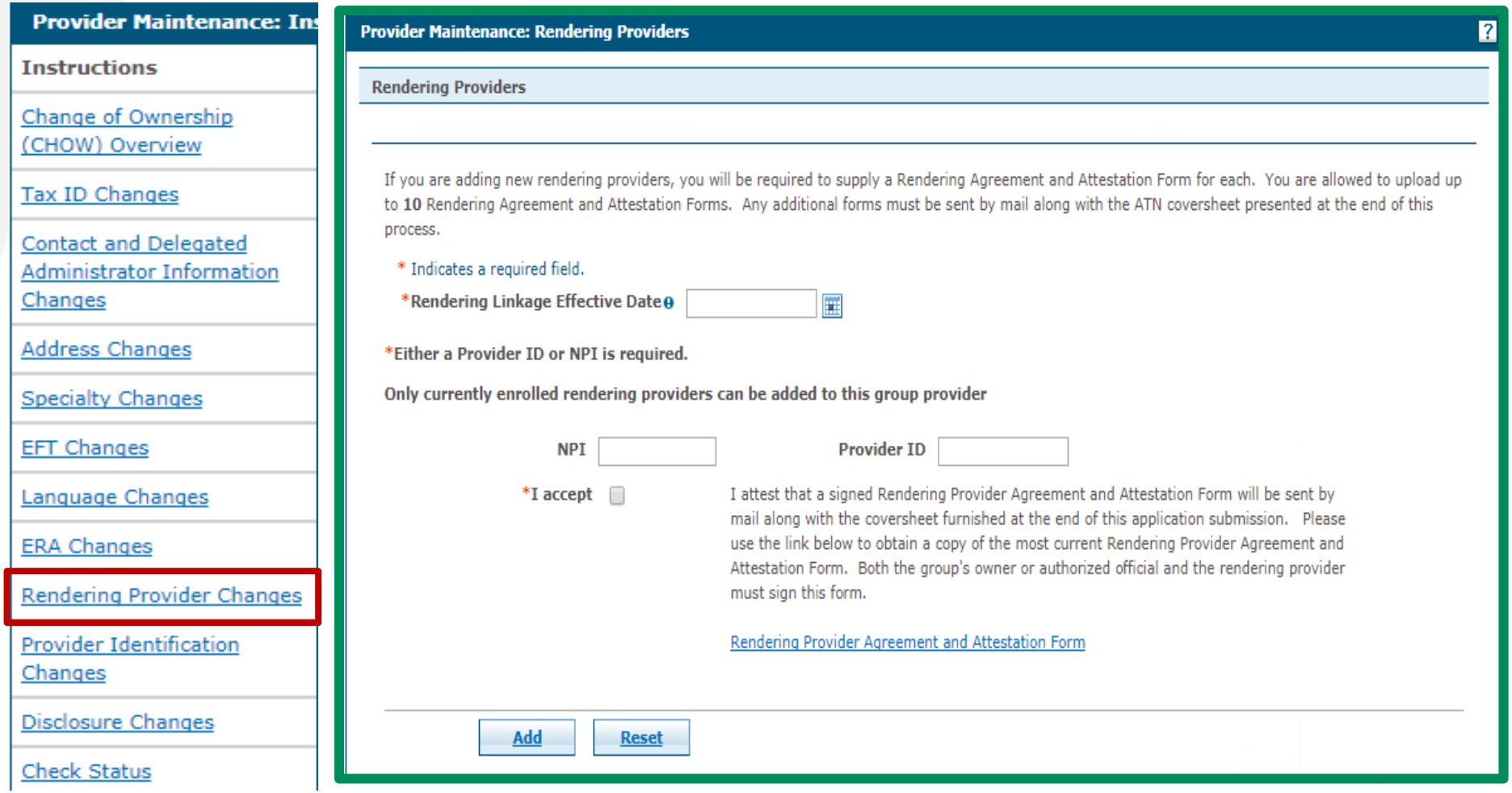
Rendering provider *IS* currently enrolled in the IHCP

Log into the Portal

Choose **Provider Maintenance**

Rendering Linkage

Rendering provider *IS* currently enrolled in the IHCP



Linking Rendering Providers to a NEW Group

- When enrolling a NEW group with more than 10 rendering providers:
  - Link up to 10 rendering providers that have been previously enrolled in the IHCP
  - After the NEW group is enrolled, link the additional rendering providers via the Portal, as instructed in previous slides
  - To request the linkage be retroactive, enclose a claim for the provider that shows a member received services from that provider on the date requested
  - Non-enrolled providers may be added, as instructed in the previous slide, at the time the NEW group is enrolled

Rendering Provider Signature Pages

The most common reason for rendering provider enrollment denials is that the Rendering Provider Attestation is missing

Appendix D

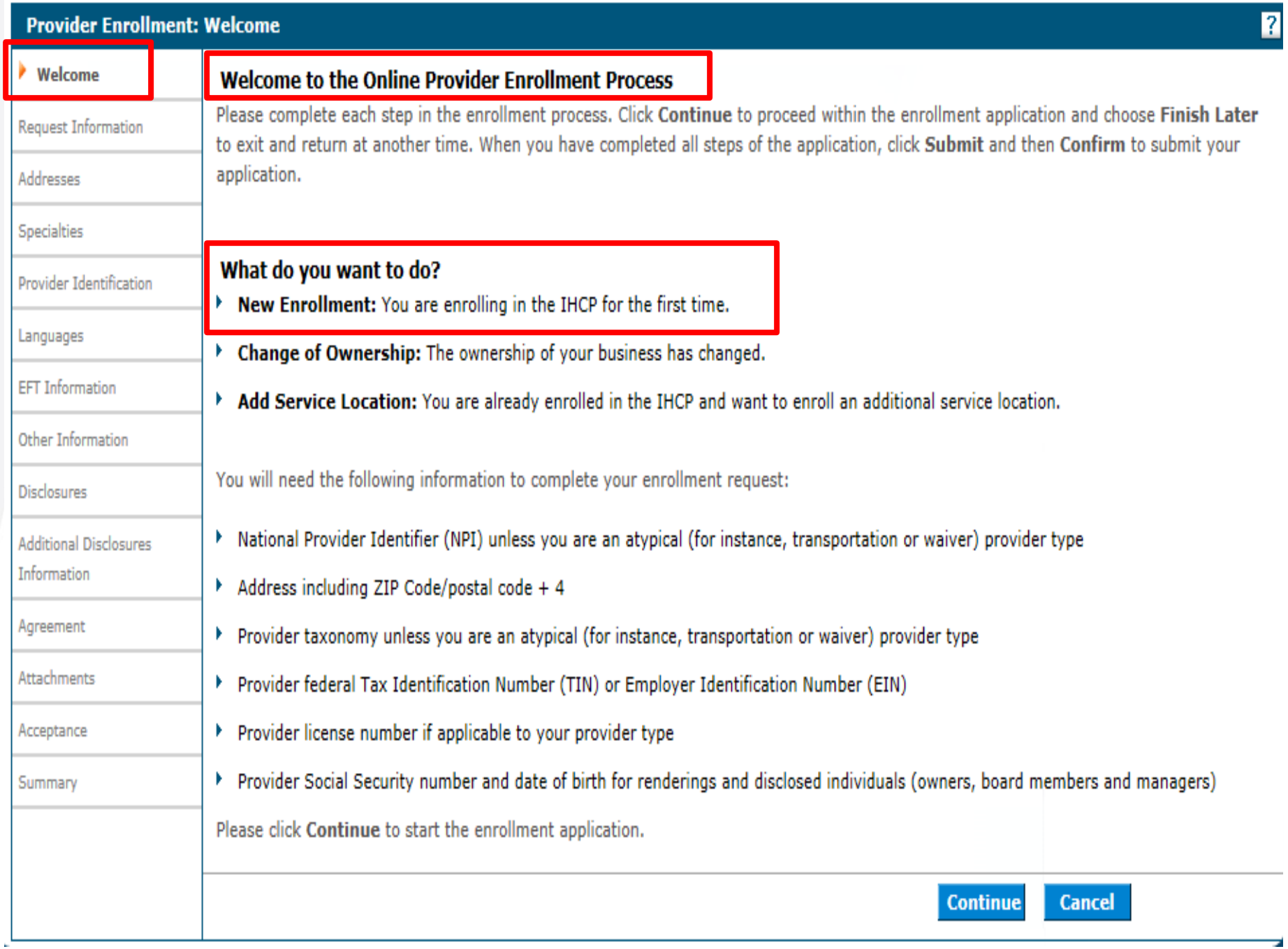
*Screen-by-screen examples of **BILLING** Provider Enrollment application*

REMINDER!

- If DMHA authorized you as an agency, you **must** enroll as a **Group** with **Rendering** providers linked to the group

- If DMHA authorized you as an individual, you **must** enroll as a **Billing** provider with your individual name and social security number.

- **EIN=group; SSN=Billing**


Provider Enrollment: Welcome
Welcome
Request Information
Addresses
Specialties
Provider Identification
Languages
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Attachments
Acceptance
Summary
Welcome to the Online Provider Enrollment Process
Please complete each step in the enrollment process. Click Continue to proceed within the enrollment application and choose Finish Later to exit and return at another time. When you have completed all steps of the application, click Submit and then Confirm to submit your application.
What do you want to do?
New Enrollment: You are enrolling in the IHCP for the first time.
Change of Ownership: The ownership of your business has changed.
Add Service Location: You are already enrolled in the IHCP and want to enroll an additional service location.
You will need the following information to complete your enrollment request:
National Provider Identifier (NPI) unless you are an atypical (for instance, transportation or waiver) provider type
Address including ZIP Code/postal code + 4
Provider taxonomy unless you are an atypical (for instance, transportation or waiver) provider type
Provider federal Tax Identification Number (TIN) or Employer Identification Number (EIN)
Provider license number if applicable to your provider type
Provider Social Security number and date of birth for renderings and disclosed individuals (owners, board members and managers)
Please click Continue to start the enrollment application.
Continue
Cancel

Provider Enrollment: Request Information

- Welcome
- **Request Information**
- Addresses
- Specialties
- Provider Identification
- Languages
- EFT Information
- Other Information
- Disclosures
- Additional Disclosures Information
- Agreement
- Attachments
- Acceptance
- Summary

You are initiating a new Indiana Health Coverage Programs (IHCP) enrollment application. Complete the fields on each page and click **Continue** to move forward to each page. All required fields on a page must be completed before the **Finish Later** option can be selected.

* Indicates a required field.

Initial Enrollment Information

*Provider Classification: Billing

*Provider Type: 11 : Mental Health Provider

*Requested Enrollment Effective Date: 04/30/2019

To request a date prior to today's date, a written request explaining the need for the earlier date, plus supporting documentation, must be submitted with application.

*Enrollment Request Type: New Enrollment

The effective date of the application will be the date it is submitted, unless you request a prior date. A copy of a claim must be attached to support the prior date

Provider Identification

A Social Security number or Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

*Social Security Number

*Tax ID Type: ○ EIN ◉ SSN

*Are you currently enrolled as an IHCP provider? ○ Yes ◉ No

*Were you previously enrolled as an IHCP provider? ○ Yes ◉ No

Contact Information

Contact Information

The contact person may be contacted to answer any questions regarding the information provided in this enrollment application. Email addresses will be used for IHCP business only.

*Last Name	YOUR LAST NAME
*First Name	YOUR FIRST NAME
Title	
*Telephone Number	1234567890
Telephone Number Extension	
Fax Number	
*Contact Email	your.emailaddress@gmail.com
*Confirm Email Address	your.emailaddress@gmail.com
Preferred Method of Communication	Email

Enter contact information

Delegated Administrator Information

Delegated administrators are individuals granted authority to submit and complete applications or revalidations via the portal upon initial enrollment, or to submit applications or maintenance requests on paper. A signature of an authorized official, or owner is required to authorize or delegate the administrator(s) listed below on the IHCP Provider Agreement page. The delegated administrator may not sign the IHCP Provider Agreement. The Provider Agreement must contain the authorized official's or the owner's electronic signature, as well as indicate they authorize the delegated administrator(s) listed below.

	Delegated Administrator Name	Action
	NOT APPLICABLE	Remove
⊞	Click to add delegated administrator information	

Not applicable unless you want to authorize someone to have "signing authority"

Continue | Finish Later | Cancel

Type	Street	City	State	Action

Click to collapse.

Enter the "service location" address (the actual physical location of the provider office); must be a street address with zip+4

*Address Type: Service Location

*Service Location (DBA) Name: YOUR NAME

*Street: 950 N MERIDIAN ST

NULL

*City: INDIANAPOLIS

*County: MARION

*State: Indiana

*ZIP Code: 46204-1077

This address information must be verified each time that it is changed. Please click the **Verify Address** button below each time the addre is changed. The address cannot be saved until it has been verified.

Click "verify address"; system verifies it is a valid address with postal service

Verify Address

Email Address: your.emailaddress@gmail.com

Confirm Email Address: your.emailaddress@gmail.com

*Telephone Number: 1234567890

Telephone Number Extension:

Fax Number:

Fax Extension:

Service Address Information

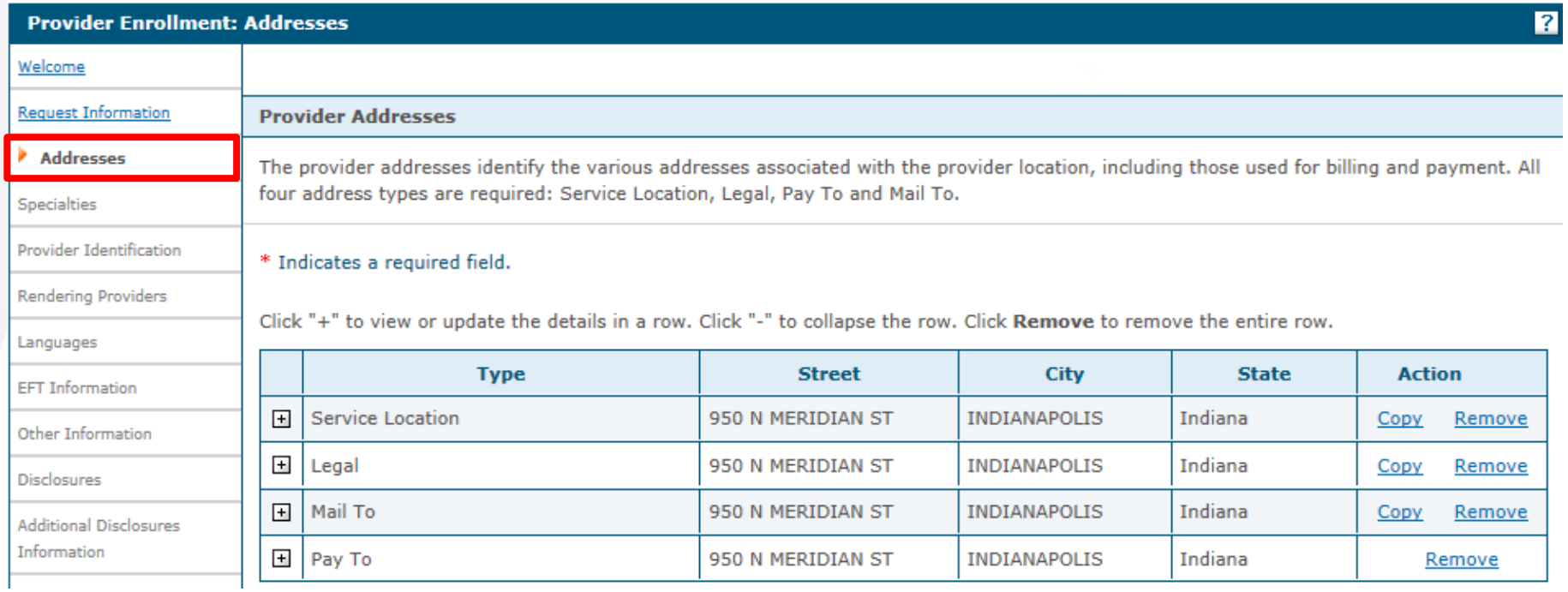
If **Address Type** is changed from "Service Location", any information entered in the **Service Address Information** section will be lost upon **Add** or **Save** of address.

Claim Documentation Kept Here ☑

Check this box to confirm that claim documentation is maintained at this address

Add Reset

Four addresses required



Provider Enrollment: Addresses

- Welcome
- Request Information
- **Addresses**
- Specialties
- Provider Identification
- Rendering Providers
- Languages
- EFT Information
- Other Information
- Disclosures
- Additional Disclosures Information

Provider Addresses

The provider addresses identify the various addresses associated with the provider location, including those used for billing and payment. All four address types are required: Service Location, Legal, Pay To and Mail To.

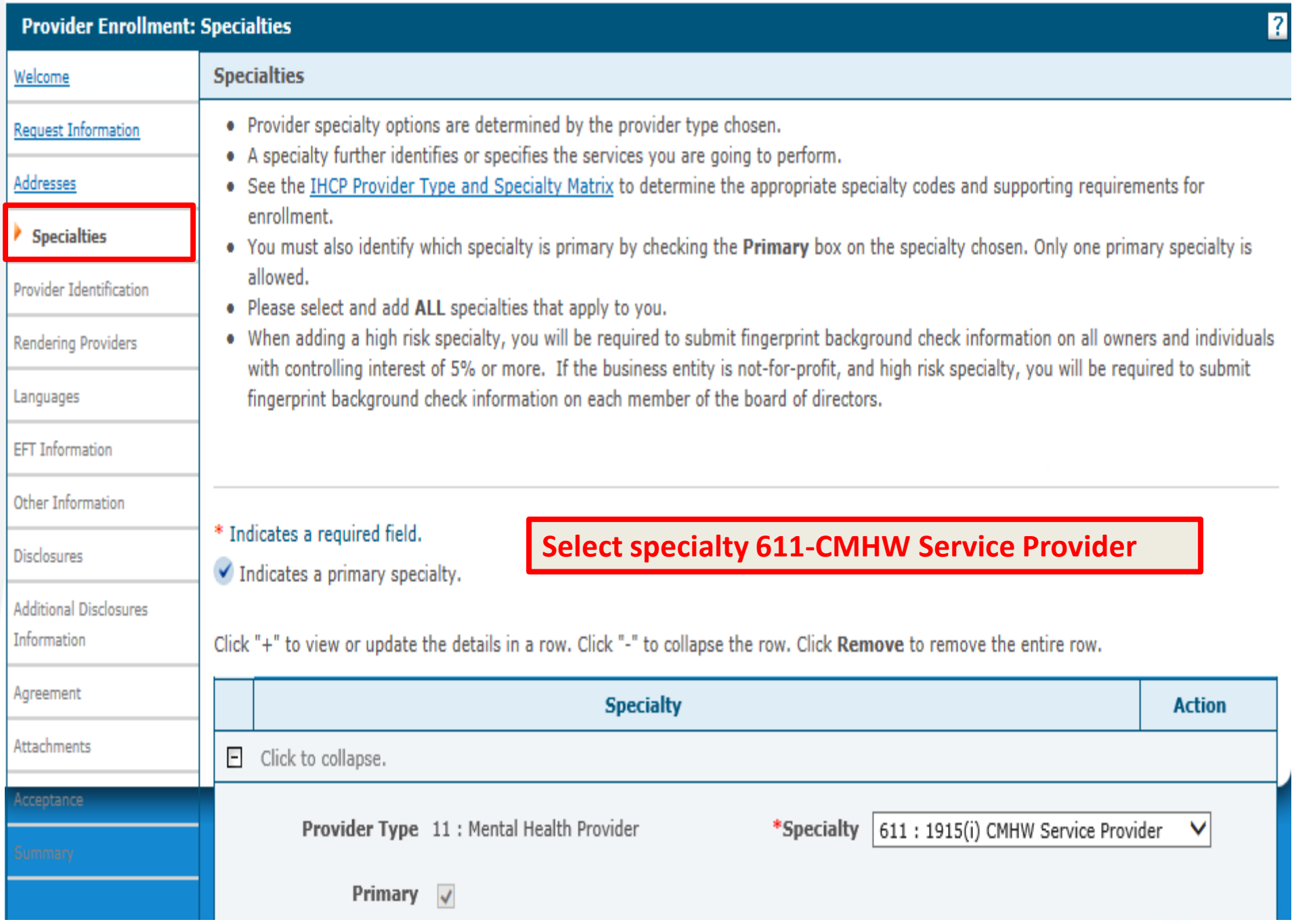
* Indicates a required field.

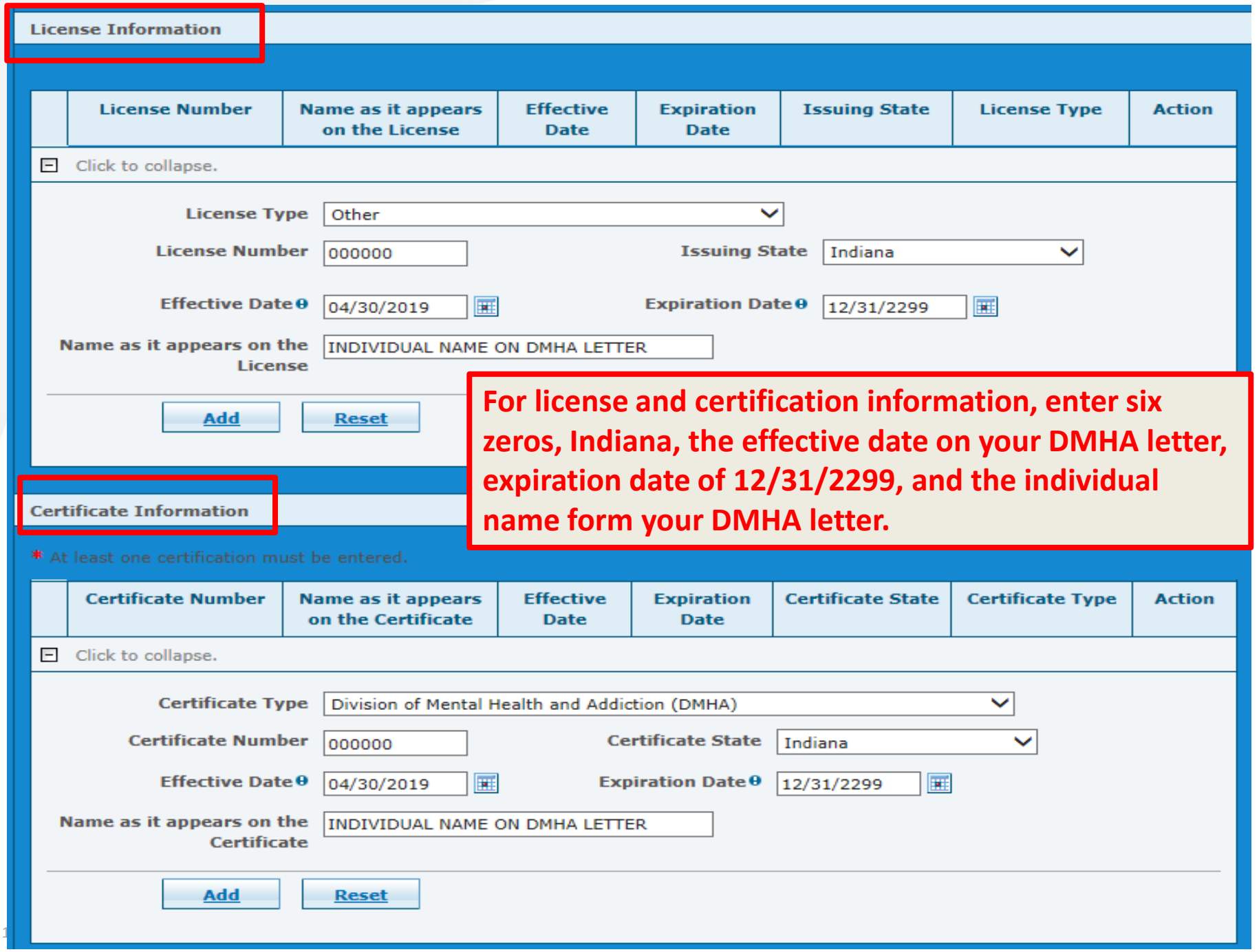
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **Remove** to remove the entire row.

	Type	Street	City	State	Action
⊞	Service Location	950 N MERIDIAN ST	INDIANAPOLIS	Indiana	Copy Remove
⊞	Legal	950 N MERIDIAN ST	INDIANAPOLIS	Indiana	Copy Remove
⊞	Mail To	950 N MERIDIAN ST	INDIANAPOLIS	Indiana	Copy Remove
⊞	Pay To	950 N MERIDIAN ST	INDIANAPOLIS	Indiana	Remove

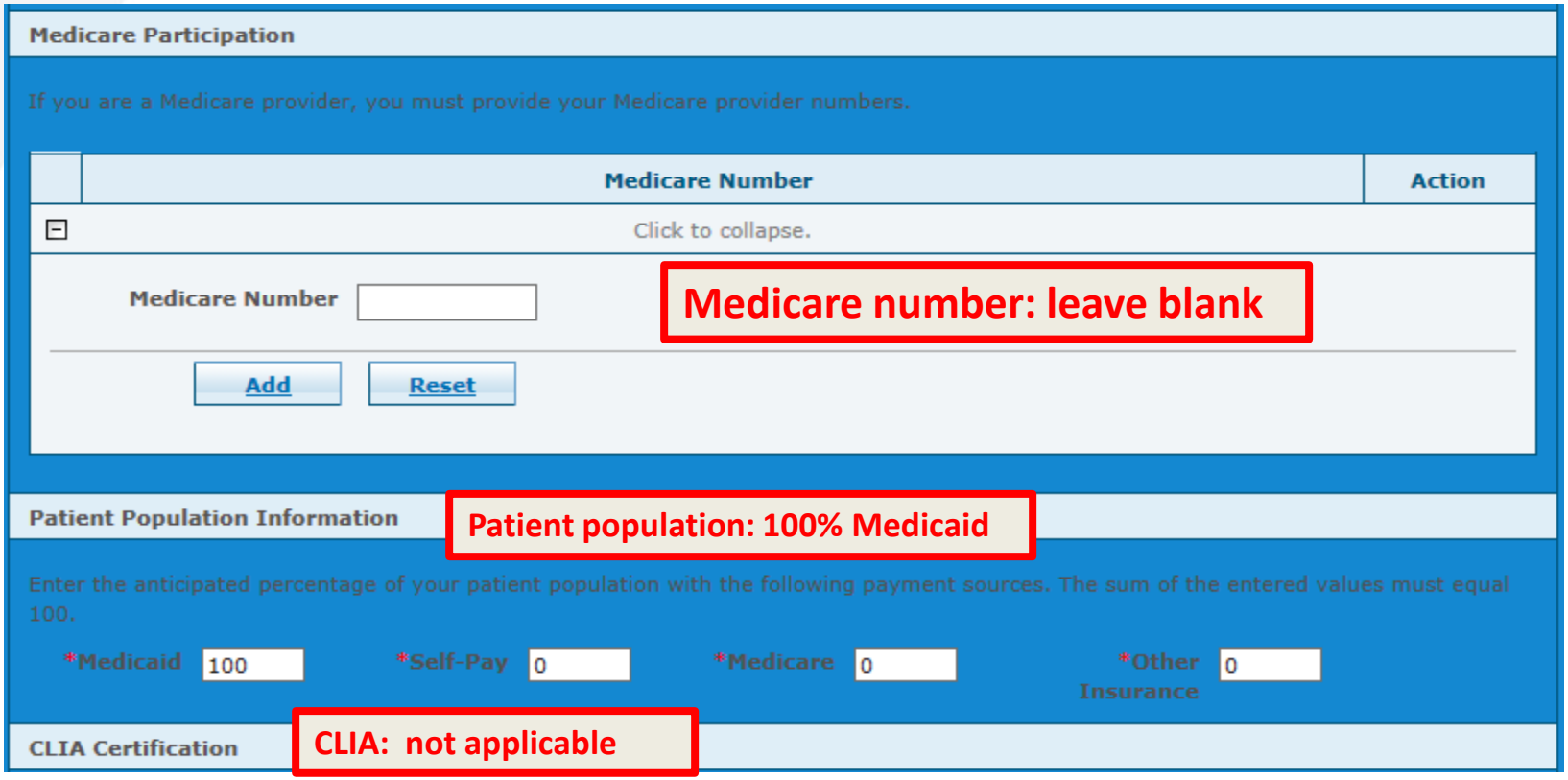
After "service location" address is entered, us the Copy button to add "legal", "mail to" and "pay to" addresses. The legal address must match EXACTLY with address put on the W-9 form

"Mail to" is where general correspondence from the IHCP is mailed
"Pay to" is where your check will be mailed if you do not elect direct deposit

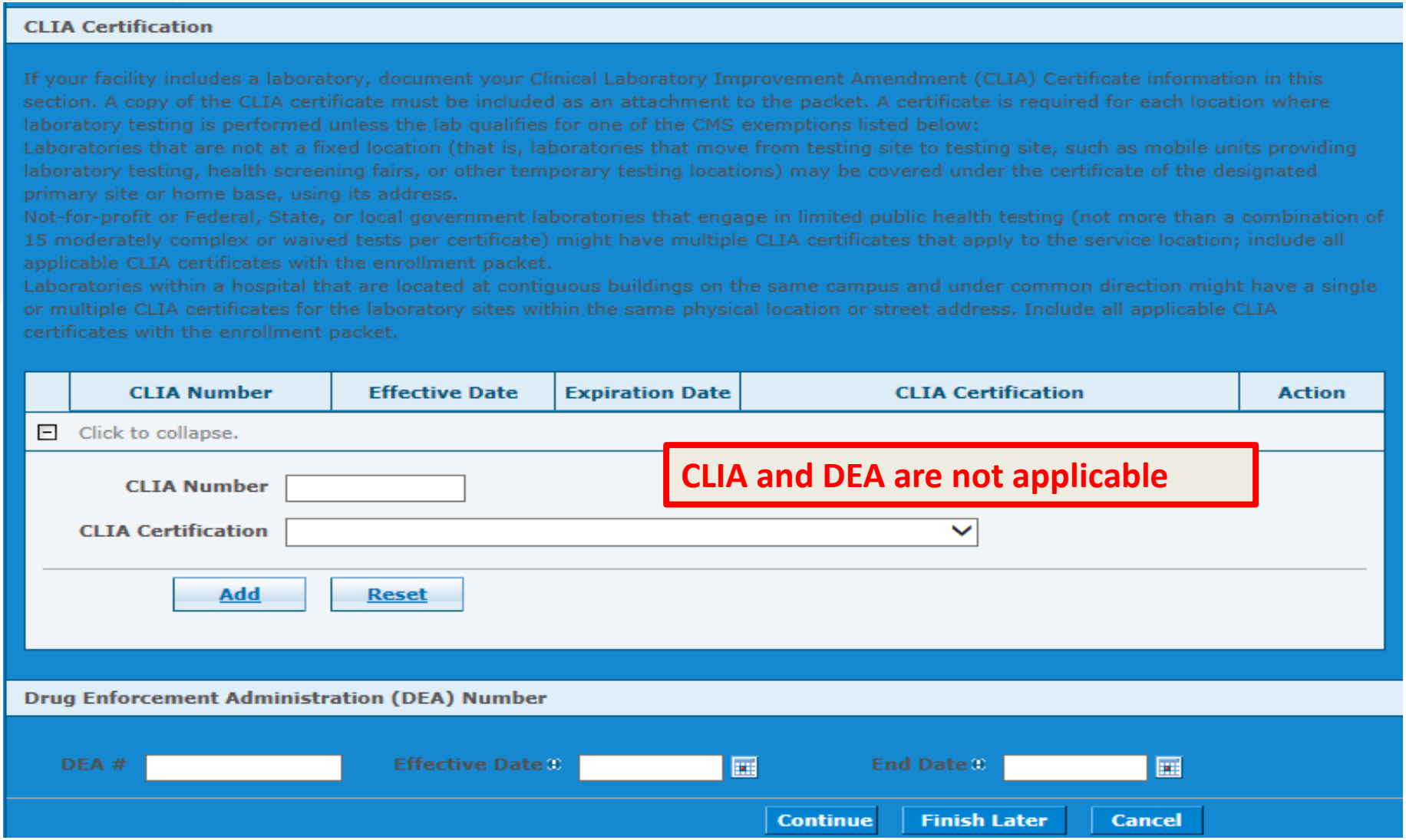

Provider Enrollment: Specialties
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Attachments
Acceptance
Summary
Specialties
Provider specialty options are determined by the provider type chosen.
A specialty further identifies or specifies the services you are going to perform.
See the IHCP Provider Type and Specialty Matrix to determine the appropriate specialty codes and supporting requirements for enrollment.
You must also identify which specialty is primary by checking the Primary box on the specialty chosen. Only one primary specialty is allowed.
Please select and add ALL specialties that apply to you.
When adding a high risk specialty, you will be required to submit fingerprint background check information on all owners and individuals with controlling interest of 5% or more. If the business entity is not-for-profit, and high risk specialty, you will be required to submit fingerprint background check information on each member of the board of directors.
* Indicates a required field.
Indicates a primary specialty.
Select specialty 611-CMHW Service Provider
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click Remove to remove the entire row.
Specialty
Action
Click to collapse.
Provider Type 11 : Mental Health Provider
*Specialty 611 : 1915(i) CMHW Service Provider
Primary


License Information
License Number
Name as it appears on the License
Effective Date
Expiration Date
Issuing State
License Type
Action
Click to collapse.
License Type
Other
License Number
000000
Issuing State
Indiana
Effective Date
04/30/2019
Expiration Date
12/31/2299
Name as it appears on the License
INDIVIDUAL NAME ON DMHA LETTER
Add
Reset
For license and certification information, enter six zeros, Indiana, the effective date on your DMHA letter, expiration date of 12/31/2299, and the individual name form your DMHA letter.
Certificate Information
* At least one certification must be entered.
Certificate Number
Name as it appears on the Certificate
Effective Date
Expiration Date
Certificate State
Certificate Type
Action
Click to collapse.
Certificate Type
Division of Mental Health and Addiction (DMHA)
Certificate Number
000000
Certificate State
Indiana
Effective Date
04/30/2019
Expiration Date
12/31/2299
Name as it appears on the Certificate
INDIVIDUAL NAME ON DMHA LETTER
Add
Reset

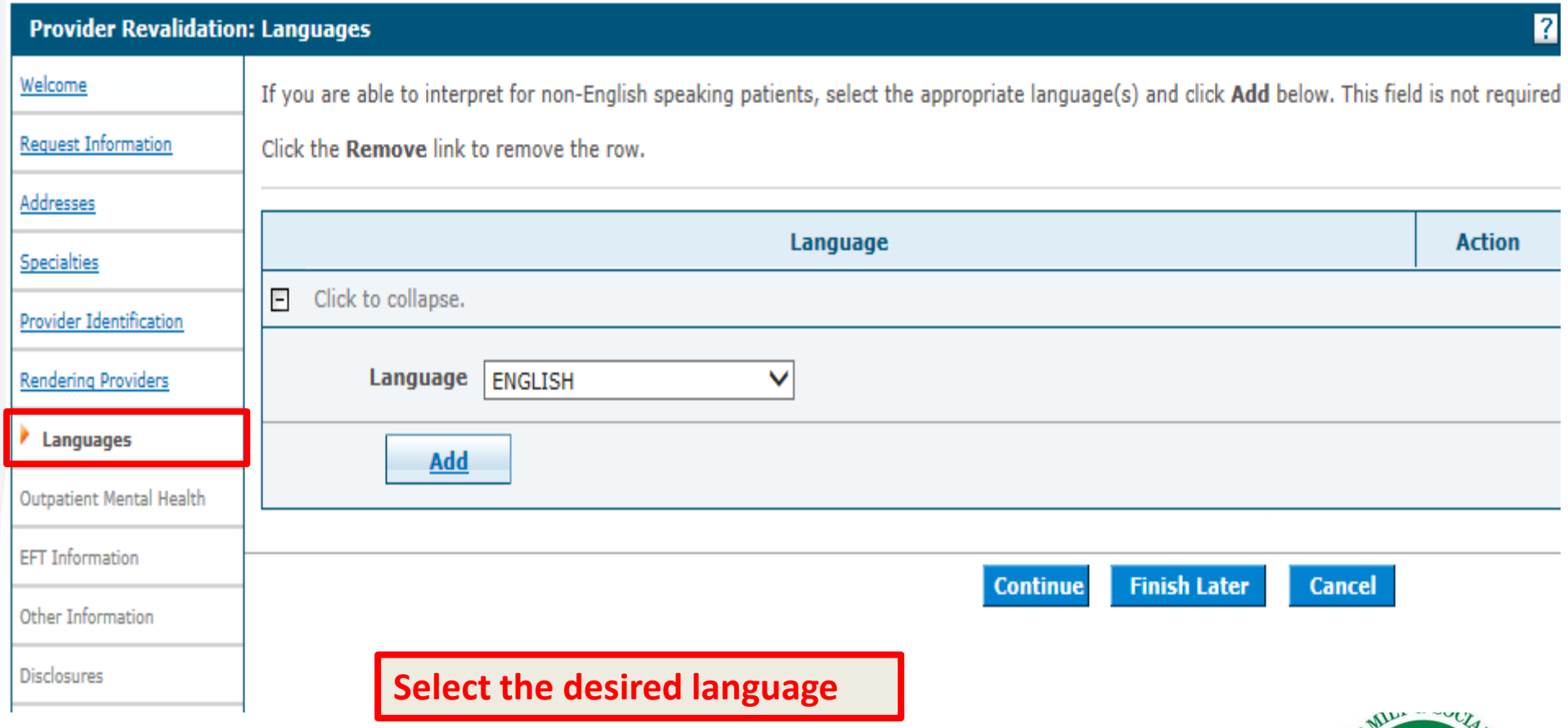
Medicare, patient population, CLIA info



CLIA, DEA


CLIA Certification
If your facility includes a laboratory, document your Clinical Laboratory Improvement Amendment (CLIA) Certificate information in this section. A copy of the CLIA certificate must be included as an attachment to the packet. A certificate is required for each location where laboratory testing is performed unless the lab qualifies for one of the CMS exemptions listed below:
Laboratories that are not at a fixed location (that is, laboratories that move from testing site to testing site, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations) may be covered under the certificate of the designated primary site or home base, using its address.
Not-for-profit or Federal, State, or local government laboratories that engage in limited public health testing (not more than a combination of 15 moderately complex or waived tests per certificate) might have multiple CLIA certificates that apply to the service location; include all applicable CLIA certificates with the enrollment packet.
Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction might have a single or multiple CLIA certificates for the laboratory sites within the same physical location or street address. Include all applicable CLIA certificates with the enrollment packet.
CLIA Number
Effective Date
Expiration Date
CLIA Certification
Action
Click to collapse.
CLIA Number
CLIA Certification
CLIA and DEA are not applicable
Add
Reset
Drug Enforcement Administration (DEA) Number
DEA #
Effective Date
End Date
Continue
Finish Later
Cancel

Language



Select the desired language

Provider Enrollment: EFT Information

- Welcome
- Request Information
- Addresses
- Specialties
- Provider Identification
- Rendering Providers
- Languages
- Outpatient Mental Health
- **EFT Information**
- Other Information
- Disclosures
- Additional Disclosures Information
- Agreement
- Application Fees
- Attachments
- Acceptance
- Summary

Providers that would like to have their claim payments deposited into a bank account should enter their relevant information below.

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.

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 will be mailed to the *Pay To* address documented. When your EFT account becomes active, direct deposits begin.

* Indicates a required field.

Would you like to have your payments electronically deposited? (•) Yes ( ) No

EFT (direct deposit) is highly recommended. If you select YES, enter your banking information. If you select NO, you will receive checks mailed to your "Pay To" address

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN) *****3333

Provider National Provider Identifier (NPI)

Provider Agent Information

Provider agent Information is optional. If you wish to include provider agent information with your application, please click the checkbox and enter the required information. If you uncheck the checkbox, any data entered will be removed.

☐ **Does account belong to a provider agent (billing agent)?**

Financial Institution Information

***Financial Institution Routing Number**

***Type of Account at Financial Institution**

***Provider's Account Number with Financial Institution**

Provider Enrollment: Other Information

- Welcome
- Request Information
- Addresses
- Specialties
- Provider Identification
- Rendering Providers
- Languages
- Outpatient Mental Health
- EFT Information
- **Other Information**
- Disclosures
- Additional Disclosures Information
- Agreement
- Application Fees
- Attachments
- Acceptance
- Summary

Additional information is requested for each enrollment, for all billing, group, and rendering providers.

* Indicates a required field.

Managed Care Program Provider

After enrolling as an IHCP provider, if you are interested in enrolling as a provider with the IHCP's Managed Care Program, you must apply directly with one or more of the managed care entities (MCEs). Please see the *Hoosier Healthwise MCEs* and *Healthy Indiana Plan MCEs* sections of the IHCP Quick Reference Guide at indianamedicaid.com for contact information.

Other IHCP Program Participation

This enrollment is to serve Medicaid members and is the first step in the process of enrollment to serve members in the managed care programs. There is also the option to have this enrollment considered as an 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 offsite facilities to individuals who reside in State institutions.

Select NO for 590 Program; Select NONE for Medical Review Program

*Participate in the 590 Program? ○ Yes ◉ No

The **Medical Review Program** provides determination of 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 submit the required forms to the Division of Family Resources Medical Review Team (MRT). The MRT is responsible for establishing a pre-Medicaid eligibility decision based on medical evidence that supports whether the applicant has a significant impairment. After the documentation has been filed, the provider may submit claims to DXC Technology 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 that elect to enroll as an IHCP provider and choose to provide MRT assessment services.
Medical Review Program Only – Providers that do not elect to enroll in the IHCP but choose to provide MRT assessment services only.
Medical Review Program – Medical Records Only – Providers that have been requested to supply MRT medical records only and want to bill for only those services.

*Medical Review Program Participation: NONE

*Medical Review Program Participation: None

340B Participation

Section 340B of the *Veteran's Health Care Act* of 1992 limits the cost of covered outpatient drugs to entities such as certain federal grantees. Federally Qualified Health Centers (FQHCs), FQHC look-alikes, and qualified disproportionate share hospitals, enabling these entities to purchase drugs at discounted rates and stretch scarce federal resources. Indiana Health Coverage Programs (IHCP) policy regarding the 340B Program is as follows:

Federal law allows eligible entities to decide if they do or do not want to service Medicaid members using 340B stock. This decision is wholly at the discretion of the entity. However, once an eligible entity makes a decision to service or not service Medicaid members with the 340B stock, the entity is "locked" into that decision and not permitted to dispense a mix of 340B and non-340B drugs to Medicaid members.

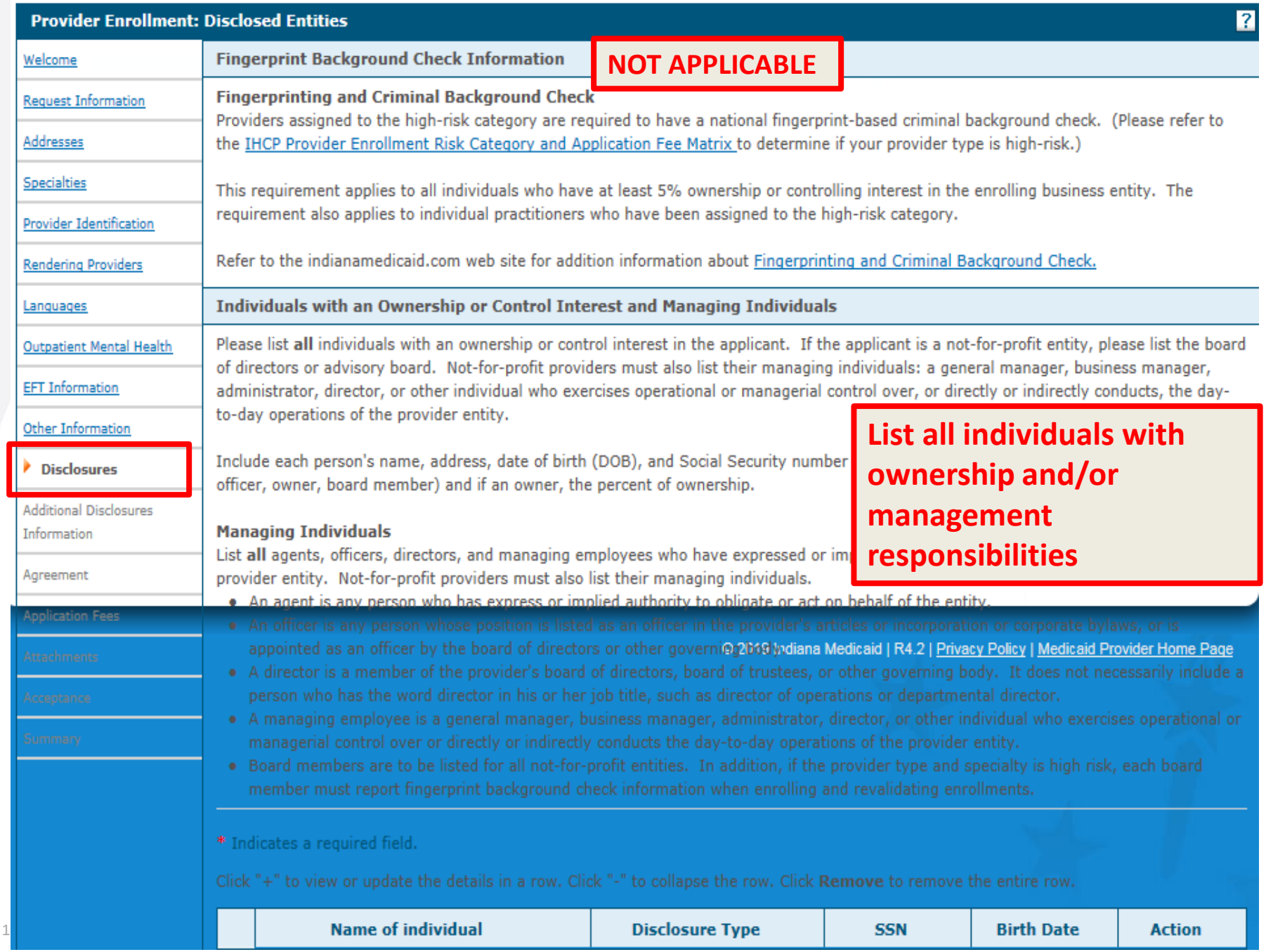
*340B Participation

- ○ The entity wishes to serve Medicaid members using 340B stock. It will only dispense 340B stock and bill the program accordingly at its acquisition cost of the drug, plus the Medicaid dispensing fee (carve-in).
- ◉ The entity wishes to serve Medicaid members using a separate non-340B stock. It will not use 340B stock at any time. The entity will bill the program at its usual and customary (U&C) charges to Medicaid (carve-out).

This section is not applicable; select either box

Federal law prohibits the entity from buying at 340B acquisition cost, providing 340B purchased stock to Medicaid members, and billing Medicaid at U&C rates.

Continue | Finish Later | Cancel


Provider Enrollment: Disclosed Entities
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Application Fees
Attachments
Acceptance
Summary
Fingerprint Background Check Information
NOT APPLICABLE
Fingerprinting and Criminal Background Check
Providers assigned to the high-risk category are required to have a national fingerprint-based criminal background check. (Please refer to the IHCP Provider Enrollment Risk Category and Application Fee Matrix to determine if your provider type is high-risk.)
This requirement applies to all individuals who have at least 5% ownership or controlling interest in the enrolling business entity. The requirement also applies to individual practitioners who have been assigned to the high-risk category.
Refer to the indianamedicaid.com web site for addition information about Fingerprinting and Criminal Background Check.
Individuals with an Ownership or Control Interest and Managing Individuals
Please list all individuals with an ownership or control interest in the applicant. If the applicant is a not-for-profit entity, please list the board of directors or advisory board. Not-for-profit providers must also list their managing individuals: 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.
Include each person's name, address, date of birth (DOB), and Social Security number
officer, owner, board member) and if an owner, the percent of ownership.
List all individuals with ownership and/or management responsibilities
Managing Individuals
List all agents, officers, directors, and managing employees who have expressed or im
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 or incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing
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.
Board members are to be listed for all not-for-profit entities. In addition, if the provider type and specialty is high risk, each board member must report fingerprint background check information when enrolling and revalidating enrollments.
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* Indicates a required field.
Click "+" to view or update the details in a row. Click "-" to collapse the row. Click Remove to remove the entire row.
Name of individual
Disclosure Type
SSN
Birth Date
Action

	Name of individual	Disclosure Type	SSN	Birth Date	Action
⊟	YOUR LAST NAME, YOUR FIRST NAME	Ownership and Control, Managing Individuals	*****6789	6/1/1980	Remove

Disclosure Type

- [x] Ownership and Control
- [x] Managing Individuals
- [ ] Board of Directors

Fingerprint Background Check Information

Confirmation Number

Confirmation Source

Date Fingerprint Obtained

Not applicable

*Last Name: YOUR LAST NAME

*First Name: YOUR FIRST NAME

Middle:

Title:

% of ownership (if applicable): 100

*Social Security Number: *****6789

*Birth Date: 06/01/1980

*Street: YOUR STREET ADDRESS

*City: YOUR CITY

*State: Indiana

*ZIP Code: 462401107

Enter required information for you, as the owner and managing individual

Save | Reset | Cancel

Corporations with an Ownership or Control Interest

Not applicable

If a corporation, please list **all** corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the primary business address, every business location, including P.O. Box address(es).

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **Remove** to remove the entire row.

	Name of Corporation	TIN	Action
⊞	Click to add disclosed entity		

Subcontractors

Not applicable

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 Tax Identification Number (TIN).

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **Remove** to remove the entire row.

	Name of subcontractor	Street Address	City, State, Postal Code	TIN	Action
⊞	Click to add disclosed entity				

Continue | Finish Later | Cancel

Provider Enrollment: Disclosures

- Welcome
- Request Information
- Addresses
- Specialties
- Provider Identification
- Rendering Providers
- Languages
- Outpatient Mental Health
- EFT Information
- Other Information
- Disclosures
- **Additional Disclosures Information**
- Agreement
- Application Fees
- Attachments
- Acceptance
- Summary

*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 — ○ Yes ◉ No

*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? — ○ Yes ◉ No

*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? — ○ Yes ◉ No

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, XVII, 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.

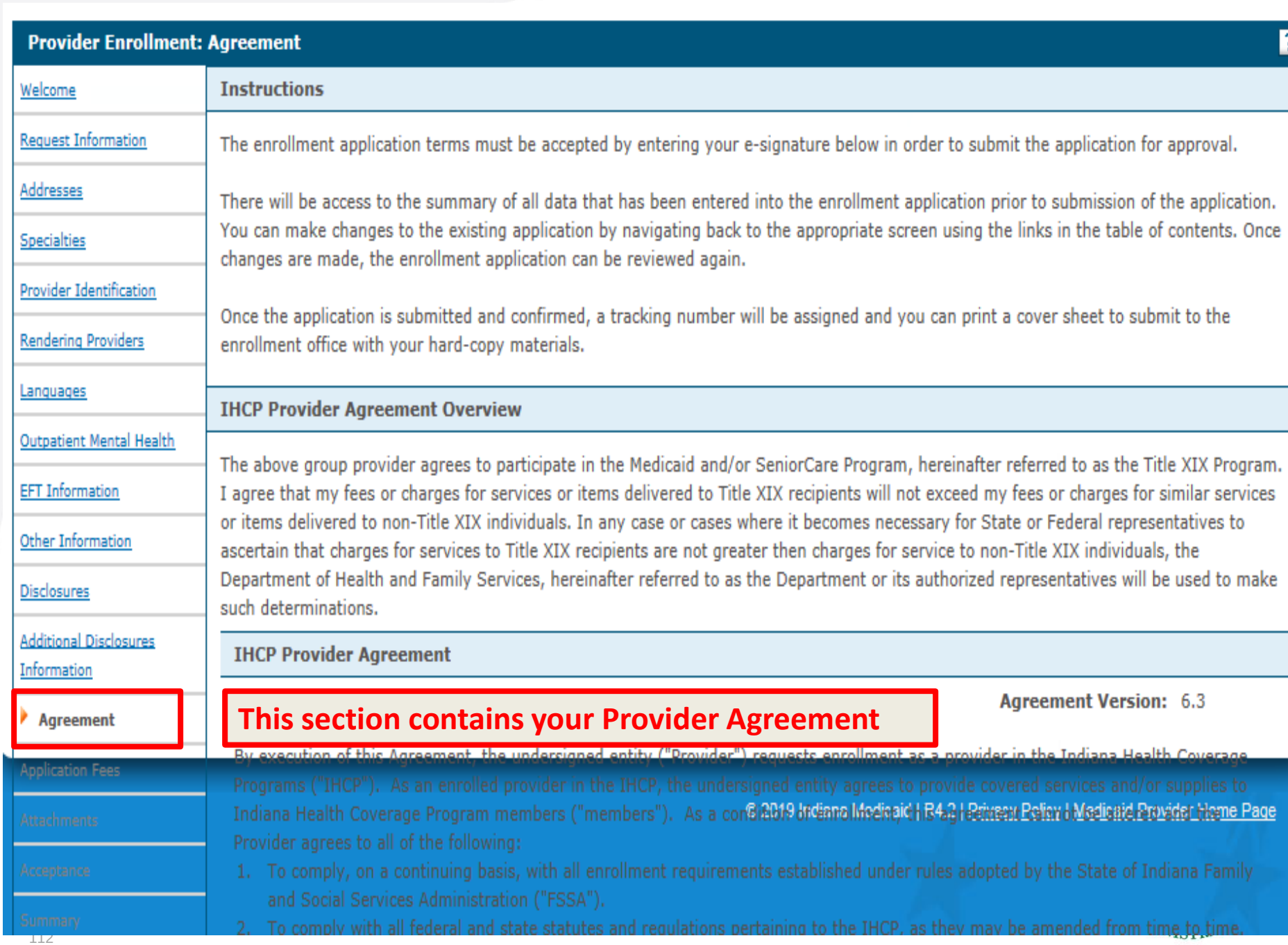
Whereas "disclosing entity" is limited to Medicaid providers, "other disclosing entity" can include entities that are not enrolled in Medicaid.

*Are there any disclosed parties with an ownership or control [illegible] 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? — ○ Yes ◉ No

*Are there any former agents, officers, directors, partners, or managing employees who have 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? — ○ Yes ◉ No

Read each section carefully and answer Yes or No

C.1 refers to "owners" listed on previous slide: C.3 refers to "management" listed on previous slide


Provider Enrollment: Agreement
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Application Fees
Attachments
Acceptance
Summary
Instructions
The enrollment application terms must be accepted by entering your e-signature below in order to submit the application for approval.
There will be access to the summary of all data that has been entered into the enrollment application prior to submission of the application. You can make changes to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.
Once the application is submitted and confirmed, a tracking number will be assigned and you can print a cover sheet to submit to the enrollment office with your hard-copy materials.
IHCP Provider Agreement Overview
The above group provider agrees to participate in the Medicaid and/or SeniorCare Program, hereinafter referred to as the Title XIX Program. I agree that my fees or charges for services or items delivered to Title XIX recipients will not exceed my fees or charges for similar services or items delivered to non-Title XIX individuals. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to Title XIX recipients are not greater then charges for service to non-Title XIX individuals, the Department of Health and Family Services, hereinafter referred to as the Department or its authorized representatives will be used to make such determinations.
IHCP Provider Agreement
Agreement Version: 6.3
This section contains your Provider Agreement
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 between the Provider and
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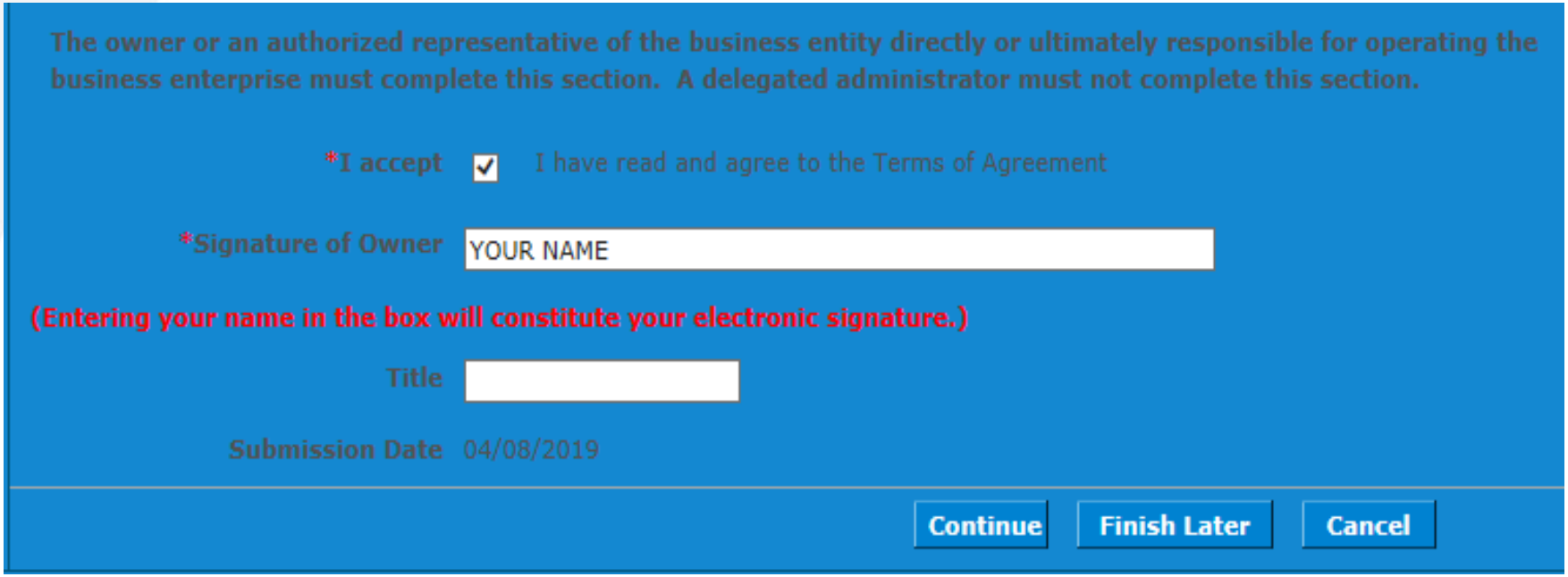
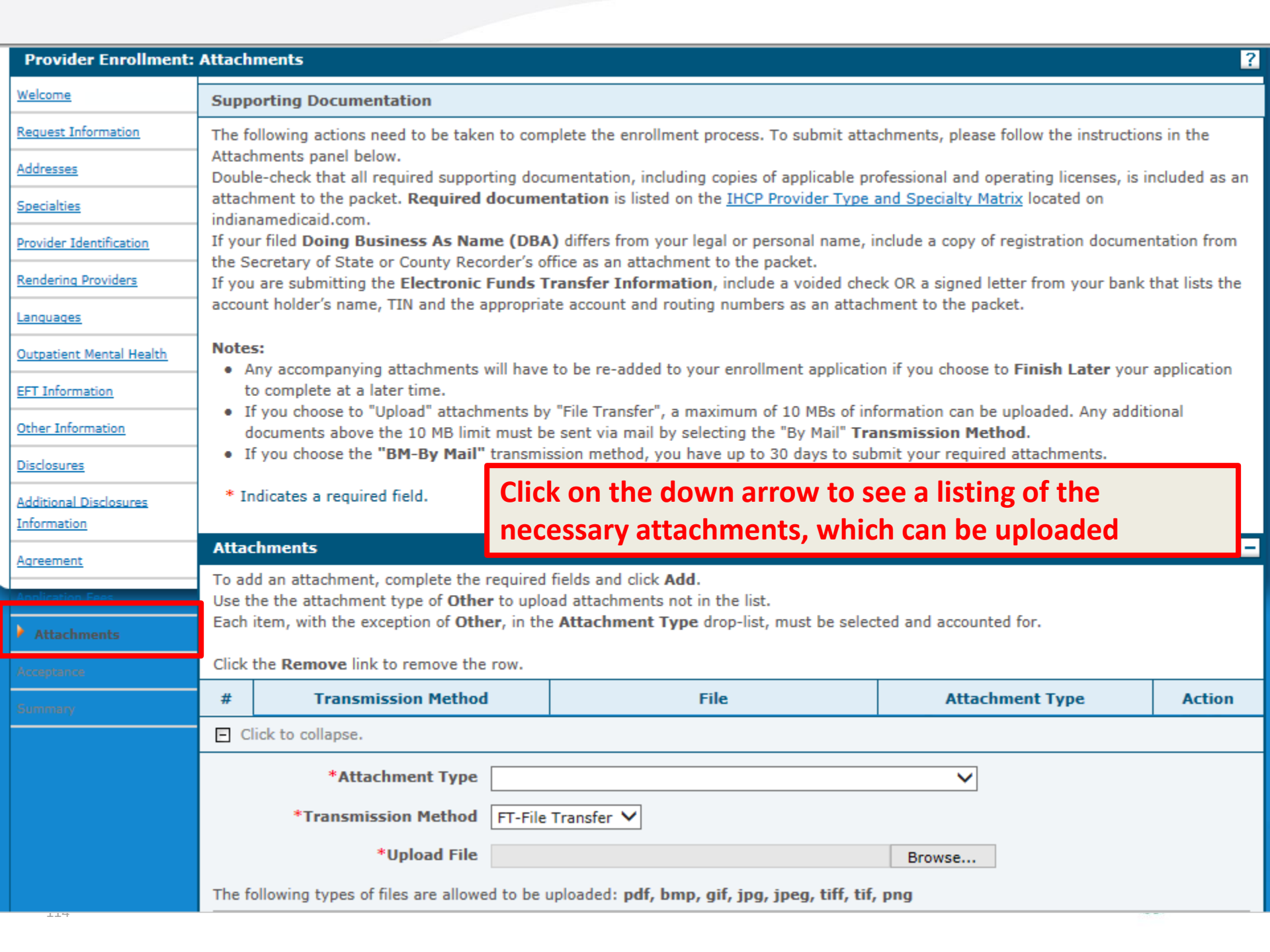
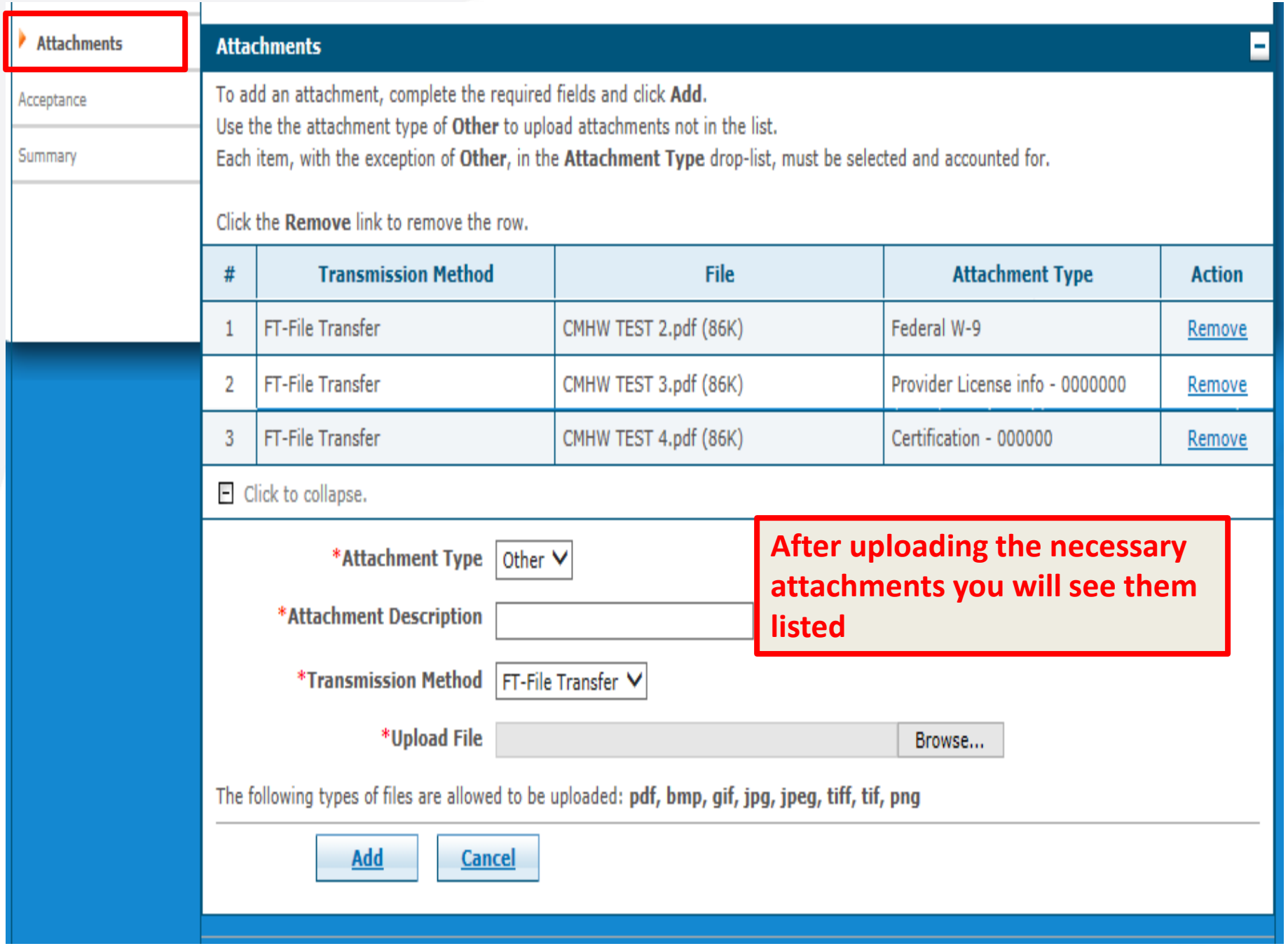
Provider agrees to all of the following:
1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("FSSA").
2. To comply with all federal and state statutes and regulations pertaining to the IHCP, as they may be amended from time to time.

Provider Agreement



After carefully reviewing your Provider Agreement type in your name, which serves as an electronic signature


Provider Enrollment: Attachments
Welcome
Request Information
Addresses
Specialties
Provider Identification
Rendering Providers
Languages
Outpatient Mental Health
EFT Information
Other Information
Disclosures
Additional Disclosures Information
Agreement
Application Fees
Attachments
Acceptance
Summary
Supporting Documentation
The following actions need to be taken to complete the enrollment process. To submit attachments, please follow the instructions in the Attachments panel below.
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 Type and Specialty Matrix located on indianamedicaid.com.
If your filed Doing Business As Name (DBA) differs from your legal or personal name, include a copy of registration documentation from the Secretary of State or County Recorder's office as an attachment to the packet.
If you are submitting the Electronic Funds Transfer Information, include a voided check OR a signed letter from your bank that lists the account holder's name, TIN and the appropriate account and routing numbers as an attachment to the packet.
Notes:
Any accompanying attachments will have to be re-added to your enrollment application if you choose to Finish Later your application to complete at a later time.
If you choose to "Upload" attachments by "File Transfer", a maximum of 10 MBs of information can be uploaded. Any additional documents above the 10 MB limit must be sent via mail by selecting the "By Mail" Transmission Method.
If you choose the "BM-By Mail" transmission method, you have up to 30 days to submit your required attachments.
* Indicates a required field.
Click on the down arrow to see a listing of the necessary attachments, which can be uploaded
Attachments
To add an attachment, complete the required fields and click Add.
Use the the attachment type of Other to upload attachments not in the list.
Each item, with the exception of Other, in the Attachment Type drop-list, must be selected and accounted for.
Click the Remove link to remove the row.
Transmission Method File Attachment Type Action
Click to collapse.
*Attachment Type
*Transmission Method
FT-File Transfer
*Upload File
Browse...
The following types of files are allowed to be uploaded: pdf, bmp, gif, jpg, jpeg, tiff, tif, png


Attachments
Acceptance
Summary
Attachments
To add an attachment, complete the required fields and click Add.
Use the the attachment type of Other to upload attachments not in the list.
Each item, with the exception of Other, in the Attachment Type drop-list, must be selected and accounted for.
Click the Remove link to remove the row.
| Transmission Method | File | Attachment Type | Action
1 | FT-File Transfer | CMHW TEST 2.pdf (86K) | Federal W-9 | Remove
2 | FT-File Transfer | CMHW TEST 3.pdf (86K) | Provider License info - 0000000 | Remove
3 | FT-File Transfer | CMHW TEST 4.pdf (86K) | Certification - 000000 | Remove
Click to collapse.
*Attachment Type
Other
*Attachment Description
*Transmission Method
FT-File Transfer
*Upload File
Browse...
The following types of files are allowed to be uploaded: pdf, bmp, gif, jpg, jpeg, tiff, tif, png
Add
Cancel
After uploading the necessary attachments you will see them listed

Provider Enrollment: Acceptance

- Welcome
- Request Information
- Addresses
- Specialties
- Provider Identification
- Languages
- EFT Information
- Other Information
- Disclosures
- Additional Disclosures Information
- Agreement
- Attachments
- Acceptance
- Summary

Instructions

The enrollment application terms must be accepted by entering your e-signature below in order to submit the application for approval.

There will be access to the summary of all data that has been entered into the enrollment application prior to submission of the application. You can make changes to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.

Once the application is submitted and confirmed, a tracking number will be assigned and you can print a cover sheet to submit to the enrollment office with your hard-copy materials.

Enter your name as an electronic signature to signify acceptance

Provider Name	YOUR NAME
Street	950 N MERIDIAN ST NULL INDIANAPOLIS Indiana, 46204-1077
Provider Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN)	*****6789
NPI	1174654305
Contact Name	YOUR FIRST NAME YOUR LAST NAME
Contact Email	your.emailaddress@gmail.com

As the actual owner or authorized representative who completed this application and agreement, please attest to the accuracy of all information entered and to the following:

I further acknowledge my agreement to and acceptance of all terms and conditions of the Electronic Funds Transfer Request, if applicable, pursuant to my completion of the EFT Information section of this application and agreement.

I hereby confirm my understanding that I am the owner or authorized representative of this business entity, that my electronic signature is equivalent to my written signature, and that my electronic signature below confirms my acceptance of all stipulations, conditions, terms, and attestations herein. All provider information and supporting documentation submitted with this application and attestation is true, complete and correct.

*Your Signature YOUR NAME

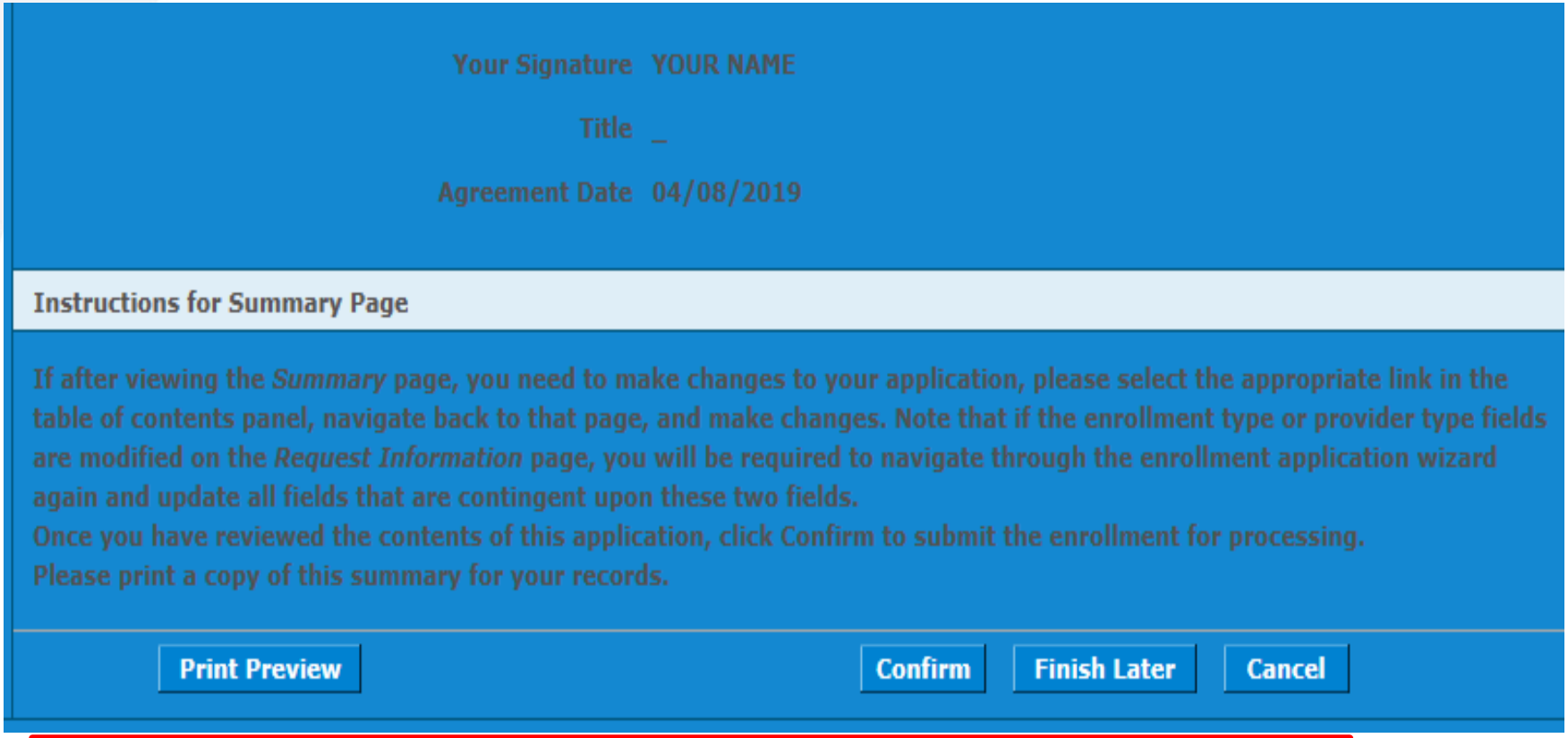
(Entering your name in the box will constitute your electronic signature)

Title

Submission Date 04/08/2019

Continue Finish Later Cancel

Summary



After acceptance you will receive a summary of all of the information entered on the application. You can review the summary for accuracy and make any corrections, if necessary. Then you will click on "Confirm" to submit the application.

Print Preview

Provider Enrollment: Summary

- Welcome
- Request Information
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- Additional Disclosures Information
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- Acceptance
- Summary

Request Information

Requested Enrollment Effective Date 04/30/2019

Provider Classification Billing

Provider Type 11 : Mental Health Provider

Enrollment Request Type New Enrollment

Print out the listing of all information entered on the application

Provider Identification

Employer Identification Number (EIN) ******6789

Are you currently enrolled as an IHCP provider? No

Were you previously enrolled as an IHCP provider? No

Contact Information

Last Name YOUR LAST NAME

First Name YOUR FIRST NAME

Title _

Telephone Number 123-456-7890

Telephone Number Extension _

Provider Enrollment: Credentials

Your enrollment application will be submitted for processing.

Once submitted, you will not be able to return to the application to review or make modifications. To check the status of this application, from the Healthcare Portal home page, click on the **Provider Enrollment** link to be taken to the Provider Enrollment page, then click on the **Enrollment Status** link.

Please provide the following information. The credentials you create will be required to revise your application at a later date. Your password must be between 8 and 20 alphanumeric characters. Your Tax Identification Number (TIN) is provided below.

Once all required information is entered, click on the Submit button to submit your application. An application tracking number will be provided. Please keep this number in a safe place. You must have the tracking number to check the status of the application as well as to make corrections/updates necessary to complete the processing of your application. Additionally, you must have your Tax Identification Number (TIN) and the password you will create below.

Along with the ATN, you will also need the password you create when submitting this application. Please make sure to keep a record of the password. Passwords cannot be reset or retrieved by the IHCP. If the password is lost or forgotten, you will need to resubmit the application in full should corrections be needed.

* Indicates a required field.

Enter this information which will be necessary if you need to check the status of your application at a later date

Provider Federal Tax Identification Number (TIN), Employer Identification Number (EIN) or Social Security Number (SSN)	*****6789
***Password**	••••••••••
***Confirm Password**	••••••••••

Below, please enter the email address where you would like your confirmation email sent.

***Email Address**	ken.guth@dxc.com
***Confirm Email Address**	ken.guth@dxc.com

Submit Cancel

Tracking information

After the application is submitted you will receive an ATN (application tracking number)

Print Preview

To print tracking information click "Print Preview"

Provider Enrollment: Tracking Information

Your application has been submitted for processing and assigned tracking number **3089**.

Please keep this number in a safe place. You must have the tracking number to check the status of the application as well as to make corrections/updates necessary to complete the processing of your application. Additionally, you must have your tax identification number (TIN) and the password you created when you started this application. The tracking number and application password are not stored in our system; therefore, they cannot be retrieved or reset should you misplace them.

To check the status of this application, from the Healthcare Portal home page, click on the **Provider Enrollment** link to be taken to the Provider Enrollment page, then click on the **Enrollment Status** link.

A confirmation email has also been sent to the contact person's email, provided in the application: your.email.address@yahoo.com.

Important Note for Mailing Attachments: If you have indicated that your required attachments will be submitted by mail, you MUST print the cover sheet and mail it, along with any required documentation to the address listed on the cover sheet.

To Print the Coversheet Click Here.

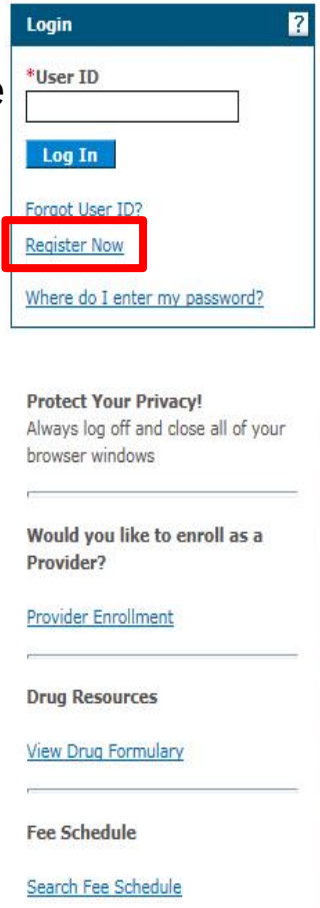
If you need to mail any attachments print the cover sheet to send with the attachments

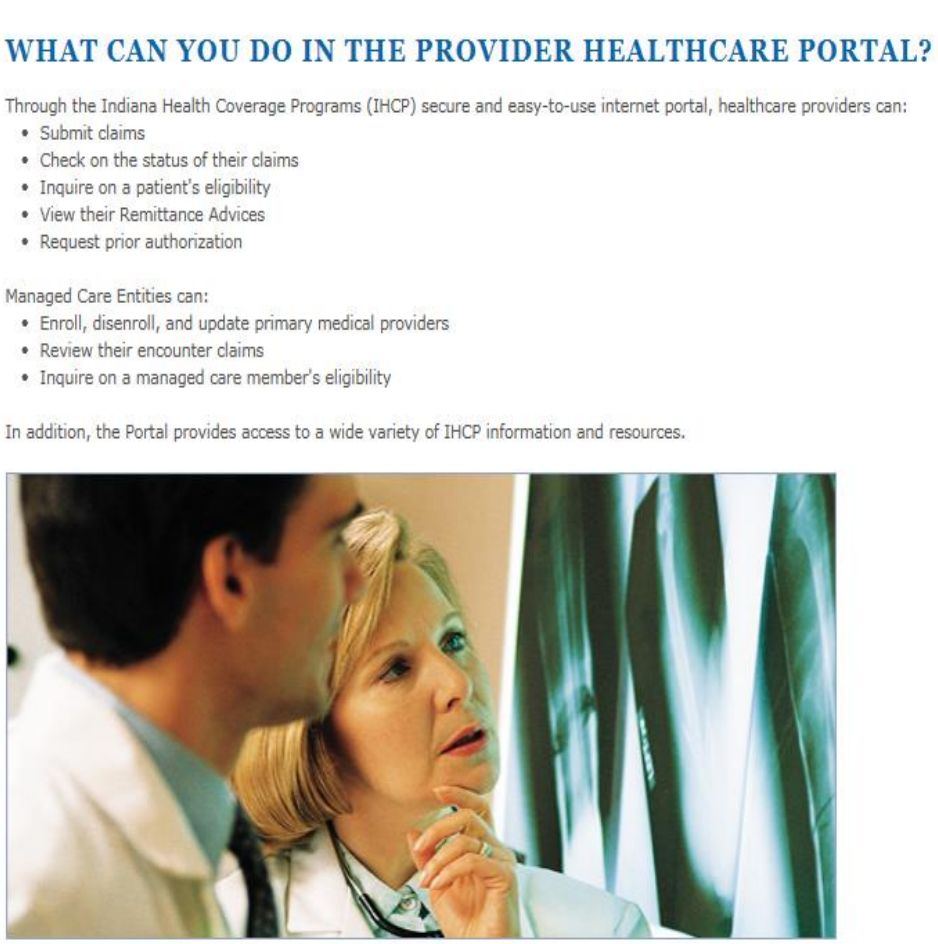
Exit

Registering on the Provider Healthcare Portal

Provider Healthcare Portal

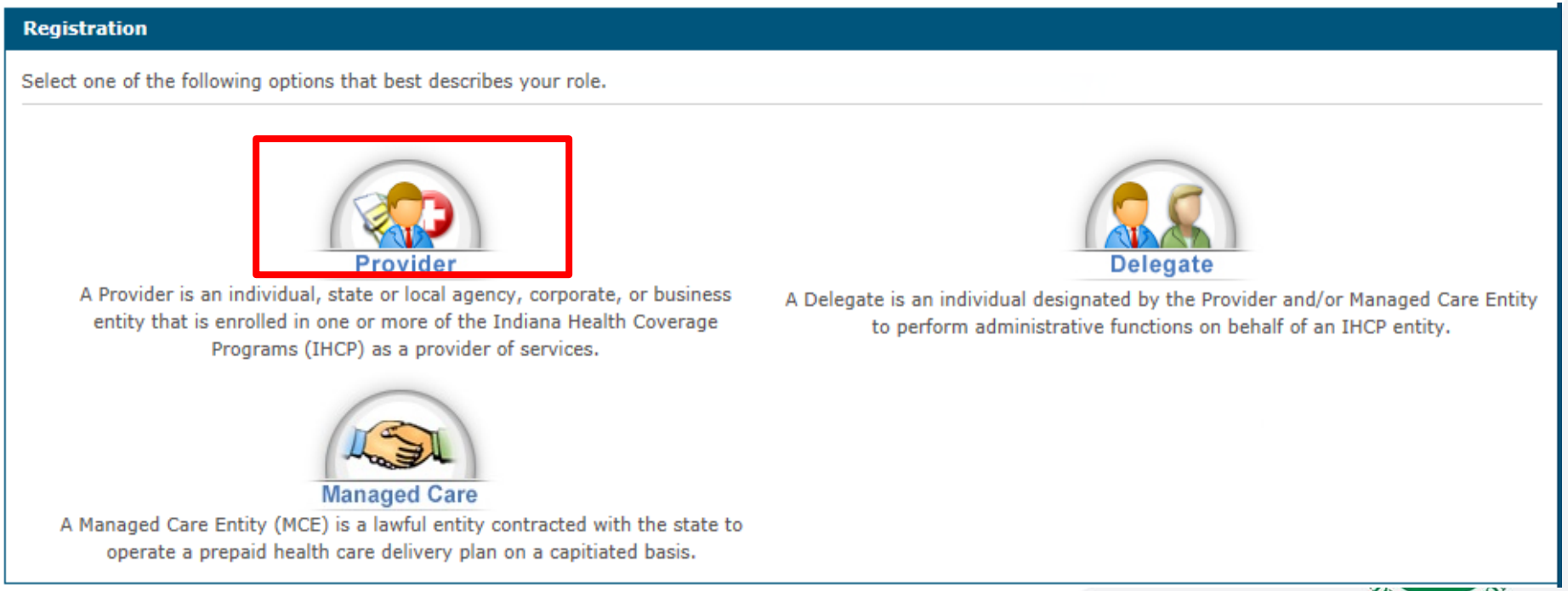
- **AFTER ENROLLED**, the group, billing or rendering provider needs to register for the Provider Healthcare Portal as a **"Provider"**
- The provider then invites **"Delegates"** (users) to register on the Portal
- The Portal allows providers to:
  - Verify member eligibility
  - File claims
  - Search claim history
  - Obtain remittance advices
  - So forth





Registering as a Provider on Portal

- Click on “Provider” to start the registration process on the Provider Healthcare Portal



Registering as a Provider on Portal

- Step 1 of registering as a Provider on the Portal is to provide you Federal Tax ID (TIN) and your Provider ID
  - TIN for groups is your EIN (employer identification number)
  - TIN for billing and rendering providers is your social security number
- The Provider ID is assigned when your enrollment application is approved
  - (numbers currently start out with 3000, i.e. 300012345)

Helpful Tools

Helpful Tools

Provider Relations Consultants

REGION	FIELD CONSULTANT	EMAIL	TELEPHONE	COUNTIES SERVED
1	Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St.Joseph, Starke, Steuben, Whitley Chicago, Watseka Sturgis
2	Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware Fountainm Grant, Howard, Hutington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White Danville
3	Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boonem Hamilton, Hendricks, Johnson, Marion, Morgan
4	Ken Guth	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderbirgh, Vermillion, Vigo, Warrick Owensboro
5	Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Hancock, Henry, Jackson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne Louisville Cincinnati, Harrison, Hamilton, Oxford
	Judy Green		(317) 488-5026	All other out of state areas not previously listed
Team Lead	Jenny Atkins		(317) 488-5032	

Helpful Tools

IN.Gov:

- IHCP Provider Reference Modules
- Medical Policy Manual
- Contact Us – Provider Relations Field Consultants

Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
- 1-800-457-4584

Secure Correspondence:

- Via the Provider Healthcare Portal
- Written Correspondence:

  DXC Technology Provider Written Correspondence
  P.O. Box 7263
  Indianapolis, In 46207-7263

Questions