PROVIDER AGREEMENT

State Form 51396 (R2/1-08) / Part of State Publication 286
Indiana State Department of Health

By execution of this Agreement, the undersigned entity ("*Provider*") requests enrollment as a Provider in Indiana State Department of Health (*ISDH*) Programs. As an enrolled Provider in ISDH Programs, the undersigned entity agrees to provide ISDH Program-covered services and/or supplies to ISDH participants. As a condition of enrollment, Provider agrees to the following:

1. To comply with all federal and state statutes and regulations pertaining to ISDH Programs, as they may be amended from time to time.

2. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements.

3. To notify ISDH within ten (*10*) days of any change in the status of Provider's license, certification, or permit to provide its services to the public in the State of Indiana.

4. To give written notice to ISDH by completion of "Billing Provider Update Form", at least sixty (*60*) days before the effective date of the change for any of the following: name (*legal name*), DBA (*doing business as*), name as registered with the Secretary of State, address (*service location*), pay to, mail to, or home office address, Federal tax ID number(s), or change in providers direct or indirect ownership, interest or controlling interest.

5. To provide ISDH Program-covered services and/or supplies pursuant to all applicable Federal and State statutes and regulations.

6. To safeguard information about ISDH Program participants including at a minimum:

   a. name, address, and social and economic circumstances;
   b. medical services provided;
   c. medical data, including diagnosis and past history of disease or disability;
   d. any information received in connection with the identification of legally liable third party resources.

7. To release information about ISDH Program participants only to the ISDH, only when in connection with payment issues surrounding providing services for participants.

8. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility to assure that all activities under this contract are carried out.

9. To submit claims for services rendered by the Provider or employees of the provider and not to submit claims for services rendered by contractors unless the Provider is a health care facility (*such as hospital, ICF-MR, or nursing home*), or a government agency with a contract that meets the requirements described in Item 8 of this Agreement. Health care facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide ISDH Program services rendered pursuant to this Agreement.

10. To abide by the ISDH Program Provider Manual, as amended from time to time, as well as all provider bulletins and notices. Any amendments to the ISDH Program Provider Manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with ISDH.

11. To submit timely billing in arrears on ISDH approved claim forms or electronically via Electronic Data Interchange (EDI), as outlined in the ISDH Program Provider Manual, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

12. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.

13. To submit claim(*s*) for ISDH reimbursement only after first exhausting all other sources of reimbursement as required by the ISDH Provider Manual, bulletins, and banner pages.

14. To submit claim(*s*) for ISDH reimbursement utilizing the appropriate claim forms and codes as specified in the ISDH Provider Manual, bulletins and notices.

15. To submit claims that can be documented by Provider as being strictly for:

a. medically necessary medical assistance services;
b. medical assistance services actually provided to the person in whose name the claim is being made; and
c. compensation that Provider is legally entitled to receive.

16. To accept payment as payment in full, the amounts determined by ISDH as the appropriate payment, for ISDH Program covered services provided to ISDH Program participants. Provider agrees not to bill participants, or any member of a participant's family, for any additional charge for ISDH Program covered services.

17. The Provider hereby agrees to remove from collections any participant that has been wrongfully identified as delinquent within 5 business days of notice from ISDH.

18. To refund within fifteen (*15*) days of receipt, to ISDH any duplicate or erroneous payment received.

19. To make repayments to ISDH, or arrange to have future payments from the ISDH withheld, within sixty (*60*) days of receipt of notice from ISDH that an investigation or audit has determined that an overpayment to Provider has been made. A hospital licensed under *IC 16-21* has one hundred eighty (*180*) days to repay.

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

21. Obtain Prior Authorization for certain designated services for participants of various Programs of the ISDH. Failure to obtain a Prior Authorization, when required, will result in denial of payment and the participant/family may not be billed for the unauthorized services. A Prior Authorization confirms medical necessity and its relationship to an eligible medical diagnosis, but is not a guarantee of payment. Non-emergency designated services should not be provided until Prior Authorization approval is received from ISDH. Charges for services provided while their Prior Authorization determination is pending, will be the provider responsibility, in the event that authorization is denied by ISDH**.** Authorization of emergency services must be requested within five (*5*) days of services being provided.

22. CSHCS must be billed for all services provided to participants and participant/family may not be billed directly.

23. Payment will be based upon the Medicaid rate, in accordance with state statutes and regulations. Payment as determined by the CSHCS Program shall be accepted as payment in full. Balances cannot be billed to the family.

24. To cease any conduct that ISDH or its representative deems to be abusive of the ISDH Program.

25. To promptly correct deficiencies in Provider's operations upon request by ISDH.

26. To cooperate with ISDH or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

27. To comply with civil rights requirements as mandated by federal and state statutes and regulation by ensuring that no person shall, on the basis of race, color, national origin, ancestry, disability, age, sex, religion or sexual orientation, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of a ISDH Program-covered service.

28. To abide by and agree to the terms and conditions set out in Schedule A (*Certification Statement for Providers Submitting Claims*), which is incorporated herein by reference.

29. To furnish to ISDH or its agent, as a prerequisite to the effectiveness of this Agreement, the information set out in Schedules B and C to this Agreement, which are incorporated herein by reference, and to update this information, when it changes.

30. To abide by and agree to the terms and conditions set out in the various addenda applicable to the ISDH Programs, with which the provider participates, which are incorporated herein by reference.

31. That this Agreement may be terminated as follows:
   a. By ISDH for Provider's breach of any provision of this Agreement as determined by ISDH; or
   b. By ISDH, or by Provider, upon thirty day (*30*) written notice.

32. That this Agreement has not been altered, and upon execution by provider & approval by ISDH, supersedes and replaces any Provider Agreement previously executed with ISDH, by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, HEREBY AGREES, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

FURTHER, THE UNDERSIGNED HEREBY BINDS ALL SUCCESSORS, ASSOCIATES AND ASSIGNEES TO THE STIPULATIONS SET FORTH IN THIS AGREEMENT.

Provider-Authorized Signature – All Schedules

NOTE - The owner or an authorized officer of the business entity must complete this section.

I certify, under penalty of law, that the information stated in Schedules B and C is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified, I may be considered for suspension from the program and/or prosecution for Fraud. I hereby authorize the Indiana State Department of Health to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana State Department of Health Programs.

Provider DBA Name_____

Officer Name _____ Title _____

Signature _____ Date _____

Telephone Number _____

NOTE: Failure to complete this section will result in ISDH returning the application for incomplete information.

PROVIDER AGREEMENT
SCHEDULE A

Part of State Publication 286
Indiana State Department of Health

This is to certify that any and all information contained on any Indiana State Department of Health (*ISDH*) billings submitted on my behalf by electronic, telephonic, mechanical, and/or standard paper means of submission shall be true, accurate, and complete. I accept total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (*i. e. either by myself, my staff, and/or a third party acting in my behalf, such as a service bureau*). I fully recognize that any billing intermediary or service bureau that submits billings to the ISDH is acting as my representative and not that of ISDH. I further acknowledge that any third party that submits billings on my behalf shall be deemed to be my agent for purposes of submission of ISDH claims.

I understand that payment and satisfaction of any claims that shall be submitted on my behalf will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable federal and/or state law. The provider will hold harmless and indemnify ISDH from any and all claims, actions, damages, liabilities, costs and expenses, including reasonable attorneys' fees and expenses, which arise out of or are alleged to have arisen out of or as a consequence of the submission of ISDH billings by the provider through electronic, telephonic, mechanical, and/or standard paper means of submission unless the same shall have been caused by negligent acts or omissions of ISDH.

I acknowledge that the fees and charges paid to providers for all medical services rendered or materials supplied shall be in accordance with federal and state law and regulation with recognition of the provider's traditional right to charge for services rendered. I hereby certify that the charges submitted upon my claims shall be my usual and customary charges for my services with recognition of the provider's traditional right to charge for his services. I am aware of the restricted funding of ISDH Programs, and I agree to accept as full payment for any services billed on any claims, the payment allowance determined by the ISDH.

I further certify that no supplemental charges will be billed to any ISDH Programs member or to the family of any member for any covered service of the ISDH Programs.

I agree to keep such records as may be necessary to fully disclose the extent of services provided to individuals under the ISDH Programs, and to furnish such information regarding any ISDH payments claimed for providing such services to ISDH or its designee, upon request, for a period not less than three years from the date of service, or any such period ISDH may require. In those cases when information substitutes are allowed, I further acknowledge that I will maintain all required supporting claim documentation in my place of business and make such documentation available for review by ISDH. I agree to keep records independent of any paper claims, tapes, telephonic submission, or other electronic media that have been sent to ISDH for claims payment, to document the accuracy of the service for which I have billed the ISDH Programs. I agree to submit such records as may be required by ISDH or the federal government.

I agree to notify ISDH of any changes in my provider name or address. Further, I agree to comply with such minimum substantive and procedural requirements for claims submission, as may be required by ISDH.

I understand that the standard paper claim form may include a signature line. I understand that all of the stipulations, conditions, and terms of the certification statement apply in the event that I fail, for any reason, to sign the paper claim and the claim is approved for payment. I agree that payment of a paper claim that did not contain my signature, in no way absolves me of the terms stated herein to which I have agreed.

PROVIDER AGREEMENT
BILLING PROVIDER ENROLLMENT APPLICATION
SCHEDULE B

State Form 51452 (R/1-08) / Part of State Publication 286
Indiana State Department of Health

Provider Information

1. Provider Type and Specialty

Please complete the information about your licensure as determined and maintained by the official licensing board for your provider type and specialty. **Refer to ISDH Billing Provider Specialty List to determine the provider type and specialty numbers for your primary and secondary specialty**. **Taxonomy Codes:** (*When mandated*.)

Provider Type _____ _____

Primary Specialty _____ _____

Secondary Specialty _____ _____

Primary Sub-Specialty _____ _____

Secondary Sub-Specialty _____ _____

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

2. Which of the following best describes this service location?

Please indicate the choice that best describes the provider location being enrolled. Only one choice may be checked.

☐ Individual Practice ☐ Group Practice ☐ Facility or Organization ☐ Other _____

Note: For Provider Agreements covering more than one individual, please complete the attachment "Individuals Covered Under Provider Agreement".

3. Locality

Please check the locality that best describes the service location. Please check **only one** item.

☐ Metropolitan ☐ Rural ☐ Urban

4. Service Location Name and Address

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

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

Provider Name: _____ County: _____

DBA Name: _____

Street Address: _____

City: _____ State: _____ ZIP + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

5. Legal Name and Home Office Address

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

Legal Name: _____

Street Address: _____

City: _____ State: _____ ZIP + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

6. Mailing Name and Address

Please complete the information for the addressing of bulletins, provider manual updates, and general correspondence, **if different from the Service Location information**. A post office box is acceptable for a mailing address.

Name: _____

Street Address: _____

City: _____ State: _____ ZIP + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

7. Pay To Name and Address

Please complete the information for the addressing of checks, remittance advices, and general claims payment information, **if different from the Service Location information**. A post office box is acceptable for this address.

Name: _____

Street Address: _____

City: _____ State: _____ ZIP + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

8. Billing Agent (*If you would have us contact your Billing Agent with questions concerning billing issues, please provide the following information.*)

Name: _____

Street Address: _____

City: _____ State _____ ZIP + 4 _____

Contact Person: _____ Telephone: _____ Ext: _____

Fax: _____

E-Mail Address: _____

9. **Federal Tax Identification Number:** _____ Effective Date: _____

National Provider Identification Number (*NPI*) _____ **Taxonomy Codes**_____

Attach Copy of NPI Notification correspondence

Important: Sections 10-14 require copies of the following documents for verification, as applicable.

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

10. License/Registration/Certification

License/Registration/Certification Number: _____ Issuing Board: _____

Effective Date: _____ Expiration Date: _____

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

11. CLIA Certification

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

Certification Type:

CLIA Number: _____

Effective Date: _____

Expiration Date: _____

☐ Waiver

☐ Provider-Performed Microscopy Procedure (*PPMP*)

☐ Registration

☐ Compliance

☐ Accreditation

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

12. Federal DEA Certification

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

DEA Number: _____

Effective Date: _____ Expiration Date: _____

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

13. Medicaid Participation

Indiana Medicaid Number: _____ Effective Date: _____

14. Medicare Participation

Please complete the appropriate Medicare identification numbers.

Medicare Number: _____ Medicare Number State: _____

Universal Provider Identification Number (*UPIN*): _____

DME Supplier Number: _____

PROVIDER AGREEMENT
BILLING PROVIDER ENROLLMENT APPLICATION
SCHEDULE C

State Form 51453 (R/1-08) / Part of State Publication 286
Indiana State Department of Health

Ownership Information

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

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

☐ For Profit Corporation ☐ Partnership ☐ Sole Proprietorship

☐ Not-for-Profit Corporation ☐ Government Owned

2. Is this entity chain affiliated?

If yes, the information regarding the chain must be included in **Item 4** below.

☐ Yes ☐ No

3. Is this entity operated by a management company, or leased in whole or part by another Organization?

☐ Yes ☐ No

4. List all owners and officers of the business entity

List below the Name, Title, Social Security Number, and Address of each Officer, owner, and / or trustee of the provider entity, and the Name, Tax ID (TIN), and Address of any organization, corporation, or entity having direct or indirect ownership or controlling interest in the provider entity. Attach additional pages as necessary to list all officers, owners, management and ownership entities.

Name	Tax ID Number	Address
Relationship or Title		City, State, ZIP + 4

Name	Tax ID Number	Address
Relationship or Title		City, State, ZIP + 4

Name	Tax ID Number	Address
Relationship or Title		City, State, ZIP + 4

5. Has there been a change in ownership or control within the past year, or is a change of ownership anticipated?

If yes, you must submit the enclosed CHANGE OF OWNERSHIP ADDENDUM form for the current provider entity, and a new application for the new ownership entity.

☐ Yes ☐ No

6. Has there been a past bankruptcy or do you anticipate filing for bankruptcy within a year?

☐ Yes ☐ No If yes, when? _____

7. Background Information

Has any agent, managing employee, or owner of the provider entity been excluded from or convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX or ISDH program since the inception of those programs?

☐ Yes ☐ No

If **yes,** state below the Name, SSN, and position within the provider entity:

_____

_____

_____

_____

_____

PROVIDER AGREEMENT
BILLING PROVIDER SPECIALTY LIST

Part of State Publication 286
Indiana State Department of Health

Please review the list to find the primary and secondary specialty that best describes the service location being enrolled and record the specialty numbers in the appropriate fields in Schedule A, item 7.

Note: A secondary specialty may be designated only if it is included in the same provider type as the primary specialty.

If you are an **INTERNIST** or **PEDIATRICIAN,** please also record your applicable subspecialty from the list in the space provided. If you do not have a subspecialty in these two categories, please choose **GENERAL INTERNIST (*Specialty 344*)** or **GENERAL PEDIATRICIAN (*Specialty 345*).**

Provider Type	Provider Specialty
01 Hospital	010 Acute Care Hospital 011 Psychiatric Hospital 012 Rehabilitation Hospital
02 Ambulatory Surgical Center	020 Ambulatory Surgical Center
03 Extended Care Center	030 Nursing Home/Nursing Facility 031 Intermediate Care Facility for the Mentally Retarded (*ICF/MR*) 032 Pediatric Nursing Facility 033 Group Home/Residential Care Facility
04 Rehabilitation Facility	040 Rehabilitation Facility
05 Home Health Agency	050 Home Health Agency
06 Hospice	060 Hospice Agency
08 Clinic	080 Federally Qualified Health Clinic (*FQHC*) 081 Rural Health Clinic (*RHC*) 082 Medical Clinic 083 Family Planning Clinic 084 Nurse Practitioner Clinic 085 Title V Clinic 086 Dental Clinic 087 Therapy Clinic
09 Advanced Practice Nurse	090 Pediatric Nurse Practitioner 091 Obstetric Nurse Practitioner 092 Family Nurse Practitioner 093 Nurse Practitioner (*Other*) 094 Certified Registered Nurse Anesthetist (*CRNA*) 095 Certified Nurse Midwife
10 Mid-Level Practitioner	100 Physician Assistant 101 Anesthesiology Assistant

Provider Type	**Provider Specialty**
11 Mental Health Provider	110 Out Patient Mental Health Clinic
	111 Community Mental Health Center
	112 Psychologist
	113 Certified Psychologist
	114 Health Service Provider in Psychology (*HSPP*)
	115 Master of Social Work (*MSW*)
	116 Clinical Social Worker
	117 Psychiatric Nurse
12 School Corporation	120 School Corporation
13 Public Health Agency	130 County Health Department
14 Podiatrist	140 Podiatrist
15 Chiropractor	150 Chiropractor
16 Nurse	160 Registered Nurse (*RN*)
	161 Licensed Practical Nurse (*LPN*)
	162 Registered Nurse Clinical (*RNC*)
17 Therapist	170 Physical Therapist
	171 Occupational Therapist
	172 Respiratory Therapist
	173 Speech/Hearing Therapist
18 Optometrist	180 Optometrist
19 Optician	190 Optician
20 Audiologist	200 Audiologist
21 Case Manager	210 Care Coordinator for Pregnant Women
	211 HIV Case Manager
	213 Targeted Case Manager
22 Hearing Aid Dealer	220 Hearing Aid Dealer
23 Dietitian	230 Registered Dietitian
24 Pharmacy	240 Pharmacy
25 DME/ Medical Supply Dealer	250 DME/Medical Supply Dealer
26 Transportation Provider	260 Ambulance
	261 Air Ambulance
	262 Bus
	263 Taxi
	264 Common Carrier (*Ambulatory*)
	265 Common Carrier (*Non-Ambulatory*)
	266 Family Member
27 Dentist	270 Endodontist
	271 General Dentistry Practitioner
	272 Oral Surgeon
	273 Orthodontist

Provider Type	**Provider Specialty**
27 Dentist (*continued*)	274 Pediatric Dentist 275 Periodontist 276 Mobile Dental Van 277 Prosthesis
28 Laboratory	280 Independent Laboratory 281 Mobile Laboratory
29 Radiology Provider	290 Freestanding X-Ray Clinic 291 Mobile X-Ray Clinic
30 End Stage Renal Disease Clinic	300 Freestanding Renal Dialysis Clinic
31 Physician	310 Allergist 311 Anesthesiologist 312 Cardiologist 313 Cardiovascular Surgeon 314 Dermatologist 315 Emergency Medicine Practitioner 316 Family Practitioner 317 Gastroenterologist 318 General Practitioner 319 General Surgeon 320 Geriatric Practitioner 321 Hand Surgeon 322 Internist (with Subspecialty) Subspecialty List: Adult Critical Care Medicine Adolescent Medicine 323 Neonatologist 324 Nephrologist 325 Neurological Surgeon 326 Neurologist 327 Nuclear Medicine Practitioner 328 OB/GYN 329 Hematologist/Oncologist 330 Opthalmologist 331 Orthopedic Surgeon 332 Otologist, Laryngologist, Rhinologist 333 Pathologist 334 Pediatric Surgeon 335 Pediatrician (with Subspecialty) Subspecialty List: Adolescent Medicine Diagnostic Lab Immunology Developmental Pediatrics Medical Toxicology Neonatal-Perinatal Medicine Pediatric Allergy Pediatric Cardiology Pediatric Critical Care Medicine Pediatric Dermatology Pediatric Emergency Medicine

Provider Type	**Provider Specialty**
31 Physician (*continued*)	335 Pediatrician (*with Subspecialty*) – (*continued*) Subspecialty List: Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Neurology Pediatric Otolaryngology Physical Medicine & Rehabilitation Pediatric Pulmonology Pediatric Rheumatology Pediatric Sports & Fitness Medicine Pediatric Urology 336 Physician Medicine & Rehab Practitioner 337 Plastic Surgeon 338 Proctologist 339 Psychiatrist 340 Pulmonary Disease Specialist 341 Radiologist 342 Thoracic Surgeon 343 Urologist 344 General Internist (without Subspecialty) 345 General Pediatrician (without Subspecialty)
32 Waiver Provider	350 Aged and Disabled Waiver 351 Autism Waiver 352 ICF/MR Waiver 353 OBRA Developmentally Disabled Waiver 354 Medically Fragile Children's Waiver 356 Traumatic Brain Injury Waiver
33 Other (*Not otherwise classified*)	

ELECTRONIC DATA INTERCHANGE (EDI) TRADING PARTNER PROFILE – CLEARINGHOUSE

State Form 51441 (R/1-08) / Part of State Publication 286
Indiana State Department of Health

Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 North Meridian Street
Indianapolis, IN 46204 – 3010
(317) 233-9803

Provider of service, _____ has informed us that they would like to begin doing Electronic Data Interchange (*EDI*) transactions with the Indiana State Department of Health (*ISDH*). They have informed us that you are their Business Associate for their EDI transactions. Therefore, in order to begin the process, please complete this document and sign the EDI Trading Partner Agreement. Please return these documents to the address above. Upon receipt of the Trading Partner Profile and Trading Partner Agreement, a member of the ISDH EDI staff will contact you concerning your EDI setup and testing. If you have already submitted a profile and an agreement to the ISDH, please notify us; you will not need to complete these forms again.

Clearinghouse:

Name
_____

Address (*include suite*)_____

City_____ State_____ ZIP + 4 _____

Contact Name
_____

Telephone number _____ Fax number_____

E-Mail: _____

Indicate below which EDI transactions you will be submitting

☐ X12 ☐ NCPDP V5.1

Inbound (*sent from you to ISDH*):

- ☐ Health Care Claim (*837*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*270*)
- ☐ Claim Status Request (*276*)
- ☐ Prior Authorization (*NCPDP P1-P4*)
- ☐ Billing / Reversal (*NCPDP B1, B2*)
- ☐ Re-bill (*NCPDP B3*)
- ☐ Eligibility Verification (*NCPDP E1*)

Outbound (*sent from ISDH to you*):

- ☐ Payment Advice (*835*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*271*)
- ☐ Claim Status Request (*277*)
- ☐ Response (*NCPDP B1, B2*)

Remittance Advices are provided twice weekly and include claims submitted electronically and on paper. Outbound transmissions will only be available with prior authorization from billing provider.

Data Transmission / Retrieval Method

☐ Asynchronous Dial-up
☐ Secure FTP (*planned for future use*)
☐ Side by Side VPN connection

Authorized Signature _____

Title of Authorized Signatory _____

Date (*mm/dd/yyyy*)_____

ELECTRONIC DATA INTERCHANGE (EDI) TRADING PARTNER PROFILE – PROVIDER

State Form 51401 (R/1-08) / Part of State Publication 286
Indiana State Department of Health

Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 North Meridian Street
Indianapolis, IN 46204 – 3010
(317) 233-9803

Provider of Service:

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Software Vendor Information:

(Providers, please complete this section if you are currently working with any Software vendor)
Please list all Software Vendor(s) used for submission of Medical, Dental, Vision, and Pharmacy electronic claims.

Software Vendor 1:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*): _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Software Vendor 2:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Clearinghouse Information:

(*Providers, please complete this section if you are currently working with any clearinghouse / switch to submit transactions to the Indiana State Department of Health)*
Please list all Clearinghouse(*s*) used for submission of Medical, Dental, Vision, and Pharmacy electronic claims.

Clearinghouse 1:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Clearinghouse 2:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Indicate your request(s) for the EDI transactions below

Inbound (*sent from you to ISDH*):

- ☐ Health Care Claim (*837*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*270*)
- ☐ Claim Status Request (*276*)
- ☐ Prior Authorization (*NCPDP P1-P4*)
- ☐ Billing / Reversal (*NCPDP B1, B2*)
- ☐ Re-bill (*NCPDP B3*)
- ☐ Eligibility Verification (*NCPDP E1*)

Outbound (*sent from ISDH to you*):

- ☐ Payment Advice (*835*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*271*)
- ☐ Claim Status Request (*277*)
- ☐ Response (*NCPDP B1, B2*)

Remittance Advices are provided twice weekly and include claims submitted electronically and on paper.

Data Transmission / Retrieval Method
(please complete if you will be submitting transactions directly from your office to Indiana State Department of Health):

- ☐ Asynchronous Dial-up
- ☐ Secure FTP (*planned for future use*)
- ☐ Side by Side VPN connection

I am authorizing the outbound transactions indicated to be retrieved by:

- ☐ Provider of Service
- ☐ Software Vendor /Third party vendor
- ☐ Clearinghouse / Switch

Authorized Signature _____

Title of Authorized Signatory _____

Date (*mm/dd/yyyy*)_____

TRADING PARTNER AGREEMENT
ELECTRONIC DATA INTERCHANGE (EDI)

State Form 51402 (R/1-08) / Part of State Publication 286
Indiana State Department of Health

This document constitutes an agreement to the following provisions for exchanging Electronic Data Interchange (*EDI*) between the Trading Partner listed under the Signatures heading in this agreement and the Indiana State Department of Health (*ISDH*).

A. Definitions.

1. "HIPAA" means the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

2. "PHI" means protected health information as defined by HIPAA, but limited to the PHI that is exchanged between the parties to this agreement.

3. "Confidential Information" means information concerning ISDH health plan participants or any information obtained by Trading Partner from ISDH.

4. "Providers" are healthcare providers who are clients and Business Associates of Trading Partner, as defined under the Administrative Simplification provisions of HIPAA.

B. The Trading Partner agrees:

1. That it will conform to the requirements of HIPAA as concerns PHI and that it will take no action which adversely affects ISDH's HIPAA compliance.

2. That it will promptly notify ISDH of any and all unlawful or unauthorized disclosures of Confidential Information or PHI that come to its attention and that it will cooperate with ISDH in the event any litigation arises concerning the unauthorized use, transfer, or disclosure of either confidential information or PHI.

3. That it will use sufficient security procedures to ensure that all HIPAA transmissions with ISDH are authorized and to protect all participant-specific PHI from improper access.

4. That all files it transmits to ISDH will comply with the national Electronic Data Interchange (*EDI*) Transaction Set Implementation Guide effective on the date of transmission.

5. That it will establish and maintain procedures and controls so that Confidential Information shall not be used by agents, officers, or employees of the trading partner other than for its intended purpose.

6. That the information stated in any EDI Trading Partner Profile(*s*) submitted with this Agreement, or subsequently, is correct and complete.

7. That it will allow ISDH 30 days after receipt of written notice from the provider if there is any change in the trading partner representative or location where electronic transactions are sent.

8. That it is bound by written agreement with the provider to comply with state and federal law, if the Trading Partner is an intermediary for the billing provider.

C. Indiana State Department of Health agrees:

1. That it will conform to the requirements of HIPAA as concerns PHI and that it will take no action which adversely affects the trading partner's HIPAA compliance.

2. That it will use sufficient security procedures to ensure that all HIPAA transmissions are authorized and to protect all participant-specific PHI from improper access.

3. That all files it transmits to Trading Partner will comply with the national Electronic Data Interchange (*EDI*) Transaction Set Implementation Guide effective on the date of transmission.

D. Both parties agree:

1. That data transmitted between them will not be considered as received and no responsibility assigned until accessible at the receiving party's computer.

2. That upon receiving any HIPAA transaction from the other, to prepare and transmit a timely response or an acknowledgment of transaction receipt. If acceptance of a transaction is required, a document is not considered received until an acceptance acknowledgement is returned.

3. That it will notify the other party within a reasonable time frame if any transmitted data are received in an unintelligible or garbled form.

4. That it will provide and maintain the equipment, software, services, and testing necessary to transmit data with the other party.

5. That it will conduct business and perform under this agreement as required by this agreement and as required by any applicable rules or regulations.

6. That this agreement will remain in effect until terminated by either party with at least 30 days prior written notice. The notice will specify the effective date of termination, but will not affect the obligations or rights of either party prior to the effective date of termination. This agreement is automatically terminated in the event the Trading Partner or provider is disqualified through a federal administrative action or state action.

7. That any document transmitted according to this agreement will be considered an original and signed when received electronically. Neither party will contest the validity or enforceability of signed documents under any applicable law concerning whether certain agreements must be signed in writing to be binding. Neither party will contest the admissibility of copies of signed documents under the business records exception to the hearsay rule, the best evidence rule, nor the basis that the signed documents were not originated in documentary form.

8. That neither party will be liable to the other for any special, incidental, exemplary, or consequential damages resulting from any delay, omission, or error in the electronic transmission or receipt of any document, even if either party has been advised such damages are possible.

9. That both parties will attempt to resolve any issues relating to this agreement.

E. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Trading Partner: _____

Authorized Signature: _____

Title of Authorized Signatory: _____

Date: _____

Address: _____

City: _____ State: _____ ZIP +4: _____

Phone: _____

Remittance Address:

Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803

Reset Form

VENDOR INFORMATION

State Form 53788 (R2 / 10-09)
Approved by Auditor of State, 2009
Approved by State Board of Accounts, 2009

Name and telephone number of the person who completed this document must be provided.

Name: _____

Daytime telephone number: _____

Print or Type

Legal Name *(Owner of the EIN or SSN as name appears on your tax return. Do not enter the business name of a sole proprietorship on this line.)*

Trade Name (Doing Business as Name D/B/A) *(Complete only if payment is to be made payable to the DBA name)*

Remit Address *(number and street, city, state, and ZIP code)*

Purchase Order Address – Optional *(number and street, city, state, and ZIP code)*

Enter 9-digit Taxpayer Identification Number (TIN) of the legal name:
(SSN=Social Security Number, EIN=Employer Identification Number)

(Individual's SSN) __ __ __ - __ __ - __ __ __ __ or EIN __ __ - __ __ __ __ __ __ __

Check legal entity type (A box must be checked in this section. Check only one box.)

☐ Individual ☐ Sole Proprietorship ☐ Partnership
☐ Estate / Trust *Note: Show above, the name and number of the legal trust, or estate, not personal representatives*
☐ Other [Limited Liability Company (LLC) *(attach IRS Form 8832 if applicable)*, Joint Venture, Club, etc.]
☐ Corporation Do you provide legal or medical services? ☐ Yes ☐ No
☐ Government (or Government operated entity)
☐ Organization Exempt from Tax under Section 501(a)

One box must be checked ☐ I am a U.S. Person *(including a U.S. resident alien)* ☐ I am not a U.S. Person *(a W-8 must be filed with the Auditor of State)*

☐ Add Deposit ☐ Change Deposit **Indiana law (I.C. 4-13-2-14.8) requires that YOU receive PAYMENT(S) by means of electronic transfer of funds.**

SECTION 1: AUTHORIZATION

According to Indiana law, your signature below authorizes the transfer of electronic funds under the following terms:

Account Holder's Name: _____ Account Number: _____

Type of Account: ☐ Checking (Demand) ☐ Savings

☐ *Please check this box if your direct deposit will be automatically forwarded to a bank account in another country.*

ATTACH A NON-ALTERED VOIDED CHECK HERE

SECTION 2: FINANCIAL INSTITUTION'S APPROVAL ***(Attach a non-altered voided check or have your financial institution complete this section)***

The financial institution identified below agrees to accept automated deposits under the terms set forth herein:

Name of Financial Institution: _____

Telephone: (_____)_____

Address: _____ _____
Number and Street, and/or P.O. Box No. Financial Institution's Authorized Signature

_____ _____
City, State, and ZIP Code (00000-0000) Title

_____ _____, 20_____
ABA Transit-Routing Number Date

ATTACH A NON-ALTERED VOIDED CHECK HERE

SECTION 3: ELECTRONIC NOTIFICATION OF ELECTRONIC FUND TRANSFER (EFT) DEPOSITS
(Complete this section only if you are requesting electronic notification. You may provide up to four email addresses.)

I hereby request that all future notices of EFT deposits to the bank account specified above be sent to the following email addresses:

_____ _____
_____ _____

I agree to the provisions contained on the reverse side of this form.

NAME *(print or type)* _____ TITLE_____

AUTHORIZED SIGNATURE _____ DATE _____ TELEPHONE NUMBER _____

REQUEST FOR VENDOR INFORMATION

THIS FORM APPLIES TO YOU, IF YOU ARE:

1) A U.S. person (including a U.S. resident alien); and
2) A person, business, or other entity who has or will receive a payment from the state; or
3) A state employee who has or will receive a payment, other than payroll, from the state.

PURPOSE OF FORM:

The Auditor of State of Indiana (Auditor) must have correct vendor information to make payments to vendors. This includes the vendor's legal name, doing business as name (if any), address, Taxpayer Identification Number (TIN), entity type, and banking information. This form allows you to provide your correct name, address, TIN, entity type, and banking information.

If you do not provide us with the information, your payments may be subject to federal income tax withholding. In addition, if you do not provide us with this information, you may be subject to a penalty imposed by the Internal Revenue Service per I.R.C. 6723.

Federal law on withholding preempts any state and local law remedies, such as any rights to a mechanic's lien. If you do not furnish a valid TIN, we are required to withhold a percentage of our payment to you. Withholding is not a failure to pay you. It is an advance tax payment. You should report all withholdings as a credit for taxes paid on your federal income tax return.

INSTRUCTIONS:

1) Enter your legal name on the designated line. Your legal name is the one that appears on your Social Security Card or, if you are a business, the Employer Identification Number (EIN) as it is in the IRS records. If you are a sole proprietor, then your legal name is the business owner's name. If you have a "doing business as" (d/b/a) name, enter this on the trade name line. Enter your remit address on the next line, and if you have a separate address for purchase orders, enter that address on the appropriate line.
2) Record the appropriate TIN in the space provided and check the box that corresponds to the correct organization type for your name. Note that individuals and sole proprietors are the only types that should record a social security number (SSN). a) If you are a corporation, you must indicate whether you provide legal or medical services. b) If you are a sole proprietor, you must show the business owner's name in the legal name box and you may show the business name in the trade name box. You cannot use only the business name. For a sole proprietor, you may use either the individual's SSN or the EIN of the business. However, we prefer you provide the SSN.
3) Check the appropriate box that indicates whether you are or are not a U.S. person.
4) Complete Section 1: Authorization
5) Have your financial institution complete Section 2: Financial Institution's Approval. Your financial institution should return the completed form to you. A voided check may be provided in lieu of having your financial institution complete this section. Attach only preprinted checks. Deposit slips, starter checks, or checks that have been altered will not be accepted.
6) Complete Section 3: Electronic Notification of Electronic Fund Transfer (EFT) Deposits, only if you choose to receive electronic EFT notifications by email. If this section is not completed, your notification will be sent by U.S. Mail to the remit address designated on the reverse side of this form.
7) Fax the completed form to (317) 234-1916 or mail to the Indiana Auditor of State, 240 Statehouse, 200 W. Washington St., Indianapolis, IN 46204.
8) Retain a copy of the completed form for your records.
9) Any form submitted without an authorized signature will be destroyed and will not be entered into the Auditor's vendor file.

BY SIGNING THIS FORM:

You represent that you understand and agree that:

1) You are authorized to provide this information on behalf of yourself or your organization.
2) The State of Indiana is authorized to initiate credits (deposits) in various amounts, by EFT through automated clearing house (ACH) processes, to the checking (demand) or savings account in the financial institution designated on the reverse side of this form.
3) If necessary, you will accept reversals from the State for any credit entries made in error to a bank account per National Automated Clearing House Association (NACHA) regulations.
4) You may only revoke this request and authorization by notifying the Auditor in writing, at the above address, at least fifteen (15) days before the effective date of revocation.
5) Any change to the account or to a new financial institution will require a new Vendor Information form be completed and submitted to the Auditor of State at the above address. Failure to provide timely notification to the Auditor that your account has changed will result in a delay in payment.
6) The State of Indiana and its entities are not liable for late payment penalties or interest if you fail to provide information necessary for an EFT transaction and/or you do not properly follow the Instructions above.
7) The email addresses provided in Section 3 for electronic EFT notification will allow for appropriate application of all payments.
8) You acknowledge that it will cause disruption to the notification process if the email addresses provided for electronic EFT notification are frequently changed or changed without promptly providing an updated email address to the Auditor.
9) You acknowledge that an email notification returned as undeliverable may be removed from the Auditor's email notification system and all future notices of EFT deposits to you will be provided by the Auditor via U.S. Mail to the remit address designated on the reverse side of this form until you have provided a valid email address to the Auditor.
10) You are responsible for contacting the Auditor if you are not receiving electronic notices of EFT deposits.