Reset Form

PROVIDER AGREEMENT
BILLING PROVIDER ENROLLMENT APPLICATION
SCHEDULE B

State Form 51452 (R5 / 12-23) / Part of State Publication 286
INDIANA DEPARTMENT OF HEALTH

Section 1

Attach copy of NPI notification correspondence.

Federal tax identification number	Effective date *(month, day, year)*
Service location National Provider Identification number (NPI)	Payee National Provider Identification number (NPI)

Section 2 – Locality

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

☐ Metropolitan ☐ Rural ☐ Urban

Section 3 – Service Location Name and Address

Please complete the Provider / DBA Name, Corporate Name, County, Telephone Number, Address, and the nine-digit ZIP Code for the site where services will be performed. You must complete a separate Schedule B for each location where services are performed, even if you bill claims from all locations under one Tax Identification Number and/or NPI 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.

The Service Location information below must reflect the service provider's address and contact information and NOT information for the billing company or other agent.

Are you registered with the Indiana Secretary of State?

☐ Yes ☐ No

Provider / DBA name	
Corporate name	
Street address *(number and street, city, state, and ZIP + 4)*	County
Name of contact person	

Telephone number	Extension	Fax number	E-mail address
( )		( )	

Section 4 – 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 Indiana 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 Identification Number.

Legal name	
Street address *(number and street, city, state, and ZIP + 4)*	
Name of contact person	

Telephone number	Extension	Fax number	E-mail address
( )		( )	

Section 5 – 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 *(number and street, city, state, and ZIP + 4)*	
Name of contact person	

Telephone number	Extension	Fax number	E-mail address
( )		( )	

Section 6 – Pay To Name and Address

Checks, EFT notices, and remittance advices will be sent to the name/address on file with the Auditor's office for the Tax Identification Number provided. Please note that the "pay to" information supplied below must match the information provided on the Direct Deposit form. If payment is to be made to a "DBA Name / Address", please be sure to enter the DBA name and address information as it is written on the Direct Deposit form. A post office box is acceptable for this address.

Name			
Street address *(number and street, city, state, and ZIP + 4)*			
Name of contact person			
Telephone number ( )	Extension	Fax number ( )	E-mail address

Section 7 – Billing Agent

If Provider of Services uses a billing agent, please provide the following information.

Name			
Street address *(number and street, city, state, and ZIP + 4)*			
Name of contact person			
Telephone number ( )	Extension	Fax number ( )	E-mail address

PROVIDER INFORMATION

Section 8 – 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 IDOH Billing Provider Specialty List to determine the provider type and specialty numbers for your primary and secondary 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.

Provider type	Taxonomy codes (*when mandated*)
Primary specialty	Taxonomy codes (*when mandated*)
Secondary specialty	Taxonomy codes (*when mandated*)
Primary sub-specialty	Taxonomy codes (*when mandated*)
Secondary sub-specialty	Taxonomy codes (*when mandated*)

Section 9 – Description of Service Location

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

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: _____

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

- ☐ **Practitioner License from Licensing Board (non-group providers only)**
- ☐ **Board Certified Behavior Analyst (BCBA) Certificate**
- ☐ **Clinical Laboratory Improvement Amendment (CLIA) Certificate**
- ☐ **Federal Drug Enforcement Administration (DEA) Certificate**
- ☐ **Medicare Provider Number Assignment Letter for Medicare Participation**

Section 10 – License / Registration / Certification *(non-group providers only)*

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 IDOH returning this application for incomplete information.

License / registration / certification number	Effective date *(month, day, year)*	Expiration date *(month, day, year)*

Issuing board

Section 11 – CLIA Certification

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

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.

CLIA number	Effective date *(month, day, year)*	Expiration date *(month, day, year)*

Type of certification

☐ Waiver ☐ Provider-Performed Microscopy Procedure (PPMP) ☐ Registration ☐ Compliance ☐ Accreditation

Section 12 – Federal DEA Certification

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

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.

DEA number	Effective date *(month, day, year)*	Expiration date *(month, day, year)*

Section 13 – Medicaid Participation

Indiana Medicaid number	Effective date *(month, day, year)*

Section 14 – Medicare Participation

Please complete the appropriate Medicare identification numbers.

Medicare number	Medicare number state

DME supplier number

Provider-Authorized Signature

Complete this section of this form ONLY if being sent independent of the CSHCS Provider Agreement.

NOTE: The owner or an authorized officer of the business entity must complete this section. Failure to complete this section when necessary will result in IDOH returning the form for incomplete information.

I certify, under penalty of law, that the information stated in this Schedule B 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 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 Department of Health Programs.

This Agreement may be executed simultaneously or in two or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument. The parties agree that this Agreement may be transmitted between them electronically or digitally. The parties intend that electronically or digitally transmitted signatures constitute original signatures and are binding on the parties. The original document shall be promptly delivered, if requested.

Doing business as (DBA) name of provider

Name of officer	Title	Telephone number ( )

Signature	Date *(month, day, year)*