Reset Form

CSHCS WEB PORTAL ENROLLMENT & CHANGE REQUEST

State Form 54354 (R5 / 12-23)
INDIANA DEPARTMENT OF HEALTH

Children's Special Health Care Services Program (*CSHCS*) offers a WEB Application for Providers to perform certain functions as it pertains to the Eligibility and Claims of the covered participants of the CSHCS Program via a secured WEB Portal.

To obtain a login to the CSHCS WEB Portal, this Enrollment Form must be completed in full and returned to:

Indiana Department of Health
Attention: OTC/EDI Department
2 N. Meridian Street, 3K
Indianapolis, IN 46204
Telephone: 317-233-9803
Fax: 317-233-8199

Enrollment Type:

Please select one: ☐ **Provider** ☐ **Billing Company** ☐ **Other**

Instructions:

For changes to existing accounts, the primary contact person should complete section 1 and check the Change Request box. Enter any changes to your account in the appropriate section(s) below.

For new enrollments, please follow instructions below:

Providers:

Please complete sections 1, 2, 3, & 4. Return to the address indicated above or send via fax.

Billing Companies:

Please complete sections 1, 2, & 4 only. Return to the address indicated above or send via fax.

Other:

Please complete sections 1, 2, & 4 only. Return to the address indicated above or send via fax.

Once your completed form has been received and verified, your login will be established and sent to each individual via e-mail with instructions for login and setting your password.

1. Demographic Information: ☐ New Request ☐ Change Request

Name: _____

Tax Identification Number (*Providers Only*): **0** _____

Service Location: _____

Street Address (*number and street*): _____

City: _____ State: _____ ZIP + 4: _____

Name of Primary Contact: _____

Telephone Number: _____ E-mail Address: _____

2. Logins:

Access to the CSHCS WEB Portal is limited to one session per login at a time. It may be necessary for a provider or billing office to have more than one login if multiple accesses are needed at the same time. Logins will be assigned per individual.

Number of Logins Requested: _____

Names of Individuals to be granted access; please print clearly.
Please attach additional sheet(*s*) as needed.

Name: Last_____ First _____ MI _____

Telephone Number: _____ Email Address: _____

Effective Date (*month, day, year*): _____ Term Date (*month, day, year*): _____

Name: Last_____ First _____ MI _____

Telephone Number:_____ Email Address: _____

Effective Date (*month, day, year*): _____ Term Date (*month, day, year*):_____

Name: Last_____ First _____ MI _____

Telephone Number:_____ Email Address:_____

Effective Date (*month, day, year*): _____ Term Date (*month, day, year*):_____

Name: Last_____ First _____ MI _____

Telephone Number:_____ Email Address:_____

Effective Date (*month, day, year*): _____ Term Date (*month, day, year*): _____

Name: Last_____ First _____ MI _____

Telephone Number: _____ Email Address:_____

Effective Date (*month, day, year*): _____ Term Date (*month, day, year*): _____

Providers Only: For privacy each Login is granted access to view claim information for claims rendered by the provider of service who is tied to that login. This is controlled by Provider's NPI Number. Please attach additional sheet(*s*) as needed.

Group NPI(*s*):

NPI number: _____

NPI number: _____

NPI number: _____

NPI number: _____

Individual NPI(*s*): ***Only if not covered by Group NPI***

NPI number: _____

NPI number: _____

NPI number: _____

NPI number: _____

3. Additional Access (*For Providers Only*): ☐ **New Request** ☐ **Change Request**

Do you use an outside Billing Company? ☐ **Yes** ☐ **No**

If yes, do you want the Billing Company to have on-line access to your claim information?
☐ **Yes** ☐ **No**

If yes, the below information is required to establish login access for the Billing Company:

Name of Billing Company: _____

Street Address (*number and street*) _____

City _____ State _____ ZIP + 4 _____

Signature of Billing Company Representative _____

Name of Contact: _____

Telephone Number _____ E-mail Address _____

Date Terminated (*month, day, year*) _____
(*Billing company will no longer have access to your patients' claim information*.)

Please list the NPI numbers that the Billing Company is authorized to view claims history for:

NPI number: _____ NPI number: _____

NPI number: _____ NPI number: _____

NPI number: _____ NPI number: _____

NPI number: _____ NPI number: _____

The provider must advise the Billing Company to complete an enrollment form. The Billing Company will not have access to the web portal without a completed enrollment form on file.

4. Authorization:

PLEASE NOTE: IT IS THE RESPONSIBILITY OF EACH PROVIDER TO NOTIFY CSHCS WHEN ITS RELATIONSHIP WITH AN EMPLOYEE OR BILLING COMPANY IS TERMINATED. SUCH NOTIFICATION SHOULD BE SENT USING THE ONLINE LOGIN TERMINATION FUNCTION OR BY COMPLETING AND SENDING THE CHANGE REQUEST INFORMATION ON THIS FORM AS SOON AS POSSIBLE.

By signing below you agree that above information is correct and that if any changes occur in the above information, a new Provider WEB Portal Application Enrollment Request Form (Change Request) will need to be completed with the updated information.

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.

Signature of Authorized Representative: _____

Title of Authorized Provider Representative: _____

Telephone Number of Authorized Representative: _____

E-mail Address of Authorized Representative: _____

Date Signed (*month, day, year*): _____