PROVIDER AGREEMENT
INDIVIDUALS COVERED UNDER PROVIDER AGREEMENT
State Form 51397 (R / 5-11) / Part of State Publication 286
Indiana State Department of Health

Group Provider Name:

Please list the names of all individuals providing services for this group. If more convenient you may also attach a list.

Only the group provider will be enrolled as a CSHCS provider for billing purposes. Individual providers within a group will not be enrolled as a separate CSHCS provider. Please use this form to notify the CSHCS program of any changes or additions to the information provided.

Provider Name (*Last*)   (*First*)   (*MI*)

Credentials   Effective Date (*mm/dd/yyyy*)   Term Date (*mm/dd/yyyy*)

Provider Name (*Last*)   (*First*)   (*MI*)

Credentials   Effective Date (*mm/dd/yyyy*)   Term Date (*mm/dd/yyyy*)

Provider Name (*Last*)   (*First*)   (*MI*)

Credentials   Effective Date (*mm/dd/yyyy*)   Term Date (*mm/dd/yyyy*)

Provider Name (*Last*)   (*First*)   (*MI*)

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Provider Name (*Last*)   (*First*)   (*MI*)

Credentials   Effective Date (*mm/dd/yyyy*)   Term Date (*mm/dd/yyyy*)

Provider Name (*Last*)   (*First*)   (*MI*)

Credentials   Effective Date (*mm/dd/yyyy*)   Term Date (*mm/dd/yyyy*)

ISDH - Provider Relations
Provider Agreement
Individuals Covered Under Provider Agreement