PROVIDER AGREEMENT
INDIVIDUALS COVERED UNDER PROVIDER AGREEMENT
State Form 51397 (R3 / 12-23) / Part of State Publication 286 Indiana Department of Health

## Name of group provider

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.

| Last name of provider |  | First name | Middle initial |
| :---: | :---: | :---: | :---: |
| Credentials | Effective date (month, day, year) | Term date (month, day, year) |  |
| Last name of provider | First name |  | Middle initial |
| Credentials | Effective date (month, day, year) | Term date (month, day, year) |  |
| Last name of provider | First name |  | Middle initial |
| Credentials | Effective date (month, day, year) | Term date (month, day, year) |  |
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