Reset Form

INSTRUCTIONS FOR STATE PUBLICATION 286, PROVIDER AGREEMENT

INDIANA STATE DEPARTMENT OF HEALTH

ALL BILLING PROVIDERS ARE REQUIRED TO:

- ☐ Sign the Provider Agreement
- ☐ Read Schedule A
- ☐ Complete Schedule B
- ☐ Provide a copy of your/your group's License/Registration/Certifications as requested in the Schedule B
- ☐ Complete the W-9 and Direct Deposit forms, dated within the past six (6) months
- ☐ Complete the Web Portal Enrollment form

IF YOU WOULD LIKE TO SUBMIT ELECTRONIC CLAIMS:

- ☐ Read and sign the Trading Partner Agreement
- ☐ Complete and sign the Trading Partner Profile - Provider
- ☐ If you have a Clearinghouse / Software Vendor, have them complete and sign the Trading Partner Profile Clearinghouse / Software Vendor

FREQUENTLY ASKED QUESTIONS

Do I have to fill out a separate agreement for each practitioner in a group?

No, we go by location and not individual practitioner. Fill out all forms with the group information.

Why do I need to fill out the Web Portal Enrollment form?

The Web Portal is the only way to check claim status and retrieve Explanation of Payment (EOP) information. We have not provided this information by phone, fax, or e-mail since 1/1/2012.

What happens if we change addresses?

You will need to submit a Schedule B to change your Service, Legal, or Mailing address.
To change your Pay-To address, you will need to submit a new Direct Deposit form.

Do I have to fill out a Direct Deposit form?

Yes – The Indiana Auditor of State's office requires Electronic Funds Transfer (EFT) into your banking account. The address in Section 1 should be your Remit address, and the bank's address in Section 2 should be either the branch location you use or their main office address.

Can I fax or e-mail my agreement, or does it need to be mailed?

The Agreement can be faxed to (317) 233-1342, contact Provider Relations at 1-800-475-1355 or 1-317-233-1351, option #5 to receive an email address for the Provider Relations Specialist assigned to you, or mail it to:

Children's Special Health Care Services
2 North Meridian Street, 5C
Indianapolis, IN 46204

PROVIDER AGREEMENT

State Form 51396 (R5 / 5-14) / 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, at least sixty (60) days before the effective date of the change, for any of the following: name (legal name), doing business as (DBA), name as registered with the Secretary of State, address (service location), pay to, mail to, or home office address, Federal tax identification 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 or e-mailed to the billing Provider's current "mail to" physical or email address on file with ISDH.

11. To submit billing in arrears, within one (1) year of the service date, 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. Any requests for exceptions to these requirements must be submitted in writing to Children's Special Health Care Services (CSHCS) and attached to the billing.

12. To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the Tax ID/NPI submitted, 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 five (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. Upon notification that a participant is enrolled in the CSHCS Program a provider shall, in accordance with this agreement, submit billing to the CSHCS Program for services provided within the last year while the participant was enrolled in the CSHCS Program. If the participant has already paid for services billed to the CSHCS Program, the CSHCS provider must reimburse participants in full for all services covered by the CSHCS Program.

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

24. 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.

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

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

27. 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.

28. 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.

29. 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.

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

31. 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.

32. 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.

33. That this Agreement has not been altered, and upon execution by provider and 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 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 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.

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)*

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
INDIVIDUALS COVERED UNDER PROVIDER AGREEMENT

State Form 51397 (R2 / 5-14) / Part of State Publication 286
Indiana State 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)*
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)*
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)*
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)*

PROVIDER AGREEMENT
BILLING PROVIDER ENROLLMENT APPLICATION
SCHEDULE B

State Form 51452 (R4 / 5-14) / Part of State Publication 286
INDIANA STATE 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 ISDH 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 ISDH 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 ISDH 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 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.

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)*

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
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 (LCSW) 117 Psychiatric Nurse
12 School Corporation	120 School Corporation
13 Public Health Agency	130 County Health Department

Provider Type	Provider Specialty
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 174 ABA 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 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

Provider Type	Provider Specialty
31 Physician *(continued)*	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 Pediatric Endocrinology Pediatric Gastroenterology Pediatric Hematology-Oncology Pediatric Infectious Diseases Pediatric Nephrology Pediatric Neurology Pediatric Otolaryngology Pediatric Pulmonology Pediatric Rheumatology Pediatric Sports & Fitness Medicine Pediatric Urology Physical Medicine & Rehabilitation 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)	

TRADING PARTNER AGREEMENT
ELECTRONIC DATA INTERCHANGE (EDI)

State Form 51402 (R3 / 12-11) / Part of State Publication 286
Indiana State Department of Health

Remittance Address:
Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 N. Meridian St.
Indianapolis, IN 46204-3010
Phone: (317)233-9803

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 thirty (*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 acknowledgment 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 thirty (*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.

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.

Trading Partner: _____

Authorized Signature: _____

Title of Authorized Signatory: _____

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

Address: (*number & street*) _____

City: _____ State: _____ ZIP+4: _____

Telephone: _____

ELECTRONIC DATA INTERCHANGE (EDI) TRADING PARTNER PROFILE - PROVIDER

State Form 51401 (R4 / 6-14) / Part of State Publication 286
INDIANA STATE DEPARTMENT OF HEALTH

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

Reason for submission ☐ New enrollment ☐ Change enrollment ☐ Cancel enrollment	Nine (9) digit taxpayer identification number (TIN) of the legal name

Enter ten (10) digit National Provider Identification Numbers (NPI) of the legal name.

Payee NPI			
Service NPI	Service NPI	Service NPI	Service NPI
Service NPI	Service NPI	Service NPI	Service NPI

PROVIDER OF SERVICE

Name or provider			
Address *(number and street, suite)*	City	State	ZIP + 4
Name of contact			
Telephone number ( )	Fax number ( )	E-mail address	

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, Institutional, Vision, and Pharmacy electronic claims. Attach additional Software Vendor(s) as needed.

Software vendor ☐ X12 ☐ NCPDP	Name		
Address *(number and street, suite)*	City	State	ZIP + 4
Name of contact			
Telephone number ( )	Fax number ( )	E-mail address	

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 the submission of Medical, Dental, Vision, and Pharmacy electronic claims.

Clearinghouse 1 ☐ X12 ☐ NCPDP	Name of clearinghouse1		
Address *(number and street, suite)*	City	State	ZIP + 4
Name of contact			
Telephone number ( )	Fax number ( )	E-mail address	
Clearinghouse 2 ☐ X12 ☐ NCPDP	Name of clearinghouse1		
Address *(number and street, suite)*	City	State	ZIP + 4
Name of contact			
Telephone number ( )	Fax number ( )	E-mail address	

EDI TRANSACTIONS	
Indicate your request(s) for the EDI transactions below. *Remittance Advices are provided twice weekly and include claims submitted electronically and on paper.*	
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 Response (*271*) ☐ Claim Status Request (*277*) ☐ Response (*NCPDP B1, B2*)

DATA TRANSMISSION / RETRIEVAL
Please complete if you will be submitting transactions directly from your office to Indiana State Department of Health.
Method of data transmission / retrieval ☐ Secure FTP ☐ Side by side VPN connection

AUTHORIZATION	
I am authorizing the outbound transactions indicated to be retrieved by: ☐ Provider of Service ☐ Software Vendor / Third party vendor ☐ Clearinghouse/ Switch	
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.	
Authorized signature	Date *(month, day, year)*
Title of authorized signatory	

ELECTRONIC DATA INTERCHANGE (EDI) TRADING PARTNER PROFILE CLEARINGHOUSE/SOFTWARE VENDOR

State Form 51441 (R3 / 12-11) / Part of State Publication 286
Indiana State Department of Health

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

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

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 Response (*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 the billing provider.

Data Transmission / Retrieval Method

- ☐ Secure FTP
- ☐ Side by Side VPN connection

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.

Authorized Signature _____

Title of Authorized Signatory _____

Date *(mm/dd/yyyy)* _____

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

AUTOMATED DIRECT DEPOSIT AUTHORIZATION AGREEMENT

State Form 47551 (R7 / 5-18)
Approved by State Board of Accounts, 2018
Prescribed by Auditor of State, 2018

* This agency is requesting disclosure of your Federal Identification Number / Social Security Number in accordance with IC 4-1-8-1. Disclosure is mandatory, and this record cannot be processed without it.

In accordance with IC 4-13-2-14.8, a person who has a contract with the State of Indiana or submits invoices to the State of Indiana for payment shall authorize the direct deposit by electronic funds transfer of all payments by the state to the person.

This form must be completed in order to receive payment from the State of Indiana and any time there is a change in banking information. This form must be accompanied by a W9. If you are changing an e-mail address to receive electronic notifications of EFT deposits, please contact vendors@auditor.in.gov.

☐ New Enrollment

☐ Change of Existing Account Prior Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Prior Account Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

SECTION 1: AUTHORIZATION

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

Name of Company or Individual (*as shown on the account*)

Federal Identification Number / Social Security Number *

Address (*Number and Street and/or PO Box Number*)

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

SECTION 2: DIRECT DEPOSIT INFORMATION

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.**

Financial Institution: _____

Routing Number *(9 digits)*: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Number *(maximum 17 digits – include leading zeros)*: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

SECTION 3: E-MAIL ADDRESS TO RECEIVE ELECTRONIC NOTIFICATION OF ELECTRONIC FUND TRANSFER (EFT) DEPOSITS *Required*

(Please contact vendors@auditor.in.gov to add more than four addresses.)

All future notices of EFT deposits to the bank account specified above will be sent to the following e-mail addresses:

_____ _____

_____ _____

☐ **By checking this box, I authorize the information provided on this form to be accurate and I agree with the provisions on the reverse side of this form. I also authorize the State of Indiana to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account indicated above. This authorization will remain in effect until the state has received written notification of its termination and has adequate time to act upon the request.**

NAME ***(type)*** _____ **TITLE**_____ **TELEPHONE**_____

AUTHORIZED SIGNATURE* _____ **DATE** ***(month, day, year)*** _____

*** Under IC 26-2-8-106, your electronic signature on this form represents the same legal authority as your written signature.**

INSTRUCTIONS:

1. ***Complete all three sections and sign and date the bottom of the form.***
   Note: If signing electronically, the form must be saved first, and then opened in Adobe Acrobat. For help in creating a digital ID please click here.
2. ***File the completed form with the agency that you do business with.***
3. ***Retain a copy of the completed form for your records.***

By Signing This Form:

You are responsible for ensuring that this form was approved and instructions above are followed. By signing this form, you represent that it is understood by all parties that, if approved:

1. The State of Indiana must initiate credits (deposits) in various amounts, by electronic transfer of funds through automated clearing house (ACH) processes, to the listed checking (demand) or savings account designated in the financial institution named in Section 2.

2. If necessary, you will accept reversals from the State for any credit entries made in error to the bank account per National Automated Clearing House Association (NACHA) regulations.

3. You may only revoke this request and authorization by notifying the Auditor of State (AOS) by e-mailing vendors@auditor.in.gov or in writing at the following address: **Indiana Auditor of State, 200 W Washington St. Ste 240, Indianapolis, IN 46204**. The authorization will remain in effect until the office has adequate time to act upon the request.

4. A new Automated Direct Deposit Authorization Agreement is required for change in existing account information. The previous account information must be provided. Failure to timely notify the AOS of an account change will delay payment.

5. 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 electronic funds transfer and/or you do not properly follow these Instructions.

6. E-mail address(es) must be provided in Section 3 to allow for appropriate application of all payments through Electronic Notification.

7. You acknowledge that it will cause disruption to the notification process if the e-mail addresses provided for electronic funds transfer notification are frequently changed or changed without promptly providing an updated e-mail address to the AOS.

8. You acknowledge that an e-mail notification returned as undeliverable may be removed from the Auditor's e-mail notification system.

9. You are responsible for contacting the AOS if you are not receiving electronic notices of EFT deposits.

CSHCS WEB PORTAL ENROLLMENT & CHANGE REQUEST

State Form 54354 (R4 / 2-12)
Indiana State 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 State 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*): _____

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*):	Individual NPI(*s*):
NPI number: ______________________	NPI number: ______________________
NPI number: ______________________	NPI number: ______________________
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 _____

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 Representative: _____

Telephone Number of Authorized Representative: _____

E-mail Address of Authorized Representative: _____

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