IHCP Provider Ownership and Managing Individual Maintenance Form

in.gov/medicaid/providers

Providers are encouraged to use the Indiana Health Coverage Programs (IHCP) Provider Healthcare Portal (Portal) to update their provider profiles. However, all profile updates may be made by mail using the appropriate paper forms if the Portal is not an option.

Enrolled providers can use this form to update the ownership and management information for their business entity. If the change applies to more than one enrollment/service location, a separate form will need to be submitted for each IHCP Provider ID.

Who Completes This Form

Billing and group providers use this form to report ownership changes (business and individuals) and changes of managing individuals in instances such as a change in board members, officers, or directors; a partner buyout; or the death of an owner.

> *Note: If the ownership change is the result of the business entity undergoing a financial transaction such as a sale or merger, do **not** complete this form. Instead, for a change of ownership, complete and submit the appropriate IHCP provider packet. Go to Complete an IHCP Provider Enrollment Application at in.gov/medicaid/providers and select your provider type to find the appropriate provider packet. Be sure to include supporting documentation and a copy of the purchase agreement or bill of sale with the provider packet.*

Next Steps

1. Complete all applicable sections of this form.
   - When completing the sections under *Schedule C*, be sure to include the names of **all** individuals and entities that meet the disclosure requirements, even if they had been previously disclosed. When an update is processed, any previously disclosed parties that are not included on the update form will be removed from the provider profile. In other words, the previous list of disclosed individuals and entities will be **replaced** with the updated list.
   - The *Signature Authorization* section must be completed and signed according to the instructions.
   - If the *IHCP Provider Agreement* on file for this provider was signed by an individual who is no longer with the business or who has passed away, a new *IHCP Provider Agreement* must be completed and signed according to the instructions.
2. For updates related to a financial transaction such as a partner buyout, related legal documentation must be included with this form.
3. Make a copy of the completed form and other documentation for your records.
4. Mail the completed form and other required documentation to the following address:

   IHCP Provider Enrollment Unit
   P.O. Box 7263
   Indianapolis, IN 46207-7263

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Provider Information		
Complete the following fields to identify for the Indiana Health Coverage Programs (IHCP)-enrolled provider to which this provider profile update pertains.		
1. National Provider Identifier (NPI)	2. Service Location ZIP Code + 4 (Nine digits required)	3. IHCP Provider ID

Contact Information	
• The contact name and email relate to the person who can answer questions about the information provided in this form. • Providers will be signed up to receive email notifications when new information is published to in.gov/medicaid/providers. Enter the email address where these notifications should be sent. • Email addresses will be used for IHCP business only and will not be sold or shared for other purposes.	
4. Contact name	5. Telephone
6. Contact email address	
7. Email address for provider publications	

IHCP Provider Schedule C – Disclosure Information

in.gov/medicaid/providers

Overview

Please complete all four sections of this form. Nonprofit providers must provide information for the business entity that owns their taxpayer identification number (TIN).

Disclosure Information: When completing this schedule to make changes to the list of disclosed parties, be sure to include the names of all individuals and entities that meet the disclosure requirements, even if the individuals or entities had been previously disclosed. When an update is processed, any previously disclosed parties that are not shown on the update form will be removed. In other words, the previous list of disclosed individuals and entities will be **replaced** with the updated list.

Disclosure of Social Security Numbers: Schedule C is used to collect information required by state and federal regulations. Social Security numbers disclosed on this form are used to determine whether persons and entities named in this form are federally excluded parties. Refusal to provide a Social Security number will result in rejection of this enrollment maintenance form.

Consent to Release Social Security Numbers: Submission of information on this schedule indicates that consent has been given to the Indiana Family and Social Services Administration (FSSA) and its contractors to use the information, including the Social Security number, for the sole purpose of verifying eligibility to participate in the Medicaid program through the Office of the Inspector General, the Centers for Medicare & Medicaid Services, relevant licensing bodies, and other appropriate state and federal agencies. It is further understood that the FSSA and its contractors may use a Social Security number so the office may determine eligibility for continued participation in the Medicaid program.

C.1 – Disclosure Information – Individuals and/or Corporations with an Ownership or Control Interest in the Applicant

Section C.1.(A) – Individuals with an Ownership or Control Interest

Please list **all** individuals with an ownership or control interest in the applicant. Include each person's name, address, the individual's date of birth, and Social Security number. Also indicate the title (e.g., chief executive officer, owner, board member) and if an owner, the percent of ownership. Attach additional pages as needed.

* Please refer to *42 CFR 455.101* for the definition of "persons with an ownership or control interest" to ensure that all individuals are included. This should also include officers, directors, or partners as defined in sections *455.101(e)* and *(f)*.

1a. Name of individual			
2a. Address			
3a. Title	4a. % of ownership (if applicable)	5a. Social Security number	6a. Date of birth
1b. Name of individual			
2b. Address			
3b. Title	4b. % of ownership (if applicable)	5b. Social Security number	6b. Date of birth
1c. Name of individual			
2c. Address			
3c. Title	4c. % of ownership (if applicable)	5c. Social Security number	6c. Date of birth
1d. Name of individual			
2d. Address			
3d. Title	4d. % of ownership (if applicable)	5d. Social Security number	6d. Date of birth
1e. Name of individual			
2e. Address			
3e. Title	4e. % of ownership (if applicable)	5e. Social Security number	6e. Date of birth
1f. Name of individual			
2f. Address			
3f. Title	4f. % of ownership (if applicable)	5f. Social Security number	6f. Date of birth

Section C.1.(B) – Corporations with an Ownership or Control Interest

If a corporation, please list **all** corporations with an ownership or control interest in the applicant. Include the percent of ownership in the applicant, the taxpayer identification number (TIN), the primary business address, every business location, and P.O. Box address(es). Attach additional pages if needed.

1a. Name of corporation	
2a. % of ownership	3a. TIN
4a. Primary business address	
5a. Every business location	6a. P.O. Box address(es)
1b. Name of corporation	
2b. % of ownership	3b. TIN
4b. Primary business address	
5b. Every business location	6b. P.O. Box address(es)
1c. Name of corporation	
2c. % of ownership	3c. TIN
4c. Primary business address	
5c. Every business location	6c. P.O. Box address(es)

Section C.1.(B) – Corporations with an Ownership or Control Interest *(continued)*

If a corporation, please list **all** corporations with an ownership or control interest in the applicant. Include the percent of ownership in the applicant, the taxpayer identification number (TIN), the primary business address, every business location, and P.O. Box address(es). Attach additional pages if needed.

1d. Name of corporation	
2d. % of ownership	3d. TIN
4d. Primary business address	
5d. Every business location	6d. P.O. Box address(es)
1e. Name of corporation	
2e. % of ownership	3e. TIN
4e. Primary business address	
5e. Every business location	6e. P.O. Box address(es)
1f. Name of corporation	
2f. % of ownership	3f. TIN
4f. Primary business address	
5f. Every business location	6f. P.O. Box address(es)

C.2 – Disclosure Information – Subcontractors

(Attach additional copies of this page if you need space for additional names.)

Subcontractors – Please list all subcontractors in which the applicant has a 5% or more ownership or control interest. Include any subcontractor and their address and taxpayer identification number (TIN). Attach additional pages as needed.

Name of subcontractor	Address	TIN

C.3 – Disclosure Information – Managing Individuals

(Attach additional copies of this page if you need space for additional names.)

Managing Individuals – List ALL agents, officers, directors, and managing employees who have expressed or implied authority to obligate or act on behalf of the provider entity. Not-for-profit providers and government-owned businesses must also list their managing individuals.

- An agent is any person who has express or implied authority to obligate or act on behalf of the entity.
- An officer is any person whose position is listed as an officer in the provider's articles of incorporation or corporate bylaws, or is appointed as an officer by the board of directors or other governing body.
- A director is a member of the provider's board of directors, board of trustees, or other governing body. It does not necessarily include a person who has the word director in his or her job title, such as director of operations or departmental director.
- A managing employee is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over or directly or indirectly conducts the day-to-day operations of the provider entity.

1a. Name of individual		
2a. Address		
3a. Title	4a. Social Security number	5a. Date of birth
1b. Name of individual		
2b. Address		
3b. Title	4b. Social Security number	5b. Date of birth
1c. Name of individual		
2c. Address		
3c. Title	4c. Social Security number	5c. Date of birth
1d. Name of individual		
2d. Address		
3d. Title	4d. Social Security number	5d. Date of birth
1e. Name of individual		
2e. Address		
3e. Title	4e. Social Security number	5e. Date of birth
1f. Name of individual		
2f. Address		
3f. Title	4f. Social Security number	5f. Date of birth

C.4 – Disclosure Information – Relationships and Background Information

(Attach additional copies of this page if you need space for additional names.)

1. Are any parties listed in C.1 or C.3 related to each other as a spouse, parent, child, or sibling? If "Yes," please list their names and the relationship.

Name of person 1	Name of person 2	Relationship

2. Are any parties listed in C.1 or C.3 related to any individuals with an ownership or control interest in any of the subcontractors listed in C.2? If "Yes," please list their names and the relationship.

Name of person 1	Name of person 2	Relationship

3. Do any of the owners included in C.1. have an ownership or control interest in another organization(s) that would qualify as a disclosing entity?

As defined under 42 CFR 455.101, "other disclosing entity" means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

b) Any Medicare intermediary or carrier; and

c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Whereas "disclosing entity" is limited to Medicaid providers, "other disclosing entity" can include entities that are not enrolled in Medicaid.

☐ Yes ☐ No

If yes, please list the name of each owner and the name of the other disclosing entity(ies) in which they have an ownership or control interest. If the entity is a non-profit organization and does not have any "owners," please check NA ☐ .

Owner's name	Disclosing entity(ies)

4. Please list any party with an ownership or control interest, or who is an agent or managing employee, who has ever had a healthcare-related criminal conviction since the inception of the Medicare, Medicaid, or Title XX services programs.

Name of convicted party	**Date of conviction**

5. Indicate any former agent, officer, director, partner, or managing employee who has transferred ownership to a family member (spouse, parent, child, or sibling) related through blood or marriage, in anticipation of or following a conviction or imposition of an exclusion.

Name of person 1	**Name of person 2**	**Relationship**

IHCP Provider Signature Authorization

in.gov/medicaid/providers

Signature Authorization	
The owner or an authorized official of the business entity, directly or ultimately responsible for operating the business, is the authorized signatory of this form. A delegated administrator may sign this form if it has been expressly indicated on an IHCP Delegated Administrator Addendum/Maintenance Form, on file or attached. *The undersigned, being the provider or having the specific authority to bind the provider to the terms of the provider agreement, does hereby agree to abide by and comply with all the stipulations, conditions, and terms set forth therein. The undersigned acknowledges that the commission of any Medicaid or Children's Health Insurance Program (CHIP)-related offense, as set out in* 42 USC 1320a-7b, *may be punishable by a fine of up to $25,000 or imprisonment of up to five years or both.*	
1. Legal name of provider's business (please print)	2. Taxpayer identification number (TIN)
3. Authorized official's name (please print)	4. Title
5. Authorized official's signature	6. Date

IHCP Provider Agreement

in.gov/medicaid/providers

IHCP Provider Agreement Overview

You must provide a completed and signed Provider Agreement in the following instances:

- If you are enrolling for the first time in the Indiana Health Coverage Programs (IHCP);
- If you are enrolling a new service location;
- If you are revalidating your enrollment with the IHCP;
- If you are reporting a change of ownership; or
- If you are changing your primary provider type.

In each of the above instances, a full enrollment packet, including a newly signed Provider Agreement must be submitted for processing. An owner or authorized official with your business must sign the *IHCP Provider Agreement*. An original signature is required. A delegated administrator must not sign this form. A new IHCP number is assigned to each Provider Type enrolled in the IHCP.

The Provider Agreement details the requirements for participation in the IHCP. Included are provider responsibilities regarding updating provider information, protecting patient health information, and requirements for claims processing, overpayments, and record retention. In addition, the Agreement details obligations regarding the appeals process, regulatory compliance, utilization controls, ownership and control, and disclosure rules. The entire Agreement must be read, signed, and returned with the packet. A signed copy must be retained by the provider.

IHCP Provider Agreement

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This agreement must be completed, signed, and returned to the IHCP for processing.

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider in the Indiana Health Coverage Programs ("IHCP"). As an enrolled provider in the IHCP, the undersigned entity agrees to provide covered services and/or supplies to Indiana Health Coverage Program members ("members"). As a condition of enrollment, this agreement cannot be altered and the Provider agrees to all of the following:

1. To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration ("FSSA").
2. To comply with all federal and state statutes and regulations pertaining to the IHCP, as they may be amended from time to time.
3. To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty including all provisions of the State of Indiana Medical Assistance law, State of Indiana Children's Health Insurance Program law, or any rule or regulation promulgated pursuant thereto.
4. To notify FSSA or its agent 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.
5. To provide covered services and/or supplies for which federal financial participation is available for members pursuant to all applicable federal and state statutes and regulations.
6. To safeguard information about members including at a minimum:
   a. members' name, address, and social and economic circumstances;
   b. medical services provided to members;
   c. members' medical data, including diagnosis and past history of disease or disability;
   d. any information received for verifying members' income eligibility and amount of medical assistance payments;
   e. any information received in connection with the identification of legally liable third party resources.
7. To release information about members only to the FSSA or its agent and only when in connection with:
   a. providing services for members; and
   b. conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of IHCP covered services.
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 of the contractor to the agency to assure that all activities under the contract are carried out.
9. To notify the IHCP in writing of the name, address, and phone number of any entity acting on Provider's behalf for electronic submission of Provider's claims. Provider understands that the State requires 30 days prior written notice of any changes concerning Provider's use of entities acting on Provider's behalf for electronic submission of Provider's claims and that such notice shall be provided to the IHCP.
10. To submit claims, using only the billing number assigned to it by FSSA or its fiscal agent, 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 healthcare facility (such as hospital, ICF-IID, or nursing home), or a government agency with a contract that meets the requirements described in item 8 of this Agreement. Healthcare facilities and government agencies may, under circumstances permitted in federal law, subcontract with other entities or individuals to provide services covered by the IHCP pursuant to this Agreement.
11. To abide by the state's *Medical Policy Manual* and *IHCP Provider Reference Modules* as amended from time to time, as well as all provider bulletins, banner pages, and notices. Any amendments to the policy manual or reference modules, including provider bulletins, banner pages, and notices, will be communicated on the official state Medicaid website and shall be binding upon publication.
12. To update and maintain a current service location address as required.
13. To submit timely billing on IHCP-approved electronic or paper claims, as outlined in the policy manual, reference modules, bulletins, and banner pages, in an amount no greater than Provider's usual and customary charge to the general public for the same service.

14. To certify that any and all information contained on any IHCP billings submitted on the Provider's behalf by electronic, telephonic, mechanical, or standard paper means of submission shall be true, accurate, and complete. The Provider accepts total responsibility for the accuracy of all information obtained on such billings, regardless of the method of compilation, assimilation, or transmission of the information (whether by the Provider, the Provider's employees, agents, or a third party acting on the Provider's behalf, such as a service bureau). The Provider fully recognizes that any billing intermediary or service bureau that submits billings to the FSSA or its fiscal agent contractor is acting as the Provider's representative and not that of the FSSA or its fiscal agent contractor. The Provider further acknowledges that any third party that submits billings on the Provider's behalf shall be deemed to be the Provider's agent for the purposes of submission of the IHCP claims. The 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 state laws.
15. The Provider understands that the standard paper claim form may include a signature line. The Provider understands that all the stipulations, conditions, and terms of the provider agreement apply in the event that the Provider fails, for any reason, to sign the paper claim, even if the claim is approved for payment. The Provider agrees that payment of a paper claim that does not contain the Provider's signature in no way absolves the Provider of the terms stated in the provider agreement.
16. To submit claim(s) for IHCP reimbursement only after first exhausting all other sources of reimbursement as required by the policy manual, reference modules, bulletins, and banner pages.
17. To submit claim(s) for IHCP reimbursement utilizing the appropriate claim forms specified in the policy manual, reference modules, bulletins, banner pages, and notices.
18. 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.
19. To accept as payment in full the amounts determined by FSSA or its fiscal agent, in accordance with federal and state statutes and regulations as the appropriate payment for IHCP covered services provided to members. Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for IHCP covered services, excluding any co-payment permitted by law.
20. To refund duplicate or erroneous payments to FSSA or its fiscal agent within fifteen (15) days of receipt.
21. To make repayments to FSSA or its fiscal agent, or arrange to have future payments from the IHCP withheld, within sixty (60) days of receipt of notice from FSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending. Outstanding overpayments made under prior provider agreements will remain collectable under this provider agreement.
22. To pay interest on overpayments in accordance with *Indiana Code (IC) 12-15-13-3, IC 12-15-21-3*, and *IC 12-15-23-3*.
23. To make full reimbursement to FSSA or its fiscal agent of any federal disallowance incurred by FSSA when such disallowance relates to payments previously made to Provider under the IHCP.
24. To fully cooperate with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
25. To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of IHCP payments made to Provider, to assure the proper administration of the IHCP and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in *405 Indiana Administrative Code (IAC) 1-5* and in the policy manual, reference modules, bulletins, and banner pages, and shall include, without being limited to, the following:
    a. medical records as specified by *42 United States Code (USC) 1396(a)(27)*, and any amendments thereto;
    b. records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Title XIX or Title XXI Program, including the authority for and the date of administration of such treatment, drugs, or services;
    c. any records determined by FSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the IHCP;
    d. documentation in each patient's record that will enable the FSSA or its agent to verify that each charge is due and proper;
    e. financial records maintained in the standard, specified form;
    f. all other records as may be found necessary by the FSSA or its agent in determining compliance with any federal or state law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the FSSA; and
    g. any other information regarding payments claimed by the provider for furnishing services to the plan.

26. To cease any conduct that FSSA or its representative deems to be abusive of the IHCP.
27. To promptly correct deficiencies in Provider's operations upon request by FSSA or its fiscal agent.
28. To make a good faith effort to provide and maintain a drug-free workplace. Provider will give written notice to the State within ten (10) days after receiving actual notice that the provider or an employee of the provider has been convicted of a criminal drug violation occurring in the provider's workplace.
29. To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
    a. the petitioner is the person to whom the order is specifically directed;
    b. the petitioner is aggrieved or adversely affected by the order; or
    c. the petitioner is entitled to review under the law.
30. Provider must file a statement of issues within the time limits listed below, setting out in detail:
    a. the specific findings, actions, or determinations of FSSA from which the Provider is appealing; and
    b. with respect to each finding, action, or determination, all statutes or rules supporting the Provider's contentions of error and why the Provider believes that the office's determination was in error.
31. Time limits for filing an appeal and the statement of issues are as follows:
    a. A provider must file an appeal of any of the following actions within sixty days of receipt of FSSA's determination:
        (1) A notice of program reimbursement or equivalent determination regarding reimbursement or a year end cost settlement.
        (2) A notice of overpayment.

        The statement of issues must be filed with the request for appeal.
    b. All appeals of actions not described in (a) must be filed within 15 days of receipt of FSSA's determination. The statement of issues must be filed within 45 days of receipt of FSSA's determination.
32. To cooperate with FSSA 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.
33. To comply with the advance directives requirements as specified in *42 Code of Federal Regulations (CFR) Part 489, Subpart I*, and *42 CFR 417.436(d)*, as applicable.
34. 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 or religion, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination in the provision of an IHCP covered service.
35. The Provider and its agents shall abide by all ethical requirements that apply to persons who have a business relationship with the State, as set forth in *IC § 4-2-6 et seq.*, *IC § 4-2-7, et seq.*, the regulations promulgated thereunder, and *Executive Order 04-08*, dated April 27, 2004. If the Provider is not familiar with these ethical requirements, the Provider should refer any questions to the Indiana State Ethics Commission, or visit the Indiana State Ethics Commission Web site at http://www.in.gov/ethics/. If the Provider or its agents violate any applicable ethical standards, the State may, in its sole discretion, terminate this Agreement immediately upon notice to the Provider. In addition, the Provider may be subject to penalties under *IC § 4-2-6, IC 4-2-7, IC 35-44-1-3*, and under any other applicable laws.
36. To disclose information on ownership and control, information related to business transactions, information on change of ownership, and information on persons convicted of crimes in accordance with *42 CFR, Part 455, Subpart B*, and *405 IAC 1-19*. Long term care providers must comply with additional requirements found in *405 IAC 1-20*. Pursuant to *42 Code of Federal Regulations, part 455.104(c)*, OMPP shall terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
37. To submit within 35 days of the date of request by the federal or state agency full and complete information about:
    a. ownership of subcontractors with whom the provider has had more than $25,000 in a twelve month hearing period;
    b. any significant business transactions between the provider and any wholly owned supplier; and
    c. any significant business transactions between the provider and any subcontractor, during five-year period ending with the date of request.
38. To furnish to FSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in the IHCP Provider Application and maintenance forms, which are incorporated here by reference, and to update this information as it may be necessary.
39. The effective date of this Agreement will be the date set out in the provider enrollment notification letter. This Agreement has not been altered, and upon execution, supersedes and replaces any provider agreement previously executed by the Provider. This Agreement shall remain in effect until terminated in accordance with item 40 below.

40. That this Agreement may be terminated as follows:
    a. By FSSA or its fiscal agent for Provider's breach of any provision of this Agreement as determined by FSSA pursuant to *405 IAC 1-1-6*; or
    b. By FSSA or its fiscal agent, or by Provider, without cause upon 60 days' written notice.
41. For long term care providers involved in a change of ownership, this agreement acts as an amendment to the transferor's agreement with IHCP to bind the transferee to the terms of the previous agreement; and any existing plan of correction and pending audit findings in accordance with *405 IAC 1-20*.
42. New owners of nursing facilities or intermediate care facilities for the intellectually disabled, must accept the assignment of the provider agreement executed by the previous owner(s) as required by *42 CFR 442.14*.
43. For any entity that receives or makes annual payments totaling at least $5,000,000 annually as described in *42 U.S.C. 1396a(a)(68)*, shall add written policies to their employee handbook that provide detailed information about federal and state False Claims Acts, whistleblower protections, and entity policies and procedures for preventing and detecting fraud and abuse. In any inspection, review, or audit of the entity by FSSA or its contractors, the entity shall provide copies of the entity's written policies regarding fraud, waste, and abuse upon request. Entity shall submit to FSSA a corrective action plan within 60 days if the entity is found not to be in compliance with any part of the requirements stated in this paragraph.
44. To verify and maintain proof of verification that no employee or contractor is an excluded individual or entity with the Health and Human Services (HHS) Office of the Inspector General (OIG). Providers shall review the HHS-OIG List of Excluded Individuals/Entities (LEIE) database for excluded parties. This LEIE database is accessible to the general public at http://www.oig.hhs.gov/fraud/exclusions.asp.
45. To allow FSSA and its representatives to perform safety inspections of motor vehicles used for transportation services of Medicaid recipients. The Provider shall require all of its contractors and subcontractors to agree to the same.
46. To receive email updates and communication from IHCP at the email address(es) provided on its enrollment application. Providers may opt-out of receiving these email communications by clicking the link found at the bottom of each email following the message prompts. Opting out does not affect the provider's obligation to stay abreast of IHCP updates and communications as required by this agreement.

AS A CONDITION OF PAYMENT AND CONTINUED ENROLLMENT IN THE IHCP 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, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN. THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY INDIANA HEALTH COVERAGE PROGRAM RELATED OFFENSE AS SET OUT IN *42 USC 1320a-7b* MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

Provider Agreement-Authorized Signature – All Schedules and Applicable Addenda	
The owner or an authorized representative of the business entity directly or ultimately responsible for operating the business enterprise must complete this section. A delegated administrator must not sign this form.	
1. Legal name of provider's business (please print):	2. Taxpayer Identification Number (TIN):
3. Authorized official's name (please print):	4. Title:
5. Authorized official's signature:	6. Date: