Reset Form

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)*
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