



ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

(Louisiana Medicaid Program)

Basic Enrollment Packet For Individuals (With Instructions)

**(Common Forms for All Individual
Provider Types)**

(Enrollment packet is subject to change without notice)



To Whom It May Concern:

This is the Basic Enrollment Packet for the Louisiana Medical Assistance Program (also known as the Louisiana Medicaid program). You should carefully review these materials, including all instructions, before completing the necessary forms.

After completing the enrollment packet materials, please return all forms with original signatures to:

**Molina Medicaid Solutions Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159**

Please be sure to include NPIs—both Type 1 Individual and Type 2 Organizational—you want linked to the Medicaid provider number. Claims will not automatically cross electronically from Medicare to Medicaid unless these NPI numbers are linked in our system.

The Medicaid Program requires all providers to be state certified for claims to be processed. The Molina Medicaid Solutions Provider Enrollment Unit in conjunction with the Department of Health and Hospitals will take necessary steps to certify you as a provider and participant in the Louisiana Medical Assistance Program once all required documents have been received. Upon certification, you will be notified via U.S. Postal Service of your Medicaid provider number.

Molina Medicaid Solutions Provider Relations will forward a provider manual to you within two (2) weeks of notification of enrollment with the exception of Pharmacy and Dental Providers. If you do not receive the manuals within four (4) weeks of enrollment notification, please call Provider Relations at (800) 473-2783 or (225) 924-5040.

Pharmacy and Dental Providers are directed to download their own manuals from the “Provider Manuals” link at www.lamedicaid.com.

If you have any questions concerning the completion of this enrollment packet, please contact the Provider Enrollment Unit at the above address or at (225) 216-6370. Thank you for your interest in becoming a Louisiana Medicaid provider.

Sincerely,

Provider Enrollment Unit
Louisiana Medicaid Program

Statutorily Mandated Revisions to all Provider Agreements

“The 1997 Regular Session of the legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

“MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437.14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

- 1) comply with all federal and state laws and regulations;
- 2) provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- 3) have all necessary and required licenses or certificates;
- 4) maintain and retain all records for a period of at least five (5) years;
- 5) allow for inspection of all records by governmental authorities;
- 6) safeguard against disclosure of information in patient medical records;
- 7) bill other insurers and third parties prior to billing Medicaid;
- 8) report and refund any and all overpayments;
- 9) accept payment in full for Medicaid recipients providing allowances for copay authorized by Medicaid;
- 10) agree to be subject to claims review;
- 11) the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
- 12) notification prior to any change in ownership;
- 13) inspection of facilities; and
- 14) posting of bond or letter of credit when required.

“MAPIL’s provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

“The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

“The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

“Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify provider enrollment in writing within ten (10) working days of the date of this letter that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.”

Office for Civil Rights Policy Memorandum

“The Department of Health and Human Services, Office for Civil Rights, recently issued a policy memorandum regarding nondiscrimination based on national origin as it relates to individuals who are limited-English proficient. Enclosed is the Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Statement which expresses our Agency’s commitment to ensuring that there is no discrimination in the delivery of health care services through CMS programs.

“We have committed ourselves to full compliance with the requirements contained in this policy statement. As our partner with the administration of the Medicaid program, you likewise are obligated to comply with those statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The Office for Civil Rights of the Department of Health and Human Services has previously advised CMS that detailed implementation

regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

“It has been asked that we share this policy statement with you and what you do likewise with health care providers and all others involved in the administration of CMS programs.

Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Policy Statement

“The Health Care Financing Administration’s vision in the current Strategic Plan guarantees that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all CMS program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of CMS funds. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all CMS operating components. Promoting attention to and ensuring CMS program compliance with civil rights laws are among my highest priorities for CMS, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of CMS programs.

“CMS, as the agency legislatively charged with administering the Medicare, Medicaid and Children’s Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. CMS will, with your help, continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

“To achieve its civil rights goals, CMS will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities including: collecting data on access to, and the participation of minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing CMS publications, program regulations, and instructions to assure support for civil rights; and working closely with the Department of Health and Human Services (DHHS), Office for Civil Rights, to initiate orientation and training programs on civil rights. CMS will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

“DHHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, CMS will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

“CMS’s mission is to assure health care security for the diverse population that constitutes our nation’s Medicare and Medicaid beneficiaries; i.e., our customers. We will enhance our communication with constituents, partners and stockholders. We will seek input from health care providers, states, contractors, and DHHS Office for Civil Rights, professional organizations, community advocates and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability”

State of Louisiana (Individual)

Instructions for Louisiana Medicaid PE-50 Provider Enrollment Form

PREPARATION

Please read the instructions in their entirety before completing forms. Complete Form PE-50 as an **original** document. The completed form may be photocopied for your records. Inaccurate/Incomplete forms will be returned to you for completion.

GENERAL INFORMATION

A Medicaid provider number will be issued to the individual whose name appears in Section A of this form. It is the responsibility of this individual to maintain accurate information on the Louisiana Medicaid provider file through submitting updates (as needed) to the Provider Enrollment Unit.

An individual Medicaid provider number can have only one (1) mailing address. Therefore, this address **MUST** be the address that the individual wishes to receive all Remittance Advice notices for claims billed under this individual number.

Linkages of Professionals to Groups – an individual’s provider number can be “linked” to a group provider number for purposes of billing as an attending provider for the specified group.

- **Active providers only require Group Link/Unlink and Working Relationship Form.**
- **New/Inactive/closed providers require a completed application, Linkage Form, and Attestation Form.**

Claims submitted under the group number, with an individual’s number included as the attending provider, will be processed and the remittance will be sent directly to the group’s mailing address. **It is not necessary for the individual’s mailing address to be the same as the Group’s mailing address for these Remittance Advice notices to be sent to the group, if billed correctly.**

All fields on the PE-50 form **MUST** be completed unless they are labeled as optional.

Louisiana Medicaid Provider Number – enter your 7-digit Louisiana Medicaid provider number (if known) in the boxes, one digit per box. If you are filing for a new enrollment, leave this blank.

This enrollment packet is for – check the appropriate box to indicate if this application is for a new enrollment, to update to an existing enrollment, to reactivate a provider number, or specify some other reason for the enrollment packet. A new enrollment is for an individual with no prior Louisiana Medicaid provider number. An update to an existing enrollment is for an individual that has a Louisiana Medicaid provider number but whose practice information (such as address, phone number, IRS number, etc.) has changed. A reactivation is for a provider who has had a Louisiana Medicaid provider number in the past but whose number is closed.

Type 1 Individual National Provider Identifier (NPI) – enter your 10-digit NPI number in the boxes, one digit per box. Visit <https://nppes.cms.hhs.gov> for more information on obtaining an NPI. You are required to have an NPI number prior to enrollment (unless you are classified as an atypical provider).

NPI Tie Breaker (Taxonomy or Zip + 4) – Providers can obtain one NPI for each Medicaid ID number **OR** use the same NPI for multiple Medicaid ID numbers. If the same NPI is used for multiple Medicaid provider numbers, the provider must use tie-breaker (either Taxonomy or Zip Code + 4) for registering the NPI **AND** on the EDI claims submission. This allows the claim/payment to be directed the correct Medicaid provider number.

Requested Enrollment Effective Date – the date that you want the provider number to be activated. In some instances, this date can be retroactive as long as it meets the timely filing policy. You must submit a valid license that covers the requested effective date.

SECTION A – INDIVIDUAL INFORMATION & PRACTICE LOCATION

Provider Type Description, Code, and Specialty Type (Required Fields) – review the following table and enter the provider description and code into this field. Entries of provider types other than those listed in this table will result in rejection of this application.

Provider Type Code – enter the code corresponding with your provider type from the table below:

Code	Description
34	Audiologist
30	Chiropractor
93	Clinical Nurse Specialist (CNS)
91	Certified Registered Nurse Anesthetist (CRNA)
27	Dentist
19	Doctor of Osteopathy (DO)
29	EarlySteps (Audiologist, Psy, OT, PT, ST) (In-State Only)
78	Nurse Practitioner (NP)
90	Nurse-Midwife
37	Occupational Therapist (In-State Only)
28	Optometrist
35	Physical Therapist (In-State Only)
20	Physician (MD)
94	Physician Assistant (PA) (In-State Only)
32	Podiatrist
31	Psychologist (In-State Only)
41	Registered Dietician
73	Social Worker (In-State Only)
39	Speech Therapist
06	Waiver - NOW Professional (Registered Dietician/Psychologist/Social Worker) (In-State Only)

Specialty – refer to the checklist in the Provider-Type Specific Packet for the possible Specialty Codes associated with your provider type.

Subspecialty – refer to the checklist in the Provider-Type Specific Packet for the possible Subspecialty Codes associated with your provider type.

Name of Individual Enrolling – enter the individual’s name in this field (must match the name on the license).

M.D., O.D., etc. – enter the abbreviation of the title held by the provider.

Area Code and Telephone # - enter the telephone number at the practice location where the enrolling individual can be reached.

Social Security Number – enter the social security number of the enrolling individual.

Are you known by or have you ever used another name? – check yes or no; if yes, check the appropriate type(s) of other name and enter the other name(s) by which you have been known.

Are you a U.S. citizen? – check yes or no. If no, answer the “Do you have legal status and work privileges in the U.S.?” question by checking the appropriate box (yes or no). If yes, attach verification.

Main Practice Street Address – enter the main practice location where the enrolling individual will be working. (For those providers who provide services at multiple locations, this address should be the address of the individual’s main location.) Occasionally, there will be an instance when mail or a document or a correspondence may be sent to the Main Practice Street Address. If mail cannot be received at the Main Practice Street Address because there is no receptacle and the postal carrier will not bring the mail inside the building, include a brief note that explains the problem and provides an alternative delivery address for the physical location only.

Practice City – enter the city in which your *Main Practice Street Address* is located.

Practice State – enter the state in which your *Main Practice Street Address* is located.

Practice Zip Code – enter the zip code in which your *Main Practice Street Address* is located.

Parish/County – enter the parish / county in which your *Practice Street Address* is located (for out-of-state providers, see county codes below).

Parish Code – enter the parish code of your physical location (see list below and enter appropriate code for the parish entered in the *Parish* field).

Acadia	01	E. Baton Rouge	17	Madison	33	St. Landry	49
Allen	02	E. Carroll	18	Morehouse	34	St. Martin	50
Ascension	03	E. Feliciana	19	Natchitoches	35	St. Mary	51
Assumption	04	Evangeline	20	Orleans	36	St. Tammany	52
Avoyelles	05	Franklin	21	Ouachita	37	Tangipahoa	53
Beauregard	06	Grant	22	Plaquemines	38	Tensas	54
Bienville	07	Iberia	23	Pointe Coupee	39	Terrebonne	55
Bossier	08	Iberville	24	Rapides	40	Union	56
Caddo	09	Jackson	25	Red River	41	Vermillion	57
Calcasieu	10	Jefferson	26	Richland	42	Vernon	58
Caldwell	11	Jefferson Davis	27	Sabine	43	Washington	59
Cameron	12	Lafayette	28	St. Bernard	44	Webster	60
Catahoula	13	Lafourche	29	St. Charles	45	W. Baton Rouge	61
Claiborne	14	LaSalle	30	St. Helena	46	W. Carroll	62
Concordia	15	Lincoln	31	St. James	47	W. Feliciana	63
DeSoto	16	Livingston	32	St. John	48	Winn	64

Out of State Providers (Use the chart below to determine the county/state codes)

Bordering states with counties identified as a “trade-area” to Louisiana have specific county codes that must be used, as follows:

Use the state code unless your practice location is in one of the trade-area counties. If your practice location is in one of the trade-area counties, be sure to use the appropriate county code (NOT the state code).

State	State Code	Trade-Area County	County Code
Texas	87	Cass, Harrison, Jefferson, Marion, Newton, Orange, Panola, Sabine, Shelby	90
Mississippi	88	Adams, Amite, Claiborne, Hancock, Issaquena, Jefferson, Marion, Pearl River, Pike, Walthall, Washington, Warren, Wilkinson	91
Arkansas	89	Ashley, Chicot, Columbia, Lafayette, Miller, Union	92
ALL OTHER STATES			99

State Status – check “In (0)” if your *Practice Street Address* is located within Louisiana or “Out (1)” if it is located outside Louisiana.

Location Type – check “Urban (1)” if your *Practice City* is an urban (city) location or “Rural (2)” if it is a rural (away from city centers) location.

License # - enter the professional (medical) license number for the person identified in the *Name of Individual Enrolling* field.

Do you currently hold (or have in the past held) a professional license in this or any other state? – check yes or no. If yes, list the state, type of license, and license numbers. If necessary, you may attach additional pages to the PE-50 form.

Medicare Number (Legacy) (optional) – enter the legacy Medicare Number if available.

Date of Birth – enter the date of birth for the individual. This is a required field and the forms will be returned for correction if it is left blank.

UPIN (if known) – enter your universal provider identification number.

Board Certification # (optional) - enter the number relating to your Board Certification – this number is issued by the certifying board and is included on your Board Certification certificate, optional.

SECTION B – PAY-TO NAME AND MAILING ADDRESS

Provider Pay-To Name – enter the name registered with the IRS. This is the name the year-end 1099s are issued under – enter the name EXACTLY as found on the top line of the pre-printed IRS documentation being enclosed with the application. Do not abbreviate or add punctuation not found on the IRS documentation. If the Pay-To Name on the PE-50 **DOES NOT** match the IRS documentation exactly, the application may be returned to you for correction.

IRS Reporting # – enter the Federal Tax ID number assigned by the IRS. This number is used in reporting payment amounts for this provider number to the IRS. A copy of a pre-printed document from the IRS showing both the Employer Identification Number (EIN) / Tax ID Number (TIN) and the name that's registered to the EIN is required.

Provider Mailing Address – enter the address to which the Remittance Advices and other correspondence are to be mailed.

Provider Mailing City – enter the city in which your *Provider Mailing Address* is located.

Provider Mailing State – enter the state in which your *Provider Mailing Address* is located.

Provider Mailing Zip – enter the zip code in which your *Provider Mailing Address* is located.

Attn or Other (optional) – this information can be used to help get your mail delivered to a complex address (i.e., a certain person, department, floor, a particular area or section, etc.)

Provider Year-End Date – optional.

Type 2 Organizational NPI – enter the Type 2 Organizational 10-digit NPI number in the boxes provided, one digit per box. Claims will not automatically cross electronically from Medicare to Medicaid unless these NPI numbers are linked in our system.

SECTION C – CONTACT INFORMATION

Contact Name – enter the name of the person who may be contacted for additional information regarding this enrollment application.

Contact Phone # – enter the phone number of the person who may be contacted for additional information regarding this enrollment application.

Contact Fax # - enter the fax number of the person who may be contacted for additional information regarding this enrollment application.

Contact Email – enter the email address of the person who may be contacted for additional information regarding this enrollment application.

SECTION D – PROVIDER ATTESTATION OF INFORMATION

Read the information included in this section.

Print the Name of the Individual Provider - print the name of the **individual provider** who is enrolling in Louisiana Medicaid.

Individual Provider's Signature – the individual provider who is enrolling in Louisiana Medicaid must sign the form. **Signatures must be original, blue ink preferred (not BLACK)** (stamped signatures and initials are not accepted). Office Manager signatures are not accepted.

Date of Signature – enter the date this agreement was signed.

**ALL PROVIDERS MUST COMPLETE THE PE-50
FORM IN ITS ENTIRETY – INACCURATE/
INCOMPLETE FORMS WILL BE RETURNED TO
THE MAILING ADDRESS FOR CORRECTION**

All fields must be completed unless labeled as optional

Louisiana Medicaid Provider # (if known)		This enrollment packet is for a <input type="checkbox"/> New Enrollment <input type="checkbox"/> Update to existing enrollment <input type="checkbox"/> Reactivation <input type="checkbox"/> Other (Please specify):	
Type 1 Individual NPI		NPI Tie Breaker (Taxonomy or Zip + 4)	Effective Date:

A	See PE-50 instructions to get your Provider Type Description and Provider Type Code		See Provider-Type Specific Checklist	
	Provider Type Description	Provider Type Code	Specialty Type	Subspecialty (optional)
	Name of Individual Enrolling (Last Name, First Name, Middle Name)	M.D., O.D., etc.	Area Code & Telephone # () -	Social Security # (required) - -
	Are you known by (or have you ever used) another name? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Former or Maiden Name <input type="checkbox"/> Professional Name <input type="checkbox"/> Other (Describe): If yes, please enter name(s) here:			
	Are you a U.S. citizen? <input type="checkbox"/> Y <input type="checkbox"/> N If no, do you have legal status and work privileges in the U.S.? <input type="checkbox"/> Y <input type="checkbox"/> N (If yes, attach verification.)			
	Main Practice Street Address			
	Practice City	State	Zip Code	
	Parish/County	Parish/County Code	State Status <input type="checkbox"/> In (0) <input type="checkbox"/> Out (1)	Location Type <input type="checkbox"/> Urban (1) <input type="checkbox"/> Rural (2)
	License #			
	Do you currently hold (or have in the past held) a professional license in this or any other state? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, list the state, type of license, and license numbers. If necessary, attach additional page:			
Medicare Number (Legacy) (optional)	Date of Birth	UPIN (if known)	Board Certification # (optional)	

B	Pay-To Name and Mailing Address		Provider Pay-To Name (MUST match the first line on the IRS document EXACTLY)		IRS Reporting #
	Provider Mailing Address	Provider Mailing City	Provider Mailing State	Provider Mailing Zip Code	
	Attn or Other (Optional)	Provider Year-End Date (optional)	Type 2 Organizational NPI (required if you have one):		

C	Contact Information		The following person may be contacted for additional information regarding this enrollment application:		
	Contact Name:				
	Contact Phone # ()	Contact Fax #			
Contact email:					

D	Provider Attestation of Information			
	I, the undersigned, certify the following			
	<ol style="list-style-type: none"> 1. I have read the contents of this enrollment packet including the PE-50 Addendum and the information contained herein is true, correct, and complete; 2. I understand that it is my responsibility to maintain current information on the Louisiana Medicaid files and failure to do so may result in delayed payments or closure of the Medicaid Provider Number; 3. I am the individual named in Section A and I legally bind into this agreement through my signature below; and 4. I understand that the Louisiana Medicaid files will be updated with information supplied on these forms. <p style="text-align: center;">Use colored ink (not black) to eliminate the concern of copied signatures.</p>			
Print the Name of the Individual Provider		Individual Provider's Signature		Date of Signature

PE-50 ADDENDUM – PROVIDER AGREEMENT

Provider Name _____

I, the undersigned, certify and agree to the following:

Enrollment in Louisiana Medicaid

1. I have read the contents of this Louisiana Medical Assistance Program Enrollment Packet and the information supplied herein is true, correct and complete;
2. I understand that it is my responsibility to ensure that all information is kept up to date on the Louisiana Medicaid Provider File;
3. I understand that failure to maintain current information may result in payments being delayed or closure of my Medicaid provider number;
4. I understand that if my number is closed due to inaccurate information, I will have to complete a new enrollment packet in its entirety to reactivate my provider number;
5. I attest that I am a U.S. citizen or that I have legal status and work privilege in the U.S.
6. I understand that it is my responsibility to ensure that all my employees and/or authorized representatives are U.S. citizens or have legal status and work privilege in the U.S.
7. I understand that it is my responsibility to ensure that neither I, nor any owner(s), manager(s), employee(s), agent(s) or affiliate(s) are not now or have ever been:
 - denied enrollment;
 - suspended, or excluded from Medicare, Medicaid or other Health Care Programs in any state;
 - employed by a corporation, business, or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or other Health Care Programs in any state;
 - convicted of any crimes.

I will report any of the above conditions to Program Integrity at the Department of Health and Hospitals prior to enrolling in Louisiana Medicaid or upon discovery once enrolled.

8. I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, the Social Security Numbers of any owner(s), manager(s), and board of directors, etc., must be provided.
 - I understand that failure to provide the Social Security Numbers will result in the rejection of my enrollment or re-enrollment request.

Providing Services to Louisiana Medicaid Recipients

9. I agree to conduct my activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL Louisiana R.S. Title 46, Chapter 3, Part VI-A) as required to protect the fiscal and programmatic integrity of the medical assistance programs;
10. I understand that services and/or supplies provided by me must be medically necessary and medically appropriate for each individual patient based on needs presented on the date the service is provided and/or delivered;
11. I agree to charge no more for services to eligible recipients than is charged on the average for similar services to others;
12. I understand that as the provider I am held responsible for any and all claims submitted under any Louisiana Medicaid provider number issued to me;
13. I agree to maintain all records necessary for full disclosure of services provided to individuals under the program and to furnish information regarding those records as well as payments claimed/received for providing such services that the State Agency, the DHH Secretary, the Louisiana Attorney General, or the Medicaid Fraud Control Unit may request for five years from the date of service;
14. I agree to report and refund any discovered overpayments;
15. I agree to participate as a provider of medical services and shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by me as a Medicaid patient. I agree to accept a client's Medicaid card as payment in full for covered services rendered. I agree to bill Medicaid for **all** services covered by Medicaid that will be provided to eligible Medicaid clients;
16. I agree to accept Medicaid payment for covered services as payment in full and not seek additional payment from any recipient for any unpaid portion of a bill, with the exception of state-funded spend-down Medically Needy recipients as indicated by the agency's form 110-MNP or any recipient co-payments as established by the DHH;
17. I agree to adhere to the published regulations of the Department of Health and Hospitals (DHH) Secretary and the Bureau of Health Services Financing, including, but not limited to, those rules regarding recoupment and disclosure requirements as specified in 42 CFR 455, Subpart B;
18. I agree to adhere to the federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the federal Department of Health and Human Services, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA;

-- continued --

19. I understand the Louisiana Medicaid Program must comply with Department of Health and Human Services (DHHS) regulations promulgated under Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; and the American Disabilities Act of 1990 which require that:
- No person in the United States shall be excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of age, color, handicap, national origin, race or sex under any program or activity receiving Federal financial assistance.

Under these requirements, Louisiana's Department of Health and Hospitals, Bureau of Health Services Financing cannot pay for medical care or services unless such care and services are provided without discrimination based on age, color, handicap, national origin, race or sex. Written complaints of non-compliance should be directed to Secretary, Department of Health and Hospitals, PO Box 91030, Baton Rouge, LA 70821-9030 or DHHS Secretary, Washington, DC or both.

20. The Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a)(68) of the Social Security Act, set forth in that subsection and as the Secretary of the US Department of Health and Human Services may specify. As an enrolled provider/entity, it is your obligation to inform all of your employees and affiliates of the provisions of the Federal False Claims Act, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. When monitored or audited, you will be required to show evidence of compliance with this requirement.

Medicaid Direct Deposit (EFT) Authorization Agreement

21. I have reviewed the Medicaid Direct Deposit (EFT) Authorization Agreement and the Medicaid Provider Requirements and Conditions as listed below and agree to this agreement:
- I understand that payment and satisfaction of any claims will be from Federal and State Funds; and any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.
 - I understand that DHH may revoke this authorization at any time.
 - I hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account and the depository name referenced on the EFT Authorization Agreement form. These credits will pertain only to direct deposit transfer payments that the payee has rendered for Medicaid services.
 - I certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature below is authorized by the stated Board of Directors to enter into or change this agreement.
 - I agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I further understand that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility and failure to notify the Provider Enrollment Unit as noted may result in Medicaid payments being electronically transmitted to incorrect accounts. I understand that such changes may not be able to be accommodated if less than 15 business days notice is given.

Certification of Claims (Paper & Electronic)

22. I certify that all claims provided to Louisiana Medicaid recipients will be necessary, medically needed and will be rendered by me or under my personal supervision;
23. I understand that all claims submitted to Louisiana Medicaid will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws;
24. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate, and complete.

Print Name of Individual Provider

Signature of Individual Provider

Date of Signature

LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

INSTRUCTIONS

1. Medicaid Provider Number: Enter your **FULL 7-DIGIT** Louisiana Medicaid Provider Number, if known
(Only one provider number per form)
2. National Provider Identifier (NPI) Enter the 10-digit National Provider Identifier
3. Name of Individual Enrolling: Enter the name of the individual to enroll as a Louisiana Medicaid Provider
4. Contact Person Enter the name of the person designated as the contact for Medicaid direct deposit issues on behalf of the provider. **Not a bank representative.**
5. Contact Person's Phone Number: Enter the phone number through which we may contact the individual listed in number 4 above.
6. Account Type Check the appropriate block (only one) to indicate the type of account
(savings or checking only) to which the direct deposit will be transferred.
7. Reason for Change in Account Information For a new enrollment, leave as is.
8. Country of Bank Circle "Y" if the account is from a bank located in the United States; circle "N" if the bank is not located in the U.S.

If "N" is specified, enter the name of the country in which the bank is located.
9. Voided Check: Tape a copy of a voided check showing the ABA routing number and account number. *Deposit slips are not accepted.* If a voided check is unavailable, a letter on bank letterhead identifying the name associated with the account, the ABA routing number, the account number, and the type of account may be substituted.
10. Print Name of Individual Enrolling Plainly print the name of the individual enrolling.
11. Signature of Individual Enrolling and Date Sign the form and enter the date the form was signed. **ORIGINAL SIGNATURES ONLY; NO STAMPS OR COPIED SIGNATURES WILL BE ACCEPTED. INDIVIDUAL PROVIDERS MUST SIGN THEIR OWN FORMS. (BLUE OR COLORED INK PREFERRED – NOT BLACK INK).**

Please be sure to complete this form in its entirety. It will not be accepted for processing and will be returned to you if any field is incomplete.

**INDIVIDUAL
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT**

1. Medicaid Provider Number (7 digits)

--	--	--	--	--	--	--

2. National Provider Identifier (NPI) (10 digits)

--	--	--	--	--	--	--	--	--	--

3. Name of Individual Enrolling: _____

4. Contact Person: _____

5. Contact Person's Phone Number: _____

ACCOUNT INFORMATION
(All fields must be completed)

6. Account Type: *(Check One)*
 CHECKING SAVINGS

7. Reason for change in account information:

8. Is the account identified below located in the United States? Y N

8a. If No, please identify the country of location. _____

9. Attach Copy of Voided Check (Deposit Slips are not Acceptable)

**If Change of Ownership (CHOW) occurred, an entire enrollment packet is required.
Direct Deposit Info is not to be updated before the CHOW is processed.**

**TAPE COPY OF VOIDED CHECK HERE – NO STAPLES
DEPOSIT SLIPS ARE NOT ACCEPTED**

**** To avoid interruption in payment, DO NOT close current account with the bank until a new direct deposit form has been processed.**

If a voided check is unavailable, you may submit a letter on Bank Letterhead identifying the name associated with the account, the ABA Routing Number and the Account Number. The letter must be signed by a Bank Representative.

*** Attach a voided check (deposit slip not acceptable) showing account number and routing (ABA) number.** Original signature required (stamped signature or initials not accepted).

- I understand that payment and satisfaction of this claim will be from Federal and State Funds and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws. I understand that DHH may revoke this authorization at any time.
- I hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account and depository named above. These credits will pertain **only to direct deposit transfer payments** that the payee has rendered for Medicaid services.
- I certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature below is authorized by the stated Board of Directors to enter into this agreement.
- I agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I further understand that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility and failure to notify the Provider Enrollment Unit as noted may result in Medicaid payments being electronically transmitted to incorrect accounts. I understand that such changes may not be able to be accommodated if less than 15 business days notice is given.

10. Print Name of Individual Enrolling

11. Signature of Individual Enrolling

Date

BE SURE THAT ALL FIELDS ARE COMPLETED

Louisiana Medicaid Ownership Disclosure Information

Please note: It is recommended that the Internet be used to report ownership information instead of filling out the two-page form that follows.

- **Using the Provider Ownership Enrollment web application to report ownership data eliminates rejection of enrollment application due to improperly reported ownership data.**

To use the Provider Ownership Enrollment web application, please go to www.lamedicaid.com and click on the “Provider Enrollment” link on the left-hand sidebar. Then click on the “Applications for New Enrollments, Reactivations, and Change of Ownership” link.

- **If you use the web application to register ownership information, DO NOT complete or submit the next two pages.**

After reporting your ownership information on the Louisiana Medicaid web site, you must print and sign the signature page that the application provides for you, and submit the signature page along with the other enrollment documents identified on the appropriate checklist to:

**Molina Medicaid Solutions Provider Enrollment
P.O. Box 80159
Baton Rouge, LA 70898-0159**



Louisiana Medicaid Program

Disclosure of Ownership Information Form For Individuals

**Mail to:
Molina Medicaid Solutions
Provider Enrollment
P.O. Box 80159
Baton Rouge, LA 70898-0159**

(Forms are subject to change without notice)

**Reference Material for
Louisiana Medicaid Ownership Disclosure Information
For an Individual**

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid Disclosure of Ownership form can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address: <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl>

1) Section 100 – Purpose:

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.1&idno=42>

2) Section 101 – Definitions:

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.2&idno=42>

3) Section 102 - Determination of ownership or control percentages:

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.3&idno=42>

4) Section 103 – State plan requirement

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.4&idno=42>

5) Section 104 – Disclosure by Medicaid providers: Information on ownership and control:

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.5&idno=42>

6) Section 105 - Disclosure by providers: Information related to business transactions:

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.6&idno=42>

7) Section 106 – Disclosure by providers: Information on persons convicted of crimes:

<http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.7&idno=42>

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (*Louisiana Register*, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: <http://www.law.cornell.edu/uscode/42/1320a-3.html>

Social Security Act 1128 a: http://www.ssa.gov/OP_Home/ssact/title11/1128A.htm

MAPIL Louisiana R.S., Title 46:437.1-14. <http://www.legis.state.la.us/lss/lss.asp?doc=100852>

Louisiana Register, Vol. 29, No. 4, April 20, 2003: <http://www.doa.louisiana.gov/osr/reg/register.htm>

Louisiana Update January/February 2009: http://www.lamedicaid.com/ProviderUpdate/provider_update0109.pdf

Instructions for Louisiana Medicaid Ownership Disclosure Information Individual

This is a multi-page form. All of the pages must be completely filled out and submitted or the application cannot be accepted. Please review the instructions in their entirety before completing the form. The following fields MUST be completed:

Note: Please enter your Provider Name at the top of each page which provides a space for that purpose.

SECTION I – ENROLLING INDIVIDUAL INFORMATION

Please read the provided information regarding disclosure, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL). **Louisiana Medicaid Provider Number** – Enter your seven- (7) digit Medicaid provider number. If this application is for a new Medicaid provider number, leave this field blank.

NPI Type 1 – Individual (10 digits) – Enter your 10-digit Type 1 (Individual) National Provider Identifier (NPI). This number can be obtained by going to <https://nppes.cms.hhs.gov>

Taxonomy/Tie Breaker, if applicable – Enter your Taxonomy Code or your ZIP+4 Tie Breaker, if necessary.

NPI Type 2 – Organizational, if applicable (10 digits) – Enter your 10-digit Type 2 (Organizational) NPI, if necessary.

Tax ID Number (only if self-incorporated) – Enter the 9 digit Tax ID number for this self-incorporated provider. If not self-incorporated, leave blank.

SS# of Individual: - Enter SS# of individual - **Notice Regarding Disclosure of Social Security Numbers: As part of the application for enrollment in Louisiana Medicaid, social security numbers are required for each individual with Direct or Indirect Ownership or Control Interest of 5% or more, each individual Corporate Officer, Director, Partner or Shareholder, and each individual Managing Employee or Agent who exercises operation or managerial control or who directly or indirectly manages the conduct of day to day operations, pursuant to Louisiana Medicaid rules and regulations and 42 U.S.C. § 1320a-3. Social security numbers are required and the application will be returned if the social security numbers are not reported.**

Date of Birth – Enter the date of birth of the enrolling person in the space provided.

This enrollment packet is for a – Check the appropriate box from among New Enrollment, Currently Enrolled, or Re-Enroll.

Provider Type – enter the Louisiana Medicaid Provider Type for this Individual.

Enrolling Individual Provider Information – Enter the First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Doing Business As Name (if self-incorporated) and the Telephone Number(s) of Enrolling Individual in the spaces provided. Enter the Practice Street Location Address and the Email Address(es) in the spaces provided.

Is the enrolling individual a U.S. citizen? – Check the Yes box or the No box.

SECTION II – ENROLLING INDIVIDUAL ADDITIONAL INFORMATION

Has the enrolling individual listed in Section I ever:

- Held a professional license in any state other than Louisiana?** – Check the Yes box or the No box. If yes, list the state(s) and Professional License Numbers in the spaces provided.
- Practiced as a Medicare/Medicaid healthcare provider in any state other than Louisiana?** – Check the Yes box or the No box. If yes, list the state(s), Medicare Provider Numbers, and the Medicaid Provider Numbers in the spaces provided.
- Used or been known by any incorporated or Doing Business As (DBA) names?** – Check the Yes box or the No box. If yes, list all names and Tax IDs in the spaces provided.
- Used or been known by any other name including married, maiden, hyphenated, or alias?** – Check the Yes box or the No box. If yes, enter the names in the spaces provided.

SECTION III – ENROLLING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

A. - C. Read all questions carefully and respond by checking the appropriate boxes. If yes to any question, attach or list the required documentation, as directed.

SECTION IV – ENROLLMENT IN HEALTHCARE PROGRAMS

Is the Social Security Number and/or Tax ID number(s) in Section I currently enrolled in any other Federal/State funded healthcare programs? – Check the Yes box or the No box. If yes, check off the plans and, in the spaces provided, enter the DBA Name(s), Tax ID(s), and Louisiana Plan Number(s), and State/ID#(s) for enrollments in other states.

SECTION V – OWNERSHIP IN ENTITIES/BUSINESSES ENROLLED IN GOVERNMENT FUNDED HEALTHCARE PROGRAMS

Does the enrolling individual have any direct, indirect or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in Federal/State funded healthcare programs? – Check the Yes box or the No box. If yes, check off the plans and list the DBA Name(s), the Tax ID(s), the Social Security Number(s), and the Plan Number(s) in the spaces provided.

SECTION VI – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

Enter the First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Telephone Number(s) of the person preparing the Disclosure of Ownership in the spaces provided. Enter the street Address and the Email Address in the spaces provided. Optionally, enter additional telephone number(s) and email address(es) in the spaces provided.

SECTION VII – INFORMATION ON EACH MANAGER/AGENT

Carefully read the Louisiana Medicaid policy statements and definitions of managers/agents so that you can properly fill out Section VII.

Does this enrolling individual as a self-incorporated health entity/business employ Managers/Agents? – Check on the Yes Box or the No Box. If yes, make one photocopy of Section VII for each manager/agent you report. If no, proceed to Section VIII.

MANAGER – or – AGENT – Check on a box to specify whether the person is a Manager or an Agent. Enter the Title or Job Position, the Social Security Number, the First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable) in the spaces provided.

Is this individual with management/agent duties a U.S. citizen? – Check on the Yes box or the No box. Enter the current address of the manager/agent in the spaces provided. Enter the Telephone Number and the Date of Birth in the spaces provided.

A-C. Has the manager/agent named above ever – Read the questions carefully and check the Yes box or No box. If yes to any question, attached the requested documentation.

D. Used or been known by any other name including married, maiden, hyphenated, or alias? – Check the Yes box or the No box. If yes, enter the name(s) in the spaces provided.

E. Does this manager/agent have ownership or controlling interest in any other entity currently participating in a Federal/State funded healthcare program? – Check the Yes box or the No box. If yes, check off the plans and list the DBA Name(s), State(s) and Plan Number(s).

F. Does this manager/agent reside out-of-state (not in Louisiana)? – Check the Yes or No box. If yes, has this out-of-state manager/agent been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes or No Box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided.

SECTION VIII – SUBCONTRACTOR INFORMATION

Read Federal Regulations 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2). Read Section VII carefully, as you are entering into an agreement with the Louisiana Department of Health and Hospitals by which you agree to and may be requested to provide the specified subcontractor information.

SECTION IX – PROVIDER SIGNATURE

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date.

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION INDIVIDUAL

Under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(a) (1), (2).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(a)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest. *(See Federal Regulations 42 CFR § 455.104(a) (3)* http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html

In addition, Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (**MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A**) and Administrative Rules, (*Louisiana Register, Vol. 29, No. 4, April 20, 2003*), as well as **Louisiana Provider Update January/February 2009** (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers.

SECTION I – ENROLLING INDIVIDUAL INFORMATION

Louisiana Medicaid Provider Number (7 digits) (Leave blank if applying for new number)	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 14.28%;"></td> <td style="width: 14.28%;"></td> <td style="width: 14.28%;"></td> <td style="width: 14.28%;"></td> <td style="width: 14.28%;"></td> <td style="width: 14.28%;"></td> <td style="width: 14.28%;"></td> <td style="width: 14.28%;"></td> </tr> </table>										
NPI Type 1 – Individual (10 digits)	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>										
Taxonomy/Tie Breaker, if applicable	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>										
NPI Type 2 – Organizational, if applicable (10 digits)	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>										
Tax ID Number (only if self-incorporated)	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>										
SS# of Individual (Required)	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>										
Date of Birth (Required)	<table border="1" style="width: 100%; height: 25px; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%; text-align: center;">/</td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%; text-align: center;">/</td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td><td style="width: 10%;"></td> </tr> </table>			/			/				
		/			/						

This enrollment packet is for a <input type="checkbox"/> New Enrollment <input type="checkbox"/> Currently Enrolled <input type="checkbox"/> Re-Enroll	Provider Type:
---	-----------------------

ENROLLING INDIVIDUAL PROVIDER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Doing Business As			Telephone Number(s) of Enrolling Individual		
Practice Street Location Address			City	State	Zip
Email Address to receive official DHH Notices			Fax Number		Provider's telephone number to request medical records
			-	-	-
Is the enrolling individual a U.S. Citizen?			<input type="checkbox"/> Yes <input type="checkbox"/> No		

Provider Name: _____

SECTION II – ENROLLING INDIVIDUAL ADDITIONAL INFORMATION

Has the enrolling individual listed in Section I ever:

A. Held a professional license in any state other than Louisiana? Yes No

B. Practiced as a Medicare/Medicaid healthcare provider in any state other than Louisiana? Yes No

If you answered yes to questions A or B, please list the state(s), Medicare/Medicaid provider numbers, and Professional License Number(s) below:

1. Domicile State:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #:
2. Domicile State:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #:
3. Domicile State:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #:

C. Used or been known by any incorporated or Doing Business As (DBA) names? Yes No

If yes, list all names and Tax IDs below:

1. DBA Name	Legal Name	Tax ID
2. DBA Name	Legal Name	Tax ID
3. DBA Name	Legal Name	Tax ID

D. Used or been known by any other name including married, maiden, hyphenated, or alias? Yes No

If yes, enter name(s) below:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

SECTION III – ENROLLING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Has the enrolling individual listed in Section I ever:

A. Been convicted of a healthcare related felony or any other criminal offense, State and/or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? Yes No

If yes, attach explanation details of conviction or plea, including date of occurrence and state in which conviction occurred. Court documentation required.

B. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification? Yes No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and state in which this action occurred, regarding the disciplinary action for all individuals/entities/agents/subcontractors, and/or businesses involved. Reinstatement letter required.

C. Been denied enrollment, suspended, terminated from participation, or excluded from Medicare, Medicaid or other healthcare program in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been suspended, terminated from participation or excluded from Medicare, Medicaid or other healthcare program in any state or U.S. Territory? Yes No

If yes, attach documents (notice of enrollment rejection, suspension, termination from participation, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals/entities/businesses involved. Reinstatement letter required.

Provider Name: _____

SECTION IV – ENROLLMENT IN HEALTHCARE PROGRAMS

Is the Social Security Number and/or Tax ID number(s) in Section I currently enrolled in any other Federal/State funded healthcare programs? Yes No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s), Social Security Number(s), and the plan number(s):

Plan	Doing Business As (DBA) Name	Tax ID and SSN	Plan Numbers for Louisiana Enrollments	Plan Numbers for Other State Enrollments	
				State	ID#
<input type="checkbox"/> Medicaid					
<input type="checkbox"/> Medicare Part A					
<input type="checkbox"/> Medicare Part B					
<input type="checkbox"/> Medicare Part C					
<input type="checkbox"/> Medicare Part D (Pharmacies only)					
<input type="checkbox"/> CHAMPUS					
<input type="checkbox"/> Other Government Funded Program					

SECTION V – OWNERSHIP IN ENTITIES/BUSINESS ENROLLED IN GOVERNMENT FUNDED HEALTHCARE PROGRAMS

Does the enrolling individual have any direct, indirect or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in Federal/State funded healthcare programs? Yes No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s), Social Security Number(s) and all the plan number(s):

Plan	Doing Business As (DBA) Name	Tax ID and SSN	Plan Numbers for Louisiana Enrollments	Plan Numbers for Other State Enrollments	
				State	ID#
<input type="checkbox"/> Louisiana Medicaid					
<input type="checkbox"/> Medicare Part A					
<input type="checkbox"/> Medicare Part B					
<input type="checkbox"/> Medicare Part C					
<input type="checkbox"/> Medicare Part D (Pharmacies only)					
<input type="checkbox"/> CHAMPUS					
<input type="checkbox"/> Other Government Funded Program					

Provider Name: _____

SECTION VI – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Social Security Number		Date of Birth	Job Title		
The person completing this form is (please check one): <input type="checkbox"/> Self <input type="checkbox"/> Staff <input type="checkbox"/> Third Party/Independent Agent <input type="checkbox"/> Other (explain) _____					
Address		City	State	Zip	
Telephone Number(s)		Email Address(es)			
Additional Telephone Number(s)		Additional Email Address(es)			

**Please Read before proceeding to
Section VII – Management/Agent Information:**

Be sure to make a photocopy of the following form (Section VII – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT) before you fill it out the first time; you need one page for each manager/agent. If you have a five-person management team, you need to submit five completed Section VII forms. You may NOT submit a list of names; each manager/agent must be reported with a full page of information (no attachments – use the form provided).

Section VII seeks to identify the management structure of this enrolling individual.

Manager– defined under 42 §CFR 455.101 as “a general manger, business manager/agent, administrator, director, or other individual who exercises operational or manager/agential control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency”.

Agent - Defined under 42 §CFR 455.101 as any person who has been delegated the authority to obligate or act on behalf of a provider.

Medicaid requires that an enrolling individual fully disclose **ALL** persons that provide management expertise to the enrolling individual.

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Manager/agent
- Officer
- Trustee

When reporting a name, use the individual’s FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or *Jenny Rae Jones-Smith*, not *J.R. Jones-Smith* or *Jenny Jones-Smith*.

These lists are not all-conclusive, and other activities that imply or assume similar powers or responsibilities may apply.

Provider Name: _____

SECTION VII – INFORMATION ON EACH MANAGER/AGENT
(Copy and complete a separate form for each manager/agent.)

Does this enrolling individual employ any Managers/Agents? Yes No
If yes, complete the following information for each manager/agent.
If no, proceed to the next Section.

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

In addition, Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (**MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A**) and Administrative Rules, (**Louisiana Register, Vol. 29, No. 4, April 20, 2003**), as well as **Louisiana Provider Update January/February 2009** (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, to furnish social security numbers.

<input type="checkbox"/> MANAGER – or –		Title/Job Position within this entity/business			Social Security Number (required)	
<input type="checkbox"/> AGENT						
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)	
Is this individual with management/agent duties a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Current Address of Manager/Agent						
City						
State		Email Address				
Zip Code	Telephone Number		Date of Birth (required)			
				/	/	

Has the manager/agent named above ever:

A. Been convicted of a healthcare related felony or any other criminal offense, State or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? Court documentation required. Yes No

If yes, attach explanation of conviction or plea, including date of conviction and state in which it occurred

B. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification? Yes No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and State in which this action occurred, regarding the disciplinary action for each individual/entity/agent/subcontractor, managing employees/businesses involved. Reinstatement letter required.

C. Been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, terminated, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? Yes No

If yes, attach documents (notice of enrollment rejection, suspension, termination from participation, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals/entities/businesses involved. Reinstatement letter required.

Provider Name: _____

Manager/Agent Name: _____

D. Used or been known by any other name including married, maiden, hyphenated, or alias? Yes No

If yes, enter name(s) below:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

E. Does this manager/agent have ownership or controlling interest in any other entity currently participating in a Federal/State Funded healthcare program? Yes No

If yes, check off the plans, list the DBA Name(s), and list Plan Numbers.

Plan	Name or DBA of Entity/Business	Plan Numbers for Louisiana Enrollments	Plan Numbers for Other State Enrollments	
			State	ID#
<input type="checkbox"/> Medicaid				
<input type="checkbox"/> Medicare Part A				
<input type="checkbox"/> Medicare Part B				
<input type="checkbox"/> Medicare Part C				
<input type="checkbox"/> Medicare Part D (Pharmacies only)				
<input type="checkbox"/> CHAMPUS				
<input type="checkbox"/> Other Government Funded Program				

F. Does this manager/agent reside out-of-state (not in Louisiana?) Yes No

If yes, has this out-of-state manager/agent been issued any Medicaid or Medicare provider numbers by the domicile state? Yes No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:
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SECTION VIII – SUBCONTRACTOR INFORMATION

DEFINITIONS:

Subcontractor-

1. An individual, agency or organization that you have:
 - a. contracted with or
 - b. delegated some of your management functions or responsibilities of providing medical care to your patients.

– or –

2. An individual, agency or organization with which you have entered into a contract, agreement, purchase order, or lease to obtain:
 - a. equipment,
 - b. supplies,
 - c. space, including real estate, or
 - d. services provided under the Medicaid agreement.

Wholly Owned Supplier-

A supplier (i.e., an individual, agency or organization from which a Medicaid provider purchases goods and services used in carrying out its responsibilities under Medicaid, e.g., a commercial laundry, manufacturer of hospital beds, pharmaceutical firm) whose total ownership interest is held by a Medicaid provider or by a person, persons, or other entity with an ownership or control interest in a Medicaid provider.

Provider Name: _____

SECTION VIII – SUBCONTRACTOR INFORMATION

Subcontractor information may be found in Federal Regulations 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2)

Pursuant to 42 CFR § 455.105, by enrolling in the Medicaid program, you are entering into an agreement with the Louisiana Department of Health and Hospitals by which you agree to and may be requested to provide the following information within 35 calendar days within the date of the request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have had business transactions totaling more than \$25,000 during the 12 month period ending on the date of the request; and
2. Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor, during the 5 year period ending on the date of the request.
3. Any wholly owned supplier or subcontractor with which the entity had significant business transactions of \$75,000 or more, within the past 5 years.

Louisiana State Medicaid regulations allow the Department 90 calendar days after receipt of a complete application to determine whether to enroll an applicant in the program.

Provider Name: _____

SECTION IX – PROVIDER SIGNATURE

With my signature below, I attest:

1. That I have disclosed all necessary information;
2. That I am the individual identified in Section I and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That I have reviewed the information on this Individual Disclosure form and attest that it is true, accurate and complete;
4. That I understand that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana’s Medicaid Program, or where the individual already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That I understand that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana’s Medicaid Program;
6. That I understand that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable federal or state laws;
7. That I understand it is my responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That I understand that the failure to maintain current and correct information may result in payments being delayed or closure of my Medicaid provider number;
9. That I understand if my number is closed due to inaccurate information, I will have to complete a new Provider Enrollment Packet in its entirety to reactivate my provider number;
10. I understand that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(a) (1), (2).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(a)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, I must provide Social Security numbers for each of the following persons:
 - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
 - All Individuals acting as Board of Director;
 - All Individual Corporate Officers, Directors, Partners, or Shareholders;
 - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US and I understand that it is my responsibility to ensure that all my managers, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
13. I understand that it my responsibility to ensure that I have disclosed on this form if I, or any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Manager, Employee, Agent or Affiliate, have ever:
 - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
 - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
 - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
 - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
 - been convicted of any crimes.
14. I understand that I shall report any of the above conditions to the Department of Health and Hospitals (DHH), and once enrolled, I understand that upon discovery of any of the above conditions, it is my responsibility to report them immediately in writing to DHH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
15. I understand if I answered “Yes” to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any federally funded healthcare program, I am required to submit this information and the requested documentation.
16. I understand that I am being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled “Unauthorized participation in medical assistance programs.” I understand that this criminal statute means that if I, or any managers, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or been terminated from participation in the Medicare, Medicaid, or any other Federally or State Funded Healthcare Program, it is a crime to “participate” in any medical assistance program.
17. I also understand that “participation” includes providing any services which will be billed, directly or indirectly, to Medicaid, and “participation” also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to Louisiana’s Medicaid Program;
18. I also understand that this new crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of \$20,000.00; and
19. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Please sign in colored ink (not black)

Print Name of Individual Provider

Signature of Provider

Date of Signature

**Individual
Louisiana's Medicaid Program**

**INSTRUCTIONS FOR PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA
INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE
PROGRAM**

Prior to submitting electronic claims to Louisiana Medicaid, a seven-digit submit number (450XXXX) must be obtained from the Molina Medicaid Solutions Provider Enrollment Unit. The submitter number must be linked to all provider numbers for whom claims will be submitted.

The following form(s) is (are) to be completed if the individual enrolling at this time plans to submit claims electronically to Louisiana Medicaid.

EDI Contract

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Molina Medicaid Solutions. (Leave blank if applying for a new Provider Number.)

National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.

Name of Individual Enrolling – enter the name of the individual enrolling or the provider name associated with the Provider Number and NPI listed above.

Name of Contact Person – enter the name of the person designated as the point of contact for questions regarding this request.

Contact Phone Number – enter the phone number of the Contact Person.

Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)

Billing Agent / Submitter Business Name – enter the business name of the billing / submitter agent.

Signature of Provider – enter the individual provider's signature. Note: The provider must sign the form, not an authorized representative or other agent.

Date of Signature – enter the date the provider signed the form.

EDI Power of Attorney

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Molina Medicaid Solutions. (Leave blank if applying for a new provider number.)

National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.

Name of Individual Enrolling – enter the name of the individual enrolling or the provider name associated with the Provider Number and NPI listed above.

Practice Street Address – enter the business location address of the provider name entered.

Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)

Billing Agent / Submitter Business Name – enter the business name of the billing / submitter agent.

Billing / Submitter Agent Contact Person – enter the name of the person designated as the point of contact for the Billing / Submitter Agent business.

Billing / Submitter Phone Number – enter the phone number of the Billing / Submitter Agent contact person.

Enter the Parish (or County) Name where the Notary Public is located

Enter City, State and Date of Notarization

Signature of Provider – enter the individual provider's signature. Note: The provider must sign the form, not an authorized representative or other agent.

Notary Public Signature – the Notary Public should sign the form and affix his/her seal.

If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized. Please complete the enclosed Limited Power of Attorney in its entirety to be mailed with your completed EDI Contract.

**PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS
FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM
(EDI CONTRACT FOR INDIVIDUALS)**

**PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS
FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM
(EDI CONTRACT FOR INDIVIDUALS)**

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Louisiana Medicaid Provider Number (7 digits)

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National Provider Identifier (NPI) (10 digits)

Name of Individual Enrolling:

Name of Contact Person:

Contact Phone Number:

4	5	0					
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Submitter Number (7 digits)
(leave blank if applying for new number)

Billing Agent/ Submitter Name / Name of Business that will be submitting claims
(provider name or third party biller's name):

The Medicaid File can hold a maximum of three Submitter Numbers per Medicaid Provider Number at any one time. Current policy is to close old Submitter Numbers as new ones are opened unless otherwise requested by the provider. It is also vital to identify which Submitter Number will be designated to download the Electronic Remittance Advices (ERA).

In order for Louisiana Medicaid to gather this information, complete the following, if applicable:

When a new Submitter Number is issued, it will be set up to retrieve ERAs. If a previously assigned Submitter Number is to be used to retrieve ERAs, then place it in the spaces provided below.

4	5	0					
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By checking this box you are giving authorization to have 835s produced for the Individual listed above and available for download by either this new submitter number or the previously assigned submitter number.

List other Submitter Number(s) that are currently on file which will NOT be used for 835 ERA, but which need to remain open in the spaces below:

4	5	0					
4	5	0					

I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to submit my own claims electronically to Louisiana Medicaid.

I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to use a Third Party (Clearinghouse, Billing Agent, Submitter, etc.) to submit my claims electronically to Louisiana Medicaid. **(Power of Attorney form is required.)**

- On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 16 below. This is done in consideration for the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing's (hereinafter referred to as "State Agency") processing of provider claims, as well as other valuable considerations.
- All published specifications set forth shall be met as to every entry sought to be processed. The effective date for my EDI submission will be set by Provider Enrollment once the contract has processed.

Provider Name: _____

3. The Provider, or his agent, shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers. The Provider's data processing agent for submission of medical assistance claims is stated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to the State Agency.
4. The Provider shall provide upon request of the Director of the State Agency any supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow charts, file descriptions, accounting procedures and the like.
5. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to submit electronic claims.
6. It is expressly understood that the State Agency or its Fiscal Intermediary (Molina Medicaid Solutions) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
7. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
8. The State Agency and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
9. The Provider agrees to submit to the State Agency, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
10. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
11. The Provider and the State Agency agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.
12. Further, for a period of five years, during the course of a federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested and produce such for examination and copying.
13. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify the State Agency's limited obligations as set in a certain Provider Agreement between the State Agency and the Provider.
14. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
15. I understand that all claims submitted under the conditions of this Agreement will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.
16. I attest that all information supplied with this Agreement is true, accurate and complete.
17. **Applicable to those receiving 835s:** I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information; payment information; and bank account information, provided by me and currently on file if enrolled in **Electronic Funds Transfer**, to the submitter identified above. This authorization will remain in effect until discontinued by written request or changed by a future request

Print the Name of the Individual Provider

Individual Provider's Signature

Date of Signature

**INDIVIDUAL
 MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY
 (EDI POWER OF ATTORNEY)**

This form is required by all providers who will have electronic claims submitted by a third party.

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4	5	0																									

BE IT KNOWN that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the Parish of _____, State of Louisiana, therein residing:

PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing / Submitter Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program the applicable claims for the provider type for magnetic tape, diskette, or telecommunication submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____,
 State of _____ on the _____ day of _____, 20____.

 Individual Provider Signature

 Notary Public Signature

 Print the Name of the Individual Provider

<p><i>Notary Seal or Notary Identification Number (required)</i></p>
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