



# **PROVODER TYPE SPECIFIC PACKET/CHECKLIST**

**(Louisiana Medicaid)**

# **Assistive Devices**

**(Enrollment packet is subject to change without notice)**

## GENERAL INFORMATION FOR PROVIDER ENROLLMENT

Provider Enrollment works on a three-week turnaround time frame. If enrollment requirements are not met, the entire application will be returned for correction and would need to be re-submitted once the corrections are made. Any re-submission of the enrollment packet is subject to an additional three-week turnaround period.

The effective date for this enrollment will be the day the application is actually worked by Provider Enrollment.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be made to the provider regarding automatic closure.

OCDD Waiver Service Providers must submit additional documentation to be placed on what is called the Freedom of Choice listing. This documentation is to be downloaded from the web after receiving the letter confirming enrollment in Louisiana Medicaid. The additional documentation required is a Medicaid Freedom of Choice Request Form which is found on the DHH website at: <http://new.dhh.louisiana.gov/index.cfm/page/141>. (The link to this form is located just above the map of Louisiana).

Upon completion of the Medicaid enrollment process, all OAAS Waiver Service providers and some providers of other Medicaid services will automatically be added to a Freedom of Choice listing in a web-based program called Provider Locator Tool. This enables public users to search for Medicaid and/or Home and Community Based Service providers who accept Louisiana Medicaid.

If at any time during enrollment as an OAAS Community Choices Waiver Medicaid provider or OCCD Waiver Medicaid provider, the provider has a change of physical address, the provider must first obtain an updated license indicating the new address. The one year license renewal period begins over when a provider gets a new license because of a change of address. The provider must then submit notification of the change of address along with a copy of the new license to Molina Medicaid Solutions Provider Enrollment (see address on checklist, below). Failure to report a change of address, first to Health Standards and then to Molina Medicaid Solutions Provider Enrollment, will result in your agency being incorrectly listed on the Freedom of Choice list.

## NOTICE TO WAIVER SERVICE PROVIDERS

Please note that Louisiana Medicaid will only reimburse you for waiver services rendered to Medicaid recipients who are enrolled in a waiver program (New Opportunities Waiver (NOW), Children's Choice Waiver, Supports Waiver, Residential Options Waiver (ROW), Adult Day Health Care (ADHC) Waiver and Community Choices Waiver). Medicaid will not reimburse you for waiver services provided to recipients who are not enrolled in one of the waiver programs.

Providers enrolled as type 17 (Assistive Devices) are allowed to provide services in accordance with applicable rules, regulations, and policies under waiver programs as specified below:

- Assistive Devices / Medical Supplies to OCDD New Opportunities Wavier Recipients
- Assistive Technology / Specialized Medical Equipment to OCDD Residential Options Waiver Recipients
- Assessment for and Purchase of Assistive Technology, Devices, Medical Supplies by a Home Health agency for OAAS Community Choices Waiver Recipients

# ATTENTION!!

**Waiver service providers are required to comply with all requirements contained in:**

- 1. The provider manuals located at <http://www.lamedicaid.com>**
- 2. The information located on the DHH/OAAS website at <http://new.dhh.louisiana.gov/index.cfm/subhome/12/n/7>**
- 3. The information located on the DHH/OCDD website at <http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8>**

# OCDD Waiver Assistive Devices CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Assistive Devices provider. **NOTE: This checklist is NOT for use by Home Health Agencies that will provide Community Choices Waiver Assistive Devices and Medical Supplies.**

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/> *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	<p>4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. <b>(Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.)</b></p> <p><b>Option 1:</b> Provider Ownership Enrollment Web Application. Go to <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist.</p> <p><b>-or-</b></p> <p><b>Option 2:</b> If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.</p>
<input type="checkbox"/> *	5. <b>(If submitting claims electronically)</b> Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form <b>and</b> Power of Attorney Form (if applicable).
<input type="checkbox"/>	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited ( <b>deposit slips are not accepted</b> ).
<input type="checkbox"/>	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records ( <b>W-9 forms are not accepted</b> ).
<input type="checkbox"/>	<p>8. (A) Documentation on manufacturer's letterhead that the individual/business listed on the Louisiana Medicaid Enrollment Form and Addendum (PE-50) is:</p> <ul style="list-style-type: none"> <li>• Authorized to sell and install or has a contract with an agency to sell and install <ul style="list-style-type: none"> <li>○ Assistive Technology</li> <li>○ Specialized Equipment and Supplies</li> <li>○ or Devices for assistance with activities of daily living</li> </ul> </li> <li>• <b>and</b> Has training and experience with the application, use, fitting and repair of the equipment or devices which they propose to sell or repair</li> </ul> <p><b>-or-</b></p> <p>(B) For interpreters, verification is required that interpreter has completed a course or is otherwise recognized as qualified.</p>
<input type="checkbox"/>	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 91 (Assistive Devices).

\* These forms are available in the **Basic Enrollment Packet for Entities/Businesses**.

**PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS)**

Please submit all required documentation to:  
**Molina Medicaid Solutions Provider Enrollment Unit**  
**PO Box 80159**  
**Baton Rouge, LA 70898-0159**

# OAAS Community Choices Waiver Assistive Devices & Medical Supplies

## HOME HEALTH AGENCY'S CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an OAAS Community Choices Waiver Assistive Devices & Medical Supplies provider.

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/> *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. <b>(Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.)</b>  <b>Option 1:</b> Provider Ownership Enrollment Web Application. Go to <a href="http://www.lamedicaid.com">www.lamedicaid.com</a> and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist. <b>-or-</b> <b>Option 2:</b> If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.
<input type="checkbox"/> *	5. <b>(If submitting claims electronically)</b> Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form <b>and</b> Power of Attorney Form (if applicable).
<input type="checkbox"/>	6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited ( <b>deposit slips are not accepted</b> ).
<input type="checkbox"/>	7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records ( <b>W-9 forms are not accepted</b> ).
<input type="checkbox"/>	8. Copy of Home Health Agency license issued by Health Standards
<input type="checkbox"/> **	9. Completed and notarized "Provider Verification for OAAS Community Choices Waiver Assistive Devices and Medical Supplies Services" form.
<input type="checkbox"/>	10. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 91 (Assistive Devices).
<input type="checkbox"/>	11. To report "Sub-Specialty" for Home Health Agency to provide Community Choices Waiver Assistive Devices & Medical Supplies on Section A of the PE-50, please use Code 3U.

\* These forms are available in the **Basic Enrollment Packet for Entities/Businesses**.

\*\* This form is included here.

**PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT.**

**ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS)**

Please submit all required documentation to:  
**Molina Medicaid Solutions Provider Enrollment Unit**  
**PO Box 80159**  
**Baton Rouge, LA 70898-0159**

**Provider Verification for Community Choices Waiver  
Assistive Devices and Medical Supplies Services**

**PURPOSE**

This form confirms that the home health agency specified below wishes to provide Assistive Devices and Medical Supplies under the Community Choices Waiver program, and attests that the provider will conform to prior approval and reimbursement regulations and policies.

<b>Provider Number:</b>	<b>LA Medicaid Provider #</b> (leave blank if new applicant)	<b>National Provider Identifier (NPI)</b>
<b>Provider Name:</b>		
<b>Physical Address:</b>		
<b>Contact Person for questions regarding this form:</b>		
<b>Contact Person Phone Number:</b>	(       )       -	

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct; and
- that I can receive reimbursement for services provided only to those persons within the Community Choices Waiver; and
- that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare; and
- that failure to exhaust these above referenced third party payer sources may subject this/my Medicaid enrolled agency to recoupment of funds previously paid by Medicaid; and
- that all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered; and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

\_\_\_\_\_

Print Authorized Representative' Name      Signature of Authorized Representative      Date of Signature

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

\_\_\_\_\_

Notary Public Signature

Notary Seal or Notary Identification Number (required)

**Complete this form in its entirety. Original signature required – blue ink only**