



# **PROVIDER TYPE SPECIFIC PACKET/CHECKLIST**

**(Louisiana Medicaid Program)**

## **Physicians (Group)**

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

# GENERAL INFORMATION FOR THE PHYSICIAN GROUP PROVIDER TYPE

Two or more professionals working together, providing services for 20 or more hours per week, may enroll as a Physician Group with Louisiana Medicaid.

A combination of the following professionals may form or link to a Physician Group:

- Physicians
- Doctors of Osteopathy
- Physician Assistants
- Dentists
- Chiropractors
- Podiatrists
- Nurse Practitioners
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialists
- Audiologists

**Linkages of Professional Individuals to Groups** – a professional individual's provider number can be "linked" to a group provider number for purposes of billing as an attending provider for the specified group.

- **Open professional individual providers require only Group Link/Unlink and Working Relationship Form**
- **New, Inactive, or Closed professional individual providers require an entire enrollment application as well as the group Link/Unlink and Working Relationship Form.**

Claims submitted under the group number, with a professional 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.**

When a professional individual is linking to a group as an "attending only" (not being paid individually by Medicaid), then the EDI Contract, Direct Deposit Form, and voided check are not required for this individual.

Effective with date of service July 1, 2010, claims for services rendered to CommunityCare recipients from Physicians Groups or Nurse Practitioner Groups classified as Urgent Care Centers and Retail Convenient Care Clinics will no longer require the PCP's referral/authorization to be reimbursed by Medicaid. This requirement is being eliminated in order to facilitate access to after-hours medical care and reduce costs associated with Emergency Room utilization for non-emergent conditions.

- **Urgent Care Facilities** are those facilities with the primary function of providing unscheduled medical care to patients who require immediate attention for an illness or injury not serious enough for emergency room care. These facilities may NOT also serve as primary care providers, and are not enrolled in CommunityCare.
- **Retail Convenience Clinics** are facilities, located within a retail establishment (i.e. Walgreens, CVS, Wal-Mart), whose expressed primary function is to provide unscheduled medical care when access to primary care provider is not readily available to meet the health needs of the patient. These facilities may NOT serve as primary care providers, and are not enrolled in CommunityCare.

## Physicians – Group

### 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 a Physicians Group 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.
<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 online by choosing Option 1.)</b></p> <p><b>Option 1</b> (preferred): 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 style="text-align: center;">-or-</p> <p><b>Option 2</b> (not recommended): 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"/> **	8. Completed OFS Form 24, if applicable.
<input type="checkbox"/>	9. Copy of CLIA certificate, if applicable.
<input type="checkbox"/>	10. To report "Specialty" for this provider type on Section A of the PE-50, please use 70 (group).
<input type="checkbox"/>	11. <b>Urgent Care Facilities and Retail Convenience Clinics:</b> Use 7M for Retail Convenience Clinics or 7N for Urgent Care Clinics under "Subspecialty" in Section A of the PE-50 Enrollment Form. Please note that this designation will make your facility ineligible for participation as a CommunityCare Primary Care Provider.
<input type="checkbox"/> **	12. Completed Link/Unlink and Working Relationship Form for all currently-enrolled professional individuals to be linked to this group.
<input type="checkbox"/>	13. If the professional individuals being linked to this group are not currently enrolled in Louisiana Medicaid, then a full individual enrollment application is required for those individuals.

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

\*\*Forms are 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) – DO NOT SUBMIT COPIES OF THE ATTACHED FORMS.**

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

STATE OF LOUISIANA  
DEPARTMENT OF HEALTH AND HOSPITALS

Dear Provider:

It is the policy of the Bureau of Health Services Financing that the Medicaid Program will only pay for in-office performance of certain laboratory and diagnostic services which are billed by physicians if the following conditions are met:

1. The physician has completed and has on file with Louisiana State Medicaid Program, Provider Enrollment Unit a completed OFS Form 24.
2. The completed OFS Form 24 fully describes the laboratory or diagnostic equipment required to perform these tests.
3. The OFS Form 24 information is updated as needed.

Our policy towards laboratory or diagnostic services that are performed outside of a physician office remains unchanged. Physicians may not be reimbursed for laboratory or diagnostic services ordered for their patients if these services are performed outside of their office. Only the performer of a test may seek reimbursement for these services. Any interpretive service by the attending physician is reimbursed through the physician visit payment.

The OFS Form 24 requirements only pertain to: 1) those participating physicians who own or lease laboratory or diagnostic testing equipment that is located in their office or place of practice and 2) for which use the physician will be submitting a claim to the Medicaid program.

Example 1: Dr. Jones is an individual practitioner who owns or leases a SMA-12, EKG monitor and X-Ray equipment. Dr. Jones wishes to perform laboratory and diagnostic services on Medicaid patients in his office and bill the Medicaid Program for these laboratory or diagnostic services. Dr. Jones must complete the OFS Form 24.

Example 2: Drs. Smith, Jones, Doe, and Rae are a group practice. As a group they own or lease laboratory and diagnostic equipment. It is their desire to use this equipment in treating Medicaid recipients, and they will bill the Medicaid Program for these services. If each physician is individually enrolled in the Medicaid Program, each physician in the group must complete the OFS Form 24, even though the descriptive information will be identical. If the physicians are enrolling as a group, only one OFS Form 24 is required as long as all members of the group are indicated.

Example 3: An individual or group practitioner utilizes an external source for laboratory or diagnostic tests. The individual or group practitioner would not complete the OFS Form 24, as they would not bill the Medicaid Program directly.

A Louisiana OFS Form 24 is enclosed for completion and submittal where applicable. Return the completed form to:

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

Sincerely,

Provider Enrollment Unit

### Diagnostic and/or Laboratory Equipment

Provider Number (7 digits)

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

NPI (10 digits)

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

Provider Name:

---

Provider Address:

---

### Diagnostic and/or Laboratory Equipment

Make	Model	Serial #	Capabilities

List names of individuals who will be performing the diagnostic and/or laboratory tests in the spaces below:

--	--

I certify that the above is a true and accurate listing of diagnostic and/or laboratory equipment in my office.

Signature\*

Date

\* Acceptable signatures are as follows: individual professionals must sign their own forms. An authorized representative must sign for groups. Original provider signature is required (no stamps or initials)

**COPY PAGE IF ADDITIONAL SPACE IS NEEDED**

## Louisiana Medicaid Link/Unlink and Working Relationship Form

**PURPOSE**

This form is used when an individual provider is requesting to be linked to a Professional Group or Entity. The form permits Linkage/Unlinkage for two separate professional groups. When linking to a group, the estimated number of hours is required. The form also serves as documentation that a working relationship exists between an individual and a professional group. For this form to be valid, an **ORIGINAL SIGNATURE AND DATE ARE REQUIRED.**

Individual Provider Name:													
Individual Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> UNLINK	Termination Date:						
Approximate Number of Hours Worked at this Group Per Week, if linking. <b>(required)</b>													
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> UNLINK	Termination Date:						
Approximate Number of Hours Worked at this Group Per Week, if linking. <b>(required)</b>													
Contact Person for questions regarding this form:													
Contact Person Phone Number:		(            )            -											

**WORKING RELATIONSHIP AGREEMENT**

I am a medical professional who has a contractual agreement to see patients for the above named professional group(s). I have recorded the approximate number of hours to be worked at each group per week in the space(s) provided above. (I understand that upon request I must provide DHH a copy of the written contractual agreement.)

\_\_\_\_\_  
Print Individual Provider's Name

\_\_\_\_\_  
Individual Provider's Signature

\_\_\_\_\_  
Date

Original signature only – colored ink (please don't use black ink)

**Mail Completed Forms To: Molina Medicaid Solutions Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159**