ENROLLMENT PACKET FOR
THE LOUISIANA
MEDICAL ASSISTANCE PROGRAM
(Louisiana Medicaid)

Occupational Therapist
(Individual)

(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 additional three-week turnaround period.

The enrollment begin effective date for Occupational Therapists enrolling for ROW or Children’s Choice Waiver Therapy Services, only, will be the date the enrollment 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 the automatic closure.

After you receive your letter confirming your enrollment in Louisiana Medicaid as an OCDD Waiver provider, you must complete documentation to be added to the Freedom of Choice list. The Medicaid Freedom of Choice Request Form and instructions are located on the DHH website at:


Upon completion of the Medicaid enrollment process, 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.

**Occupational Therapy Assistants are not eligible to enroll in Louisiana Medicaid.**

- Individual Occupational Therapist providers may enroll in Louisiana Medicaid for:
  - Early Steps Provider (see PT 29 – Early Steps Provider Type Specific Checklist/Packet)
  - Medicare Crossover payments
  - Residential Options Waiver (ROW)
  - Both Medicare Crossover payments and ROW
  - Children's Choice Waiver Therapy Services

- Individual Occupational Therapists may enroll and bill as an Individual Occupational Therapist for the ROW program – OR - they may choose to link to and bill through the following Provider Type Agencies:
  - PT11 – Shared Living
  - PT84 – Substitute Family Care

- If a professional Individual is linking to an Entity/Business as an ‘Attending’ only (not being paid individually by Medicaid), then the EDI Contract, Direct Deposit Form, and voided check are not required.

- Claims submitted under the Entity/Business provider number, with the Individual's provider number included as the Attending provider, will be processed and documented on the Remittance Advice under the Entity/Business’s provider number.

- Individual Occupational Therapists enrolled for Medicare Crossovers ‘only’ may not bill Medicaid as the primary payer. Medicare would be the primary payer in this case, and Medicaid the secondary payer. **NOTE: Medicare enrollment will be verified by Molina Provider Enrollment staff through the PECOS system prior to Medicaid enrollment approval.**

- Individual Occupational Therapists may not link to any Medicaid enrolled Medical Groups, Rural Health Clinics, Federally Qualified Health Centers, or any other program within Louisiana Medicaid (except for the specified Waiver provider types mentioned above for ROW and Children’s Choice Waiver Therapy Services).

**NOTICE TO WAIVER SERVICE PROVIDERS**

Please note that Louisiana Medicaid will only reimburse 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 (CCW)).
ATTENTION!!

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

1. The provider manuals located at
   http://www.lamedicaid.com

   And

2. The information located on the DHH/OCDD website at
   http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8
# Occupational Therapist

## 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 Individual Occupational Therapist provider:

<table>
<thead>
<tr>
<th>Completed</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ *</td>
<td>1. Individual Louisiana Medicaid PE-50 Provider Enrollment Form.</td>
</tr>
<tr>
<td>☐ *</td>
<td>2. Completed PE-50 Addendum – Provider Agreement Form (two pages).</td>
</tr>
<tr>
<td>☐ *</td>
<td>4. Complete the Louisiana Medicaid Ownership Disclosure Information Form for Individual.</td>
</tr>
<tr>
<td>☐</td>
<td>5. 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 (deposits slips are not accepted).</td>
</tr>
<tr>
<td>☐</td>
<td>6. 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 (W-9 forms are not accepted).</td>
</tr>
<tr>
<td>☐</td>
<td>7. Printout of online medical license verification from the governing license board of your profession. This verification must contain the license numbers, the effective date of issuance, and the current status of the license. A temporary permit is only good until the expiration date.</td>
</tr>
<tr>
<td>☐</td>
<td>8. To report “Specialty” for this provider type on Section A of the PE-50, please use Code 74 (Occupational Therapy).</td>
</tr>
</tbody>
</table>

### For ROW Services:

| ☐ **      | 1. Completed Link/Unlink and Working Relationship Form. |
| ☐ **      | 2. Provider Verification Form for ROW Services. |
| ☐         | 3. To report “Subspecialty” for this provider type on Section A of the PE-50 please use Code 4W (Waiver Services). |

### For Children’s Choice Waiver Services:

| ☐ **      | 1. Provider Verification Form for Children’s Choice Waiver Therapy Services. |
| ☐         | 2. To report “Subspecialty” for this provider type on Section A of the PE-50, select all services you will provide of the following Subspecialty codes: Aquatic Therapy (7R), Art Therapy (7T), Art and Music Therapy (7U), Music Therapy (7V), Sensory Integration (7X), Therapeutic Horseback Riding (7Y), and/or Hippotherapy (7Z) |
| ☐         | 3. Submit a copy of the appropriate certificate that supports the Subspecialty chosen from the above # 14. |

* These forms are available in the Basic Enrollment Packet for Individuals.

** These 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)

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Please submit all required documentation to:

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

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(PT37 Occupational Therapist)  
Revised 03/2015
Louisiana Medicaid
Link/Unlink and Working Relationship Form

**PURPOSE**
This form is used when an Individual provider is requesting linkage to an Entity/Business for the purpose of billing through the Entity/Business as an “Attending Provider” only. The form permits Linkage/Unlinkage for two separate businesses. The form also serves as documentation that a working relationship exists between an Individual and the Business. For this form to be valid, an **ORIGINAL SIGNATURE AND DATE of Signature ARE REQUIRED.**

<table>
<thead>
<tr>
<th>Individual Provider Name:</th>
<th>LA Medicaid Provider #</th>
<th>National Provider Identifier (NPI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Provider Number:</td>
<td>LA Medicaid Provider #</td>
<td>National Provider Identifier (NPI)</td>
</tr>
</tbody>
</table>

**Entity/Business Name Linking to:**

<table>
<thead>
<tr>
<th>Provider Number Linking to:</th>
<th>LA Medicaid Provider #</th>
<th>National Provider Identifier (NPI)</th>
</tr>
</thead>
</table>

**LINK**

<table>
<thead>
<tr>
<th>Effective Date:</th>
<th>UNLINK</th>
<th>Termination Date:</th>
</tr>
</thead>
</table>

**Approximate Number of Hours Worked at this Group Per Week, if linking. (required)**

**NOT REQUIRED FOR OCCUPATIONAL THERAPIST**

<table>
<thead>
<tr>
<th>Entity/Business Name Linking to:</th>
<th>LA Medicaid Provider #</th>
<th>National Provider Identifier (NPI)</th>
</tr>
</thead>
</table>

**LINK**

<table>
<thead>
<tr>
<th>Effective Date:</th>
<th>UNLINK</th>
<th>Termination Date:</th>
</tr>
</thead>
</table>

**Approximate Number of Hours Worked at this Group Per Week, if linking. (required)**

**NOT REQUIRED FOR OCCUPATIONAL THERAPIST**

<table>
<thead>
<tr>
<th>Contact Person for questions regarding this form:</th>
<th></th>
</tr>
</thead>
</table>

| Contact Person Phone Number: | ( ) - |

**WORKING RELATIONSHIP AGREEMENT**
I am an Individual currently enrolled or enrolling in Medicaid, who has a contractual agreement to see Medicaid Recipients for the above named Entity/Business. I understand that upon request I must provide DHH a copy of the written, contractual working agreement between the Individual and the Entity/Business listed above.

__________________________________________
Print Individual Provider’s Name

__________________________________________
Individual Provider’s Signature

__________________________________________
Date

Original signature only – colored ink (please don’t use black ink)
Provider Verification for Children’s Choice Waiver Services

PURPOSE
This form confirms that the individual specified below wishes to provide Children’s Choice Waiver Services to Louisiana Medicaid recipients, and attests that this individual has provided paid services to person(s) with developmental disabilities through the OCDD program for a minimum of one year as an Occupational Therapist, Physical Therapist, Speech Therapist, Psychologist, and/or a Certified Behavioral Analyst.

Additional documentation/credentials are required for Therapy Services: Certification/Registration as Art Therapist, Certification/Registration as Aquatic Therapist, Certification/Registration as Music Therapist, Certification/Registration as Hippo Therapist, Certification/Registration in Therapeutic Horseback Riding, Certification/Registration in Sensory Integration, Psychologist Certification/Registration in Applied Behavioral Analysis-Based Therapy, Certified Behavioral Analyst with Certification/Registration in Applied Behavioral Analysis-Based Therapy.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Individual Provider Name:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Category (choose one):</td>
<td>OT ☐ PT ☐ PSY ☐ ST ☐</td>
<td></td>
</tr>
<tr>
<td>Contact Person for questions regarding this form:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact Person Phone Number:</td>
<td>(          ) -</td>
<td></td>
</tr>
</tbody>
</table>

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:
- True and correct,
- that I can receive reimbursement for services provided only to those persons within the Children’s Choice Waiver (CCW), and
- that all Professional Services provided to Children’s Choice Waiver (CCW) participants must be prior authorized before services are rendered, and
- that as a Professional providing services to Children’s Choice Waiver (CCW) participants, I have one year paid experience working with people with developmental disabilities as outlined in the Children’s Choice Waiver (CCW) Provider Manual, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

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

Print Individual Provider’s Name

Notary Public Signature

Individual Provider’s Signature
Original signature only – colored ink (please don’t use black ink)

Notary Seal or Notary Identification Number (required)

Complete this form in its entirety and mail the original to:
Provider Verification for ROW Services

**PURPOSE**
This form confirms that the individual specified below wishes to provide ROW Services to Louisiana Medicaid recipients, and attests that the individual has provided paid services to person(s) with developmental disabilities through the OCDD program for a minimum of one year as a Dietician, Occupational Therapist, Physical Therapist, Psychologist, Speech Therapist, or Social Worker.

<table>
<thead>
<tr>
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<td></td>
</tr>
<tr>
<td>Physical Address:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Professional Category (choose one):**
- Dietician
- OT
- PT
- PSY
- ST
- SW

Contact Person for questions regarding this form:

Contact Person Phone Number: 

( ) - 

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 Residential Options Waiver (ROW), and
- that all Professional Services provided to ROW participants must be prior authorized before services are rendered, and
- that as a Professional providing services to ROW participants, I have one year paid experience working with people with developmental disabilities as outlined in the ROW Provider Manual, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

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

Print Individual Provider’s Name

Notary Public Signature

Notary Seal or Notary Identification Number (required)

Individual Provider’s Signature

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

Complete this form in its entirety and mail the original to:
Molina Medicaid Solutions Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159