



UNISYS

**PROVIDER TYPE SPECIFIC
PACKET/CHECKLIST**

(Louisiana Medicaid Program)

**Occupational Therapist
(Individual)**

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR THE INDIVIDUAL OCCUPATIONAL THERAPIST PROVIDER TYPE

- Individual Occupational Therapist providers may enroll in Louisiana Medicaid for:
 - Medicare Crossover payments
 - Residential Options Waiver (ROW)
 - Both Medicare Crossover payments and ROW
- 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:
 - Share Living (PT 11)
 - Host Home (PT 84)
- 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.
- Individual Occupational Therapists may not link to any Medicaid-enrolled Groups, Rural Health Clinics, Federally Qualified Health Centers (except in the case of ROW services).

To: Prospective Residential Options Waiver Providers

From: Office for Citizens with Developmental Disabilities

RE: Residential Options Waiver Provider Enrollment/Medicaid Certification Process (Limited to ROW Recipients)

If enrollment requirements are not met, the applicant will be notified in writing regarding areas that need correction before the enrollment process can be completed. The entire enrollment packet will be returned to the applicant for correction and must be resubmitted. Provider Enrollment works on a 3-week turnaround time frame; any re-submissions are subject to an additional 3-week turnaround period.

Effective date of enrollment will be the date the application is actually worked up by Provider Enrollment.

After you receive your letter confirming your enrollment in Louisiana Medicaid as a Residential Options Waiver provider, then you must complete documentation to be added to the Freedom of Choice list. The Medicaid Freedom of Choice Request Form is located on the DHH website at <http://www.dhh.louisiana.gov/offices/publications.asp?ID=191&Detail=1217>

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

1. The provider manuals.
2. The information located on the DHH/OCDD website at

<http://www.dhh.louisiana.gov/offices/publications.asp?ID=191>

For information and documents on ROW refer to:

<http://www.dhh.louisiana.gov/offices/publications.asp?ID=191&Detail=1952>

Any Occupational Therapist applying for ROW services must send the enrollment application to the ROW Program Manager at the Office for Citizens with Developmental Disabilities. See Checklist on the next page for complete address.

Occupational Therapist

CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Unisys Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Individual Occupational Therapist provider:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Individual 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 Individual. (Only the Disclosure of Ownership portion of this enrollment packet can be done online by choosing Option 1.)</p> <p>Option 1 (preferred): Provider Ownership Enrollment Web Application. Go to www.lamedicaid.com 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>Option 2 (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 Individual.</p>
<input type="checkbox"/>	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 (deposit slips are not accepted).
<input type="checkbox"/>	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).
<input type="checkbox"/>	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. If requesting retroactive coverage, a license must be submitted that covers that time period. A temporary permit is only good until the expiration date.
<input type="checkbox"/>	8. Copy of Medicare certification letter from CMS, if requesting enrollment from Medicare crossovers.
<input type="checkbox"/>	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 74 (Occupational Therapy).
<input type="checkbox"/>	10. To report "Sub-specialty" for this provider type on Section A of the PE-50, for ROW participation, please use Code 4W (ROW).
<input type="checkbox"/>	11. Verification that paid services has been provided to individuals with developmental disabilities for the OCDD program for a minimum of one year as an Occupational Therapist.

For Linkage to an Entity/Business:

<input type="checkbox"/> **	1. Completed Link/Unlink and Working Relationship Form. Must complete number of working hours per week on this form.
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* These forms are available in the **Basic Enrollment Packet for Individuals**.

** 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)

Please submit all required documentation to the appropriate address shown below:

<p>Enrollment for Crossovers Only: Unisys Provider Enrollment Unit PO Box 80159 Baton Rouge, LA 70898-0159</p>	<p>Enrollment for ROW only or both ROW and Crossover: Office for Citizens with Developmental Disabilities ROW Program Manager P.O. Box 3117 Baton Rouge, LA 70821-3117</p>
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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. (required)													
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. (required)													
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)