



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

**Nurse Family Partnership
Program Case Management**

(Enrollment packet is subject to change without notice)



To Whom It May Concern:

Enclosed is the enrollment packet for the Louisiana Medical Assistance Program (also known as the Louisiana Medicaid program) you requested. It contains a participation agreement, enrollment data and forms with instructions. You should carefully review these materials, including all instructions, before completing the necessary forms.

The Medicaid Program requires all providers to be state certified for claims to be processed. After completing the enrollment packet materials, please return all forms to:

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

Please be sure to include any and all Medicare provider numbers you want linked to the Medicaid provider number. If you have applied for a Medicare provider number but have not received the number(s), please submit the number(s) to Provider Enrollment at the above address upon receipt. Claims will not automatically cross electronically from Medicare to Medicaid unless these provider numbers are linked in our system.

The Molina Provider Enrollment Unit will take necessary steps to certify you as a provider and participant in the Louisiana Medical Assistance Program. Upon certification, you will be notified of your Medicaid provider number that must be used for billing. Molina Provider Relations will forward a provider manual to you. If manual is not received within two (2) weeks of notification, please contact Provider Relations at (800) 473-2783 or (225) 924-5040.

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 cooperation.

Sincerely,

Provider Enrollment Unit
Louisiana Medicaid Program

Nurse-Family Partnership Program

CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as a Nurse-Family Partnership provider:

Completed	Document Name
<input type="checkbox"/>	1. Completed Louisiana Medicaid PE-50 Enrollment Form* (Read instructions carefully before completing this form)
<input type="checkbox"/>	2. Completed PE-50 Addendum – Provider Agreement*
<input type="checkbox"/>	3. Copy of printed document received from IRS showing Employer Identification Number (EIN) and official name as recorded on IRS records. - W-9 forms are not accepted
<input type="checkbox"/>	4. If provider name in Section 1 of the PE-50 is: <ul style="list-style-type: none"> • An entity—completed LA Medicaid Entity Ownership Disclosure Information form (5 pages located in the Basic Enrollment Packet) • An individual—completed LA Medicaid Individual Disclosure Information form (2 pages, located in the Basic Enrollment Packet).
<input type="checkbox"/>	5. Completed Medicaid Direct Deposit (EFT) Authorization Agreement*
<input type="checkbox"/>	6. Copy of Voided Check – for account to which you wish to have your funds electronically deposited. Deposit slips are not accepted
<input type="checkbox"/>	7. Copy of the Case Management License issued by the Department of Health and Hospitals
<input type="checkbox"/>	8. Completed Board Resolution Form* If applicable (Form must be notarized) (Not required if State Agency)
<input type="checkbox"/>	9. To submit electronic claims, a Completed EDI contract* and Power of Attorney* (if applicable) must accompany this application. Refer to Basic Enrollment Packet for details.

* Forms are included in this Enrollment Packet

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

REGIONAL OFFICES

Region 1: New Orleans

1010 Common Street, Suite 505
New Orleans, LA 70112
FAX NUMBER: (504) 599-0293

Region 2: Baton Rouge

6554 Florida Blvd., Suite 250
Baton Rouge, LA 70806
FAX NUMBER: (225) 925-6298

Region 3: Thibodaux

1148 Tiger Drive
Thibodaux, LA 70301
FAX NUMBER: (985) 449-4706

Region 4: Lafayette

128 Demanade Drive, Suite 104
Lafayette, LA 70503
FAX NUMBER: (337) 272-1087

Region 5: Lake Charles

2300 Broad Street
Lake Charles, LA 70601
FAX NUMBER: (337) 491-2005

Region 6: Alexandria

1517-B Washington Street
Alexandria, LA 71301
FAX NUMBER: (318) 487-5968

Region 7: Shreveport

3018 Old Minden Road, Suite 1214
Bossier City, LA 71112
FAX NUMBER: (318) 741-2722

Region 8: Monroe

1401 Hudson Lane, Suite 236
Monroe, LA 71201
FAX NUMBER: (318) 362-4611

Region 9: Mandeville

21454 Koop Drive, Suite 2B
Mandeville, LA 70471
FAX NUMBER: (985) 871-8346

Louisiana's Medicaid Program Board Resolution Form

STATE OF LOUISIANA, PARISH OF _____

On the _____ day of _____, 20____

At a meeting of the Board of Directors of _____

Held in the City of _____ Parish of _____

A quorum of the Directors present, the following business was conducted:

It was duly moved and seconded that the following resolution be adopted:

BE IT RESOLVED that the Board of Directors of the above corporation hereby authorized

(Name and Title)

and his/her successors in the office to negotiate, on terms and conditions that he/she may deem advisable, a contract or contracts with the Louisiana Department of Health and Hospitals, and to execute said documents on behalf of the corporation, and further do we hereby give him/her the power and authority to do all things necessary to implement, maintain, amend or renew said documents.

The above resolution was passed by a majority of those present and voting in accordance with the by-laws and articles of incorporation.

I certify that the above and foregoing constitutes a true and correct copy of a part of the minutes of a meeting of the Board of Directors of _____

held on the _____ day of _____, 20____

Secretary

Subscribed and sworn before me, _____

a Notary Public for the Parish of _____

on the _____ day of _____, 20____.