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

KIDMED
SCREENING CLINIC
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:

ACS
5700 Florida Blvd. Suite 1300
Baton Rouge, LA 70806

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.

If you have provided services to a Louisiana Medicaid recipient prior to the date you receive state certification, you must send a letter with your enrollment packet stating the earliest date that services were provided to a Louisiana Medicaid recipient. It will be necessary that all eligibility requirements are met at the time of service for Unisys to authorize retroactive eligibility. Any claims submitted prior to receipt of this letter must be resubmitted and returned with your application for enrollment.

The Unisys 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. Also, Unisys 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 Project
KIDMED
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 a KIDMED provider:

<table>
<thead>
<tr>
<th>Completed</th>
<th>Document Name</th>
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<tbody>
<tr>
<td></td>
<td>1. Completed Louisiana Medicaid PE-50 Enrollment Form* (Read instructions carefully before completing this form)</td>
</tr>
<tr>
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<td>2. Completed PE-50 Addendum – Provider Agreement*</td>
</tr>
<tr>
<td></td>
<td>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</td>
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<tr>
<td></td>
<td>4. If provider name in Section 1 of the PE-50 is:</td>
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<td></td>
<td>· An entity—completed LA Medicaid Entity Ownership Disclosure Information form (5 pages located in the Basic Enrollment Packet)</td>
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<td>· An individual—completed LA Medicaid Individual Disclosure Information form (2 pages, located in the Basic Enrollment Packet).</td>
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<tr>
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<td>5. Completed Medicaid Direct Deposit (EFT) Authorization Agreement*</td>
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<td>6. Copy of Voided Check – for account to which you wish to have your funds electronically deposited. Deposit slips are not accepted</td>
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<td>7. Completed KIDMED Provider Enrollment Supplement Agreement</td>
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<td>8. Retainer Agreement – Medical Director*</td>
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<td>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.</td>
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</table>

* Forms are included in the Basic Enrollment Packet

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

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:

ACS Health Management Corporation
5700 Florida Blvd. Suite 1300
Baton Rouge, LA 70806
In order to facilitate your enrollment as a KIDMED provider in Louisiana Medicaid, you must provide the information that is requested below. Please print.

Name of Provider: _________________________________________________

( ) Currently enrolled as Medicaid provider
If yes, Medicaid provider # _____________

( ) Not enrolled in Medicaid, PE-50 attached

Pay to (Mailing)
Address: ___________________________________________________________________________________________

Telephone: _______________________________ Fax #: ___________________________ IRS#: _____________________

( ) Disclosure of Ownership attached (Required for all types of Providers except individual).

Physical Address of KIDMED site(s):
Street Address   City  State/Zip Code  Area Code/Telephone

__________________________________________________

__________________________________________________

__________________________________________________

Check the KIDMED service(s) you wish to provide:

_____Medical Screening  _____Vision  _____Hearing  _____Diagnosis & Treatment

Check the category of medical screening (Scr) and/or diagnosis and treatment (D&T) under which you qualify:

Scr   D&T   Scr   D&T   Scr   D&T

— Public Health Clinic
— Federally Qualified Health Center (FQHC)
— Rural Health Clinic
— Local Education Agency
— Individual Physician
— Physician Group
— Nurse Practitioner
— KIDMED Clinic *

*A KIDMED Clinic may not provide diagnosis and treatment services.

List the specific days and hours the office will be open: ______________________________________________________

The Agreement, made by and between Louisiana Medicaid and _______________________________________________

_________________________________(provider), sets forth the terms of participation in KIDMED medical, vision, hearing
screening, and diagnosis and treatment services. The parties, intending to be legally bound, agree as follows:

1. The provider agrees to adhere to all general enrollment conditions of the Louisiana Medicaid Program.

2. The provider agrees to comply with all applicable KIDMED requirements for physician affiliation/medical direction,
staffing, equipment, services, timeliness standards, and reasonable standards of medical and other health professional
practices set forth in the KIDMED Provider Manual.

3. The provider agrees to maintain sufficient qualified and trained staff, facilities, equipment, and supplies to provide the
agreed-upon services.

4. The provider agrees to notify KIDMED within 10 days whenever he/she no longer meets all enrollment criteria or is unable
to provide the required services as set forth in the KIDMED Provider Manual.

5. The provider agrees to ensure that recipients are allowed to choose providers freely, except as provided under a
Medicaid-approved managed care program.
6. The provider agrees to provide screening services to Medicaid recipients under the age of 21 who are receiving diagnosis, treatment, and/or other health services reimbursed by Medicaid or to refer them to KIDMED to select a screening provider.

7. The provider agrees that the submission of a claim shall be certification that the specific KIDMED services for which payment is claimed were provided to the person identified as the recipient. The provider agrees to perform all aspects of the services in a KIDMED screening clinic. The provider agrees not to bill DHH unless all aspects of the screening are complete.

8. The provider agrees to maintain records necessary to disclose the extent of KIDMED services provided to recipients on whom claims have been filed for five years from the date of service. The provider also agrees to provide this information as requested to KIDMED or a DHH authorized representative and to cooperate with on-site reviews and other monitoring activities.

9. Publicly financed providers agree to use Medicaid funds received for these services solely for the provision and/or enhancement of health services to children. These Medicaid funds may be used for the direct provision of health services and to defray the administrative cost of providing health services to children.

10. The provider agrees to submit KIDMED claims within 60 days of the date of service for recipients under the age of 21.

11. The provider agrees to submit KIDMED claims using the KIDMED EPSDT Claim form or through approved electronic means to the Medicaid Fiscal Intermediary for payment.

12. The provider agrees to participate in KIDMED site visits and provider training.

13. The provider agrees to refer pregnant and postpartum recipients and children under the age of 5 to the Women, Infants, and Children Program (WIC) and promote participation in WIC.

14. The provider agrees to refer any suspected child abuse, neglect, and/or sexual abuse of recipients under the age of 21 promptly to the Office of Community Services in the parish where the recipient resides per Louisiana revised statute.

15. The provider agrees to refer eligible recipients and families who may present grievances which may arise from KIDMED services provided under this agreement to KIDMED and/or DHH.

16. Louisiana Medicaid agrees to reimburse the provider for KIDMED services covered by Medicaid in accordance with applicable statutes and regulations and the schedule of maximum fees for KIDMED services.

17. The effective date of this agreement shall be the date on which it is signed by Louisiana Medicaid.

18. This agreement may be terminated by either party 60 days after receipt of a written notice by the other party. The provider must continue to provide services and maintain documentation in accordance with established regulations.

19. The provider agrees to schedule appointments for recipients under 12 months of age.

20. The provider agrees to obtain KIDMED approval on marketing materials prior to distribution.

21. The provider agrees to inform DHH Provider Enrollment with any changes in personnel, locations, hours of operation, or other pertinent information.

I certify that the information provided on this form is true to the best of my knowledge.

________________________________________________________________________
Provider-Authorized Signature                                        Date

________________________________________________________________________
Please Print Name

For DHH Use Only:

________________________________________________________________________
Medicaid Director or Designee                                        Date
Complete the following on all physicians and/or nurse practitioners who are providing the services or who are affiliated with the provider. Please print and attach page(s) if necessary.

Name and Title: ___________________________ License #: ___________________________

Medicaid Provider #: __________________ IRS#: __________________ Social Security #: __________________

List days of week and times of the day spent working at this KIDMED practice. Be specific: (i.e., Monday, 9a-4p, and Thurs. 2p-8p).

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RETAINER AGREEMENT MEDICAL DIRECTOR

This agreement is entered into on this _________ day of _________________ between _______________________, M.D., hereinafter referred to as MEDICAL DIRECTOR, of ________________________ KIDMED, hereinafter referred to as FACILITY.

WHEREAS the FACILITY desires to employ the services of MEDICAL DIRECTOR, and WHEREAS the MEDICAL DIRECTOR is desirous of offering certain services, it is therefore mutually agreed that the FACILITY does employ and the MEDICAL DIRECTOR agrees to provide his/her services to all patients without regard to race, color, creed, national origin, age, sex, religion, or handicap, under the following mutual terms and conditions:

MEDICAL DIRECTOR’S RESPONSIBILITIES

Supervise the overall functions of our facility’s medical services in that the Medical Director shall:

1. Assume the administrative authority, responsibility, and accountability of overseeing our medical screening, policies, and procedures.

2. Coordinate plan of care and periodically review these planning and implement methods to keep the quality of care under constant surveillance.

3. Participate in the development of written policies, rules, and regulations to govern the medical screening and other health services provided. The medical director is responsible for seeing that these policies reflect an awareness of and provisions for meeting the needs of the patients.

4. Attend the recipient of services, once yearly under six years of age and every other year at age six and above.

5. Develop and participate in in-service training programs for nursing service and other related services.

6. Implement methods that assure continuous surveillance of the health status of employees including freedom from infection and routine health examinations.

7. Review written reports of surveys and inspections and make recommendations to the administrator.

8. Obtain and maintain during the term of this agreement a suitable professional liability and malpractice insurance policy.

9. Serve the facility as an independent contractor, it being understood and agreed that the MEDICAL DIRECTOR is not an employee of the facility.

10. Maintain the confidentiality of all patient information as established by our facility’s policies and procedures.

11. Stay abreast of all other responsibilities required of a medical director as set forth in a Federal and State laws, statutes, or regulations as enacted or as may be enacted or amended.
QUALIFICATIONS

Medical Director certifies that he/she:
1. Is licensed to practice medicine in this state.
2. Has a Medical Degree from a college or university accredited by the American Medical Association.
3. Meets the requirements as set forth by these standards.
4. Maintains the required continuing education hours to assure continued competence.

DURATION OF AGREEMENT

1. The duration of this agreement is indefinite. However, either party may:
   a) Terminate this agreement by providing the other party with a sixty (60) day written notice of such intent.
   b) Terminate this agreement when either party fails to abide by its contents.

2. This agreement shall become null and void should the medical director/facility fail to meet the licensing requirements set forth by Federal and State statutes, laws, and regulations governing such services.

FACILITY’S RESPONSIBILITIES

The facility shall be responsible for:
1. Retaining the professional and administrative responsibility for all services provided by the MEDICAL DIRECTOR.
2. Making prompt payment for services rendered.

Assuring that the MEDICAL DIRECTOR has complete access to all records and supplies within the facility necessary for the performance of his/her duties.

Delegating the necessary administrative authority, responsibility, and accountability necessary for the MEDICAL DIRECTOR to perform his/her duties.

THE WITNESS THEREOF, the parties have duly set their hands and seal the day and year first above written:

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<th>MEDICAL DIRECTOR &amp; LIC.</th>
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