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

EPSDT
Health Services

(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:

Unisys 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.

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 once the enrollment process is completed.**

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 informed of your Medicaid provider number that must be used for billing. Unisys Provider Relations will forward a provider manual to you. If manual is not received in two (2) weeks of notification, please contact Provider Relations at (800) 473-2783 or (225) 927-5040.

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
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 EPSDT Health Services 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>
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<tr>
<td></td>
<td>2. Completed PE-50 Addendum – Provider Agreement*</td>
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<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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</table>
|           | 4. If provider name in Section 1 of the PE-50 is:  
  - 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). |
|           | 5. Completed Medicaid Direct Deposit (EFT) Authorization Agreement* |
|           | 6. Copy of Voided Check – for account to which you wish to have your funds electronically deposited. Deposit slips are not accepted |
|           | 7. Completed EPSDT Health Services Supplement to Provider Enrollment Form PE-50 |
|           | 8. Copy of PE-50 EPSDT Provider Supplement Agreement B |
|           | 9. Copy of PE-50 EPSDT Provider Supplement Agreement C School Board Certification of Understanding (if applicable) |
|           | 10. Copy of the therapist’s credentials or licenses |
|           | 11. Copy of the Early Intervention license from the Department of Social Services for providers serving the 0 to 3 year old population |
|           | 12. 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 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:
Unisys Provider Enrollment Unit  
PO Box 80159  
Baton Rouge, LA 70898-0159
In order to facilitate your enrollment as an EPSDT Health Services provider in Medicaid of Louisiana, you must provide the information that is requested below.

Name of Provider:________________________________________________________________________

Medicaid Provider Number:________________________________________________________________

Address (Mailing and Street):________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Telephone Number:_______________________________________________________________________

Address and Telephone Number if Other Sites (if applicable):____________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Check the EPSDT health service(s) you wish to provide, list any restrictions related to the age or the number of children, geographical areas, or other factors, or enter “none.” Attach documentation of applicable licensing and certification for staff providing these services.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>RESTRICTIONS</th>
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<tr>
<td>_________Audiologic Evaluation</td>
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<td>_________Speech and Language Evaluation</td>
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<td>_________Speech, Language or Hearing Therapy</td>
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<tr>
<td>_________Occupational Therapy Evaluation</td>
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<td>_________Occupational Therapy</td>
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<td>_________Physical Therapy Evaluation</td>
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<td>_________Psychological Therapy</td>
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<td>_________Nursing Services</td>
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<td>_________Nutrition Services*</td>
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<td>_________Social Work Services*</td>
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<td>_________Home Visit Services*</td>
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The Agreement, made by and between Medicaid of Louisiana and ______________
_______________(Provider), sets forth the terms of participation in Early Periodic Screening and Diagnostic
Treatment (EPSDT) health services to children with disabilities. The parties, intending to be legally bound,
agree as follows.

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

2. The provider agrees to comply with all applicable program requirements for services, timeliness
   standards, and reasonable standards of medical and other health professional practices set forth in the
   EPSDT Health Services Provider Manual.

3. The provider agrees to maintain sufficient staff, facilities, equipment, and supplies to provide
   the agreed upon services and notify Medicaid of Louisiana promptly, in writing, whenever
   he/she is no longer able to provide the services.

4. The provider agrees to ensure that recipients are allowed to choose providers freely.

5. The provider agrees to establish procedures through which eligible recipients and families may
   present grievances which may arise from EPSDT services provided under this agreement.

6. The provider agrees that the submission by or on behalf of the provider of any claim shall be
   certification that the specific services for which the payment is claimed were provided to the person
   identified as the recipient.

7. The provider agrees to keep records necessary to disclose the extent of EPSDT services
   provided to recipient for five years from the date of payment, to provide this information, as
   requested, to Medicaid of Louisiana or its authorized representative, and to cooperate with on-
   site reviews, and other monitoring and training activities.

8. The provider agrees 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 these services and to defray the administrative cost of providing these
   services.

9. The provider agrees to submit claims within 1 year of the date of service and to submit these
   claims electronically.

10. The provider agrees to participate in KIDMED recipient outreach activities, including identifying
    and informing recipients of the benefits of preventive care, and how to access KIDMED
    screening services.

11. The provider agrees to provide age appropriate KIDMED medical,
vision, and hearing screening services to Medicaid recipients under the age of 21 who are receiving EPSDT health services reimbursed by Medicaid or to contact KIDMED immediately to arrange for these screening services.

12. 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.

13. Medicaid of Louisiana agrees to reimburse the provider for EPSDT health services covered by Medicaid in accordance with applicable regulations and the schedule of maximum Medicaid fees for these services.

14. The effective date of this agreement shall be the date on which it is signed by Medicaid of Louisiana unless otherwise stated.

15. This agreement may be terminated by either party upon 30 days after the receipt of a written notice by the other party.

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

_________________________________________________          _______________________
Provider-Authorized Signature       Date

_________________________________________________   ________________________
Medicaid Director or Designee       Date
The Agreement, made by and between the Bureau of Health Services Financing ("Bureau") and ________________ ("Provider") sets forth the terms of participation in EPSDT medical, vision, and hearing services and/or health services to children with special needs. The parties, intending to be legally bound, agree as follows:

1. The Provider agrees to provide EPSDT services timely and efficiently and avoid duplicate and unnecessary services.

2. The Provider agrees to adhere to all general Medicaid enrollment conditions.

3. The Provider agrees to comply with all applicable EPSDT requirements for services, timeliness, standards and reasonable standards of medical and other health professional practices set forth in the EPSDT Services Provider Manual.

4. The submission by or on behalf of the Provider of any claim shall be certification that the specific EPSDT services for which payment is claimed were provided to the person identified as the recipient.

5. The Provider agrees to keep records necessary to disclose the extent of EPSDT services provided to recipients for five years from the date of service and provide this information, as requested, to the Bureau or its authorized representative and cooperate with on-site reviews and other monitoring activities.

6. The Provider agrees to use Medicaid funds received from the Bureau solely for the provision and/or enhancement of health services to children. Medicaid funds may be used for the direct provision of these services and to defray the administrative cost of these services.

7. The Provider agrees to participate in EPSDT services provider training.

8. The Provider agrees to refer pregnant and postpartal recipients and children under age 5 to WIC and complete applicable WIC forms presented by the recipient.

9. The Provider agrees to participate in EPSDT recipient outreach activities including seeking out recipient and informing recipients of the benefits of EPSDT services, informing them of assistance, including transportation services, available and helping them use EPSDT services effectively.

10. The Provider agrees to promptly refer any suspected child abuse, neglect and/or sexual abuse of recipients under age 21 to the Office of Community Services in the parish where the recipient resides.
11. The Provider agrees to establish procedures through which eligible recipients and families may present grievances which may arise from EPSDT services provided under this agreement.

12. The Provider agrees to provide screening services to Medicaid recipients under age 21 receiving diagnosis, treatment and/or other health services reimbursed by Medicaid or refer to a screening provider for these services.

13. The Provider agrees to assure that recipients who are to be referred for services have freedom of choice providers.

14. The Provider agrees to maintain sufficient staff, facilities, equipment and supplies to provide the agreed upon services and agrees to notify the Bureau promptly, in writing, whenever it is unable to provide the required quality and quantity of services set forth in the EPSDT Services Provider Manual.

15. The Provider agrees to submit Medicaid claims within 90 days of the date of service for recipients under age 21.

16. The Bureau agrees to reimburse the Provider for EPSDT services covered by Medicaid in accordance with applicable statutes and regulations and schedule of maximum fees for EPSDT services.

17. The effective date of this Agreement shall be the date on which it is signed by the Department.

18. This Agreement may be terminated by either party upon thirty (30) days written notice to the other party.

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

_________________________________________________________________________  ______________________________________________________________________

Signature                                      Date

_________________________________________________________________________  ______________________________________________________________________

BHSF Director                                  Date
The Provider School Board acknowledges that this Certification of Understanding is required by the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, as part of the Bureau of Health Services Financing’s assurance in accordance with the Title XIX State Plan that local parish school board funds are available to the Medicaid Program to be matched with the federal share in the reimbursement of EPSDT services provided by the school board to children with special health care needs.

1. The Provider School Board understands, certifies and assures it does have the state and/or local match funds available to draw down the federal share for the EPSDT health services provided to children with special needs by the school board.

2. The Provider School Board understands, certifies, and assures that in participating in this program and qualifying for matching funds herein, no federal funds received by or available to the school board will be used in recapturing federal dollars.

3. The Provider School Board assures that adequate records and an audit trail to support the above assurances will be maintained for the individual checkwrites and will be made available to the U.S. Department of Health and Human Services and the Bureau of Health Services Financing and its designees for review.

4. The Provider School Board understands that this Certificate of Understanding is not applicable to EPSDT screening services.

__________________________________________  __________________________________________
BHSF Director                                                                                  Superintendent

__________________________________________
School Board

____________________________  ______________________________
Date  Date