



**PROVIDER TYPE SPECIFIC
PACKET/CHECKLIST**

(Louisiana Medicaid Program)

Rural Health Clinic
(Independent)

(Enrollment packet is subject to change without notice)

RHC Provider Type 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 a RHC provider:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business 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 Entity/Business. (Only the Disclosure of Ownership portion of this enrollment packet can be done 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 Entity/Business.</p>
<input type="checkbox"/> *	5. (If submitting claims electronically) Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form and Power of Attorney Form (if applicable).
<input type="checkbox"/>	6. 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"/>	7. 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"/>	8. Copy of CLIA certificate.
<input type="checkbox"/>	9. Copy of Rural Health Clinic license issued by Health Standards.
<input type="checkbox"/>	10. Copy of Medicare certification letter from CMS verifying provider is a Rural Health Clinic.
<input type="checkbox"/>	<p>11. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 94 (RHC) or Code 9L (RHC/FQHC OPH Certified School Based Health Center).</p> <ul style="list-style-type: none"> ○ If you report Specialty Code 9L, then submit copy of documentation confirming designation as SBHC with either: <ul style="list-style-type: none"> ○ OPH-ASHI (Adolescent School Health Program) Funded (MUST submit certification letter from OPH_ASHP that SBHC meets certification requirements). or ○ Other – OPH certified (MUST submit certification letter from OPH-ASHP that SBHC meets certification requirements).
<input type="checkbox"/> **	12. Completed OFS Form 24, if applicable.
<input type="checkbox"/> **	13. Completed Existing Provider Information Form.
<input type="checkbox"/> **	14. Completed Group Link/Unlink and Working Relationship Form for each individual professional with a Medicaid Provider Number linking to this RHC. (If an individual professional does not have a Medicaid Provider Number, then a full enrollment packet for that individual professional must be submitted with this Rural Health Clinic application.)

* These forms are available in the **Basic Enrollment Packet for Entities/Businesses**.

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Dear Provider:

It is the policy of the Bureau of Health Services Financing that the Medicaid Program will only pay for in-office performance of certain laboratory and diagnostic services which are billed by physicians if the following conditions are met:

1. The physician has completed and has on file with Louisiana State Medicaid Program, Provider Enrollment Unit, a completed OFS Form 24.
2. The completed OFS Form 24 fully describes the laboratory or diagnostic equipment required to perform these tests.
3. The OFS Form 24 information is updated as needed.

Our policy towards laboratory or diagnostic services that are performed outside of a physician office remains unchanged. Physicians may not be reimbursed for laboratory or diagnostic services ordered for their patients if these services are performed outside of their office. Only the performer of a test may seek reimbursement for these services. Any interpretive service by the attending physician is reimbursed through the physician visit payment.

The OFS Form 24 requirements only pertain to: 1) those participating physicians who own or lease laboratory or diagnostic testing equipment that is located in their office or place of practice and 2) for which use the physician will be submitting a claim to the Medicaid program.

Example 1: Dr. Jones is an individual practitioner who owns or leases a SMA-12, EKG monitor and X-Ray equipment. Dr. Jones wishes to perform laboratory and diagnostic services on Medicaid patients in his office and bill the Medicaid Program for these laboratory or diagnostic services. Dr. Jones must complete the OFS Form 24.

Example 2: Drs. Smith, Jones, Doe, and Rae are a group practice. As a group they own or lease laboratory and diagnostic equipment. It is their desire to use this equipment in treating Medicaid recipients, and they will bill the Medicaid Program for these services. If each physician is individually enrolled in the Medicaid Program, each physician in the group must complete the OFS Form 24, even though the descriptive information will be identical. If the physicians are enrolling as a group, only one OFS Form 24 is required as long as all members of the group are indicated.

Example 3: An individual or group practitioner utilizes an external source for laboratory or diagnostic tests. The individual or group practitioner would not complete the OFS Form 24, as they would not bill the Medicaid Program directly.

A Louisiana OFS Form 24 is enclosed for completion and submittal where applicable. Return the completed form to:

Molina Medicaid Solutions Provider Enrollment Unit,
P.O. Box 80159,
Baton Rouge, LA 70898-0159.

Sincerely,

Provider Enrollment Unit

Diagnostic and/or Laboratory Equipment

Provider Number (7 digits)

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NPI (10 digits)

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Provider Name:

Provider Address:

Diagnostic and/or Laboratory Equipment

Make	Model	Serial #	Capabilities

List names of individuals who will be performing the diagnostic and/or laboratory tests in the spaces below:

1.	2.
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I certify that the above is a true and accurate listing of diagnostic and/or laboratory equipment in my office.

Signature*

Date

* Acceptable signatures are as follows: individual professionals must sign their own forms. Only an authorized representative may sign for groups, businesses, or entities. Original provider signature is required (no stamps or initials)

COPY PAGE IF ADDITIONAL SPACE IS NEEDED

Louisiana Medicaid Link/Unlink and Working Relationship Form

If additional space is needed, please copy this form before filling it out.

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 (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 (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.

Print Individual Provider's Name

Individual Provider's Signature

Date

**MAIL Completed Forms To:
Molina Medicaid Solutions Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159**