



**PROVIDER TYPE SPECIFIC
PACKET/CHECKLIST**

(Louisiana Medicaid Program)

**Certified Nurse -
Midwife
(Individual)**

(Enrollment packet is subject to change without notice)

Certified Nurse - Midwife

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 an Individual Certified Nurse – Midwife 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 (detailed instructions can be found in the Basic Enrollment Packet). After entering ownership information online, the user is prompted to print the Summary Report; the professional individual must sign and submit page 2 of the Summary Report with any required explanatory documentation and the 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. (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 current medical license from governing license board of your profession (RN and APRN 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"/>	9. Copy of the certification from the American Midwifery Certification Board (formerly known as ACNM Certification Council, Inc.)
<input type="checkbox"/> **	10. Completed Nurse-Midwife PE-50 Supplement Form.
<input type="checkbox"/>	11. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 16 (OB-GYN).

For Group Linkages:

<input type="checkbox"/> **	1. Completed Link/Unlink and Working Relationship Form.
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* These forms are available in the **Basic Enrollment Packet for Individuals**.

** These forms are available 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

Nurse-Midwife PE-50 Supplement Form

I hereby certify that I am a member of a physician-directed health care team.

The following is a complete listing of the physician(s) who direct the health care team(s) with which I practice:

Physician Name	Louisiana Medicaid vendor # (if applicable)

When practicing and billing Louisiana's **Medicaid Program** for my services, I hereby agree to comply with Section 3709 of the Louisiana Administrative Code (the *Nurse Practitioner Act*), which requires that a nurse-midwife must work "...as a member of a physician-directed health care team."

Individual Provider's Signature

License #

Date

Print Name of Individual Provider

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)					
		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> LINK	Effective Date:	<input type="text"/>				<input type="checkbox"/> UNLINK	Termination Date:	<input type="text"/>					
Approximate Number of Hours Worked at this Group Per Week, if linking. (required)		<input type="text"/>											
Professional Group Name:													
Professional Group Provider Number:		LA Medicaid Provider #						National Provider Identifier (NPI)					
		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> LINK	Effective Date:	<input type="text"/>				<input type="checkbox"/> UNLINK	Termination Date:	<input type="text"/>					
Approximate Number of Hours Worked at this Group Per Week, if linking. (required)		<input type="text"/>											
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)

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