



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Clinical Nurse Specialist (Individual)

(Enrollment packet is subject to change without notice)

Clinical Nurse Specialist 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 Clinical Nurse Specialist 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 certification as a Clinical Nurse Specialist by the Louisiana State Board of Nursing. The certification must correspond with the specialty identified on the PE-50 (see item 12, below).
<input type="checkbox"/>	10. Verification of prescriptive authority, if applicable.
<input type="checkbox"/>	11. Must have Collaborative Practice Agreement available for review, upon request.
<input type="checkbox"/> **	12. To report "Specialty" for this provider type on Section A of the PE-50, please refer to the attached Specialty and Sub-specialty Code List.

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**.

** This list is 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

Specialty and Sub-Specialty Code List For Clinical Nurse Specialists

Specialty Code	Sub-specialty Code	LSBN Specialty Description
01		Home Health Nursing
02		Medical Surgical Nursing
08		Maternal Child Nursing
26		Child and Adolescent Psychiatric and Mental Health Nursing or Adult Psychiatric and Mental Health Nursing
37		Pediatric Nursing
37	1C	Acute and Critical Care, Neonatal
37	1E	Acute and Critical Care, Pediatrics
41	2G	Gerontological Nursing
41	2J	Oncology
44		Community Health Nursing

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)					
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, if linking. (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, if linking. (required)													
Contact Person for questions regarding this form:													
Contact Person Phone Number:		() -											

WORKING RELATIONSHIP AGREEMENT

I am a medical professional who has a written 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