Disaster Louisiana Medicaid Packet for Temporary Enrollment of Out of State (OOS) Entities/Businesses (CMS Expedited Screening)

Thank you for your assistance with our Louisiana Recipients who have been affected by and/or displaced during the recent disaster. Your response to this disaster is greatly appreciated. Please wait for a faxed confirmation of your enrollment in Louisiana Medicaid before submitting any claims.

Refer to our web site frequently for updated information and/or application packets at www.lamedicaid.com. If you have any questions concerning the completion of this enrollment packet, please refer to the intructions included below and at www.lamedicaid.com (Disaster link) prior to calling 225-216-6370.

Below are the Out-of-State entities/businesses that are eligible for this disaster enrollment:

1. Practice location outside of Louisiana (Louisiana-based entities should apply using a Basic Provider Enrollment Packet for Entities, available on www.lamedicaid.com under Provider Enrollment link)
2. One of the following provider types:

Provider Type	Additional Submission Requirements	Specialty Code
Ambulance Transportation	EMS License	59
Ambulatory Surgical Center	ACS License Medicare Certification Letter	70
DME Providers	Accreditation Certification DMERC #, if applicable	51: co. w/ Cert. Orthotist 52: co. w/ Cert. Prosthetist 53: co. w/ both Cert. Orthotist & Cert. Prosthetist
Federally Qualified Health Center	HRSA Grant Letter CLIA Certificate, if applicable	42
Hemodialysis Center	Medicare Certification Letter approving as ESRD service provider	70
Home Health Agency	License	87
Hospital	Medicare Certification Letter Hospital License CLIA Certificate	86
Independent Lab	CLIA Certificate	69
Optical Supplier	None	88
Pharmacy	License/permit	87
Rehabilitation Center	Medicare Certification Letter	75
Rural Health Center (Independent or Provider-Based)	Medicare Certification Letter RHC License CLIA Certificate	94

Required pages: Page 2 is required. Pages 3-6 are required only if you are not currently enrolled with Medicare or non-Louisiana state agency Medicaid. Page 5 of this packet is required only if you wish to receive your funds via direct deposit. All fields on the following pages are required unless otherwise noted. **See above for additional items required based on provider type.**

To look up recipient (patient) eligibility and/or pharmacy claims history:
Go to Provider Log-In on www.lamedicaid.com. Enter your NPI and then enter your login ID and password. If you do not have a login, you'll be prompted to create one. After logging in, go to Medicaid Eligibility Verification System for recipient eligiblity and Clinical Data Inquiry (e-CDI) for pharmacy claims history. You'll need to enter the recipient's name and either DOB or SSN to use both features.

Temporary disaster enrollments will be approved until the disaster declaration is lifted. Your temporary disaster enrollment will be inactivated no later than six (6) months after the disaster declaration has lifted. To remain enrolled or to become re-enrolled, you can submit a Basic Provider Enrollment Packet for Entities/Businesses, available on www.lamedicaid.com under Provider Enrollment link.

After completing and signing the application packet, please return using **one** of the below methods:

Fax	Mail
(225) 216-6392	Molina Medicaid Solutions Provider Enrollment Unit PO Box 80159 Baton Rouge, LA 70898-0159

BHSF Form PE-50

REQUIRED

Enity/Business

DISASTER Louisiana Medicaid PE-50

Provider Enrollment Form for Out of State Entities/Businesses

Louisiana Medicaid Provider # (if known)	This enrollment packet is for a ☐ New Enrollment ☐ Reactivation ☐ Other (Please specify):
Organizational NPI	Requested Enrollment Effective Date

A Entity/Business Information & Practice Location

Provider Type (see previous page)		Provider Specialty Code (see previous page)
"Doing Business As" (DBA) Name of Enrolling Entity		Business Telephone # ( ) -
Business Street Address		
Business City	Business State	Business Zip Code
Business County	License #	License Issuing State
Is the entity/business currently enrolled in Medicare? ☐ Y ☐ N	Is the entity/business currently enrolled in a non-Louisiana Medicaid program? ☐ Y ☐ N If yes, please provide state here:	

B Pay-To Information

Pay-To Name **(MUST match the first line on IRS documentation EXACTLY)**		IRS Reporting # (Federal Tax ID #)	
Pay-To Mailing Address	Pay-To Mailing City	Pay-To Mailing State	Pay-To Mailing Zip Code
Attn To (optional)			

C Hospitals & LTCs Only

***This section is only required for hospitals & LTCs.

☐ Profit (2) ☐ Nonprofit (3)

# of Certified Beds	Full Name of Hospital Administrator

D Contact Information

The following person may be contacted for additional information regarding this enrollment application:

Contact Name:	Contact E-mail:
Contact Phone # ( ) -	Contact Fax # ( ) -

E Attestation of Information

I, the undersigned, certify the following

1. I have read the contents of this form and the information contained herein is true, correct, and complete;
2. I understand that it is my responsibility to maintain current information on the Louisiana Medicaid files and failure to do so may result in delayed payments or closure of the Medicaid Provider Number;
3. I am an authorized party for the entity/business in Section A and can legally bind this entity to this agreement through my signature below;
4. I understand that the Louisiana Medicaid files will be updated with information supplied on these forms.
5. I understand that this enrollment is temporary and based on disaster needs.
6. I have read the PE-50 Provider Agreement Addendum (revision date 3/2017) and Ownership Disclosure Attestation (revision date 3/2017) available on lamedicaid.com and/or faxed to me at my request and I agree to/with all provisions contained therein, which are incorporated by reference into this provider agreement with the same force and effect as though fully set forth herein.

Authorized Representative's Printed Name	**Authorized Representative's Signature**	**Date of Signature**

REQUIRED if entity is not currently enrolled in Medicare or non-LA Medicaid

DISCLOSURE OF OWNERSHIP FOR ENTITIES/BUSINESSES

Doing Business As (DBA) Name _____

Legal Name of Entity/Business _____

Organizational National Provider Identifier (NPI)										
Tax ID Number										

A. Identify how this disclosing entity/business is registered with the Internal Revenue Service. Select only one.

Is this disclosing entity/business publicly traded? ☐ Y ☐ N A publicly traded company is one which is traded on the open market.

☐ Sole Proprietorship

☐ Partnership/Limited Liability Partnership: How many members are identified with this partnership? _____

☐ Corporation: ☐ Revenue greater than or equal to $5M annually OR ☐ Revenue less than $5M annually

In the current Articles of Incorporation: How many stakeholders/individual owners are identified? _____

How many Board of Director members are identified? _____

How many officers are identified? _____

☐ Limited Liability Corporation (LLC)

In the current Articles of Incorporation: How many members are identified? _____

How many managing employees are identified? _____

☐ Nonprofit: How many members are appointed to the governing board? _____

B. Has this disclosing entity/business used or previously been known by any name other than the Legal Name or DBA Name documented in this application? Make a copy of this page is more space is needed.

Name	**Tax ID #**
Name	**Tax ID #**

C. Is the disclosing entity/business and the disclosing entity/business tax ID listed above currently enrolled in a Federal/State Funded healthcare program? ☐ Y ☐ N

If yes, complete the section below. Make a copy of this page if more space is needed.

Plan (Name of Federal/State funded healthcare program that entity/business/TIN is enrolled in)	**Doing Business As (DBA) Name**	**Tax ID Number**	**Plan Enrollment**	
			State	**ID#**

D. List all individual owners or entities/business that have any direct stake, shareholding, ownership, or controlling interest of 5% or greater in the disclosing entity/business.

If yes, complete the section below for each related individual. Make a copy of this page if more space is needed.

Individual or Entity/Business with Over 5% Ownership	**% Ownership**

E. List all <u>entities/businesses from Section D that have direct</u> ownership of 5% or more in the disclosing entity/business. Identify the owners of 5% of more of those owning entities/businesses. The disclosing entity/business cannot be listed as an owner. Make a copy of this page if more space is needed. The amount of indirect ownership (rightmost column) is determined by multiplying the percentages of ownership in each entity. For example, if individual A owns 10% of the stock in a corporation which owns 80% of the stock in the disclosing entity. A's interest equates to an 8% indirect onwership interest in the diclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock in the disclosing entity, B's interest equates to a 4% indirect ownership interest in the diclosing entity and need not be reported.

Entity/Business with a direct ownership interest listed in Section D	Owners of the Entity/Business identified on the left	% of ownership in Entity/Business identified on the left	Indirect onwership in the disclosing Entity/Business
1.	**a.**		
	b.		
	c.		
2.	**a.**		
	b.		
	c.		
3.	**a.**		
	b.		
	c.		

F. List all <u>individuals from Section D that have direct</u> ownership of 5% or more in the diclosing entity/business. Make a copy of this page if more space is needed.

Full Name (First, Middle, and Last)	**Ever used or been known by any other name, including married, maiden, hyphen or alias?** (provide FULL other name)	**Title/Job Position within this Entity/Business**	**% Owner -ship**	**Date of Birth**	**Social Security #**	**Is this individual a US Citizen?** If no, provide alien verification #.

G. List all agents and individuals who are part of management. Make a copy of this page if more space is needed.

Full Name (First, Middle, and Last)	**Ever used or been known by any other name, including married, maiden, hyphen or alias?** (provide FULL other name)	**Title/Job Position <u>and Type</u>** (agent/officer or managing employee – choose one)	**% Owner -ship, if also owner**	**Date of Birth**	**Social Security #**	**Is this individual a US Citizen?** If no, provide alien verification #.

H. List all entities/businesses from Section D that have direct ownership of 5% or more in the diclosing entity/business. Make a copy of this page if more space is needed.

DBA Name and Legal Name	Has this entity ever used any other name? If so, list name and TIN.	Tax ID #	Street Address (and Mailing Address if different)	Phone # and Fax #	E-mail

I. Are any of the individuals listed in Section F related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the diclosing entity/business? ☐ Y ☐ N
If yes, complete the section below for each related individual. Make a copy of this page if more space is needed.

Name of Individual Owner	Related Individual's Full Name (First, Middle, and Last; include Maiden Name if applicable)	Relationship	Is this related individual an owner, agent, managing employee, or subcontractor? (choose one)	Related Individual's Job Title

J. Do any of the individuals or entities/business listed in Section D have a business transaction with any subcontractor(s) for serrvices amounting to $25,000 or more? ☐ Y ☐ N
If yes, complete the section below. Make a copy of this page if more space is needed.

Name of Individual Owner or Entity/Business	Subcontractor Business Name	Subcontractor Business Owner	Subcontractor Business Full Address	Subcontractor Phone # and E-mail

K. Are any of the entities/business listed in Section D currently enrolled in a Federal/State Funded healthcare program? ☐ Y ☐ N
Make a copy of this page if more space is needed.

Name of Entity/Business	Plan (Name of Federal/State funded healthcare program that owned/controlling business is enrolled in)	Tax ID Number	Plan Enrollment	
			State	ID#

L. Do any of the individuals or entities/business listed in Section D or agents/officers/managing employees listed in Section G have direct or indirect ownership or controlling interest of 5% or more in any other entity/business that participates in a Federal/State Funded healthcare program? ☐ Y ☐ N Make a copy of this page if more space is needed.

Name of Individual Owner, Entity/Business, or Agent/Officer/Managing Employee	Plan (Name of Federal/State funded healthcare program that owned/controlling business is enrolled in)	Doing Business As (DBA) Name	Tax ID Number	Plan Enrollment	
				State	ID#

M. Check the appropriate Yes or No box for the questions below. If Yes is answered to any question:

1) Submit a written statement providing the details on all occurrences.
2) Attach all official legal doucments regarding the occurrence, including any reinstatements.

Answer the following questions about the below groups:

Disclosing entity/business (since its existence) AND/OR any entity/business affiliated with the same Tax ID number AND/OR individual direct and indirect owners AND/OR any past or current direct or indirect agents, managing employees, or persons with a controlling interest AND/OR any direct or indirect owning entity/business (since its existence) AND/OR any entity/business associated with the same TIN as any owning entity/business?

☐ Y ☐ N	Ever been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program?
☐ Y ☐ N	Ever had any disciplinary action taken against any healthcare license or certification held in any State or US Territory, including discipinary action, nolo contendere, probation, board consent order, suspension, revocation, or voluntary surrender of a license or certification?
☐ Y ☐ N	Ever been denied enrollment, suspended, or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid, or other healthcare program(s) in any State or US Territory?
☐ Y ☐ N	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Y ☐ N	Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency?
☐ Y ☐ N	Currently have any open or pending healthcare court cases?
☐ Y ☐ N	Ever been denied malpractice insurance?
☐ Y ☐ N	Currently has or ever had any type of felony conviction(s)?

N. List any individuals authorized to sign into legal, binding documents on behalf of the enrolling entity/business, such as direct deposit forms and/or changes to the disclosure of ownership forms, etc. **Each person listed below must be disclosed elsewhere in this form.** Make a copy of this page if more spaec is needed.

Name of Authorized Individual	Type
	☐ Owner ☐ Managing Employee ☐ Other: _____
	☐ Owner ☐ Managing Employee ☐ Other: _____
	☐ Owner ☐ Managing Employee ☐ Other: _____
	☐ Owner ☐ Managing Employee ☐ Other: _____
	☐ Owner ☐ Managing Employee ☐ Other: _____

O. Complete this section for the individual that has completed this disclosure form.

Full Name (First, Middle, and Last)	**Maiden Name**, if applicable	**Social Security #**	**Date of Birth**
The person completing this form is: ☐ Staff ☐ Third Party/Independent Agent ☐ Other (Please specify):		**Telephone** # ( ) -	**E-mail**

OPTIONAL: Required if you wish to have your funds electronically deposited

MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT FOR INDIVIDUALS

1. Medicaid Provider Number (if known) | | | | | | | |

2. Organizational National Provider Identifier (NPI) | | | | | | | | | | |

3. Doing Business As (DBA) Name
Enrolling Entity: _____

ACCOUNT INFORMATION
(All fields must be completed)

4. Account Type: *(Check One)* ☐ CHECKING ☐ SAVINGS

5. Is the account identified below located in the United States? ☐ Y ☐ N

5a. If No, please identify the country of location: _____

6. Attach or tape a copy of your Voided Check (Deposit Slips are not Acceptable)

TAPE OR ATTACH COPY OF VOIDED CHECK – NO STAPLES
DEPOSIT SLIPS ARE NOT ACCEPTED

If a voided check is unavailable, you may submit a letter on Bank Letterhead identifying the name associated with the account, the ABA Routing Number and the Account Number. The letter must be signed by a Bank Representative.