



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

AMBULANCE TRANSPORTATION

(Enrollment packet is subject to change without notice)

Ambulance Transportation

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 Ambulance Transportation 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 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. 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 EMS license issued by the resident state.
<input type="checkbox"/>	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 59 (Ambulance).
<input type="checkbox"/> **	10. Completed Hold Harmless Agreement Form.

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

** Forms included here.

Out of State Enrollment:

<input type="checkbox"/>	Submit an original claim with the application for the initial date of service. This claim must meet timely filing guidelines. Be sure that the license submitted (see Item 8, above) covers the period represented by the date of service on the claim.
<input type="checkbox"/> **	Completed Molina Medicaid Solutions 105 Attachment form (Certification of Ambulance Transportation).

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

HOLD HARMLESS AGREEMENT

_____, a Medical Transportation provider enrolled in the Louisiana Medicaid Program and providing transportation services for Medicaid recipients, agrees to indemnify, defend, and hold harmless the Department of Health and Hospitals, Bureau of Health Services Financing, from any claims or liabilities whatsoever of any nature arising from the operation of a vehicle by the provider or his employees, agents, etc. and any acts of negligence or misconduct attributable to the provider or his employees, agents, etc.

Provider Signature

Witness

Witness

Notary Public

CERTIFICATION OF AMBULANCE TRANSPORTATION

Recipient Name	Origin of Services
ID # of Recipient	Destination
Date of Transport	Destination (address)

SECTION I (To Be Completed by MD/PA/NP/CNS/RN/DON)

Patient requires the level of medical transportation noted below:

Check One

<input type="checkbox"/>	Emergency Ambulance: Patient's medical condition requires immediate transport and may require medical treatment en route. Describe the medical condition of the patient which requires this type of transport:
<input type="checkbox"/>	Non-Emergency Ambulance: The patient is bed-confined, i.e. unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair, and requires non-emergency ambulance transport, either scheduled or unscheduled, or the patient may require some simple medical care en route, but is stable and is not likely to require the attendance of an EMT. Describe the medical condition of the patient which requires this type of transport:
<input type="checkbox"/>	Non-Emergency Ambulance: Patient will require transportation _____ times a week during the Month's _____, _____ to receive (dialysis, radiology, physical therapy). (Dialysis can be (number) (month(s), year) authorized for two consecutive months.)
<input type="checkbox"/>	Non-Ambulance, Non-Emergency: Patient is stable, not expected to require any medical attention en route, is ambulatory or wheelchair-bound, and can be transported in an automobile or van.

Patient transported to the above named facility for the following reasons:

Check One

	Nearest Facility
	Preference of Physician
	The patient needs services available there
	Other (describe):

SECTION II (To Be Completed by MD/PA/NP/CNS/RN/DON)

Note to Medical Professional: Signing this certification indicates that, in your professional judgment, transportation of the above named patient was necessary based on the patient's condition and in accordance with the statements in Section #1 above. Payment and satisfaction of this claim will be from federal and state funds; any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal or state laws.

I have read the above certification and I have read and understand the instructions on the reverse side of this form.

<input type="checkbox"/>	I agree with the determination
<input type="checkbox"/>	I disagree with the determination for the following reasons:

**Signature of
MD/PA/NP/CNS/RN/DON** _____

X

_____ **Printed Name**

_____ **Date**

SECTION III To Be Completed by Ambulance Drivers(s)

Signature of EMT or Paramedic	Printed Name	National EMT #	Date
Signature of EMT or Paramedic	Printed Name	National EMT #	Date

Note to Ambulance Provider: This form is a required attachment to the ambulance claim form. Providers are not permitted to bill for services rendered to any Medicaid recipient unless this form is attached to the Molina Form 105. Providers who bill electronically must retain this form on file in their offices for 5 years from the date of services. If the patient is determined not to require ambulance transportation, the reimbursement rate will not exceed the non-ambulance, non-emergency rate.

CERTIFICATION OF AMBULANCE TRANSPORTATION**Purpose**

Molina 105 Attachment is initiated to support medical necessity for ambulance transportation for those recipients residing in nursing facilities or those recipients receiving dialysis, radiology, and physical therapy services. Facility reviewers will review this form to determine whether the facility is properly requesting ambulance transportation services. Ambulance transportation reviewers will review this information to determine the patient's condition meets the need for ambulance transportation.

Preparation

Identifying Information: Recipient name, Medicaid ID number, date of transport, origin of service, destination, and destination address shall be completed by either the ambulance transportation provider or the facility. Every item is to be completed.

Certification of Ambulance Transportation Necessity (Section I): Effective with date of service July 1, 2003, the Department of Health and Hospitals has revised the certification form (Form 105 Attachment). (This form was slightly modified in October 2010 to accommodate the new financial intermediary, Molina.) The new form shall replace the Form 105 Attachment 1 currently in use by the ambulance industry. Also, the certification shall require the attending physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse (all applicable state licensure or certification requirement must be met) or nursing facility director of nursing for LTC residents to certify that the patient's condition meets the need for ambulance transportation services. Ambulance transportation was necessary because other means of transportation would endanger the life or health of the patient. In addition, signed certification statements from physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), registered nurses (RN), or nursing facility director of nursing for LTC residents are also acceptable when professional services are furnished by the same.

Type of Ambulance Transportation Necessary:

There are three types of medical transport available:

1. Emergency ambulance transport is appropriate in case of accidents or sudden medical emergency.
2. Non-emergency ambulance transport is to be utilized when the condition of the patient requires or may require medical care en route. Examples of conditions which could reasonably be expected to require non-emergency ambulance transport are: (1) unstable diabetes; (2) chronic pulmonary diseases requiring use of oxygen during transport; (3) unstable ventilator assistance; (4) IV therapy. Prior scheduling is to be utilized.
3. Non-emergency, non-ambulance transport is appropriate for routine non-emergency transport of wheelchair or ambulatory patients. Prior scheduling is to be utilized.

Medical Professional Statement (To be Completed by MD/PA/NP/CNS/RN/DON) – (Section II): The Medical Professional Statement Section is to be completed only if the recipient's physician has not issued written orders requiring ambulance transportation. Such written orders, if used in lieu of the Medical Professional Statement on this form, must specify the medical condition which requires travel by ambulance, the length of time for which ambulance transport will be necessary, and must be signed and dated by the physician. A copy of the written orders, if pertinent, must be attached to the form.

If no written orders have been issued, the Medical Professional Statement shall be completed by the treating medical doctor, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or the nursing facility director of nursing. (The physician may be the physician treating the patient, the physician who instructed the patient to travel to the medical facility, or the medical director of the facility which received the patient.) The medical professional shall check the appropriate block indicating agreement with the facility statements or indicating disagreement and the reason for disagreement.

Ambulance Driver and Attendant Designation and Signature: The names of the ambulance driver and attendant and their national EMT numbers shall be printed or typed legibly by the transportation provider. The form MUST be signed and dated by the driver and the attendant.

Disposition

The facility may file a copy of the form in the patient's record when transport is provided. In cases involving nursing facilities, this copy shall be completed, signed, and dated by the nursing facility Director of Nursing, the ambulance driver, and the ambulance attendant. The Medical Professional Statement shall also be completed unless the medical professional at the medical destination is to complete this section.

Ambulance transportation providers who submit paper claims or bill electronically shall retain the original of the form in the office available for review for a period of five (5) years from the date of service. Every claim shall have either a copy of the physician's written orders attached or the Medical Professional Statement on the form completed, signed, and dated by the appropriate medical professional.

NOTE: When the Medical Professional Statement disagrees with the certification of medical necessity, non-emergency ambulance transport shall be reimbursed at a rate not to exceed the non-emergency, non-ambulance rate.