CHECKLIST SPECIFIC PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid Program)

NOW PROFESSIONAL

(LINKING PROFESSIONALS TO HHA, PCA OR SIL)

(Enrollment packet is subject to change without notice)

PT 06
Revised 6/2021

GENERAL INFORMATION REGARDING WAIVER ENROLLMENTS

Provider Enrollment works on a three-week turnaround time frame. If enrollment requirements are not met, the entire application will be returned for correction and would need to be re-submitted once the corrections are made. Any re-submission of the enrollment packet is subject to additional three-week turnaround period.

The effective date for this enrollment will be the day the application is actually worked by Provider Enrollment.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be made to the provider regarding automatic closure.

If at any time during enrollment as a Waiver Medicaid provider, the provider has a change of physical address, then the provider must first obtain an updated license indicating the new address, and then submit notification of the change of address along with a copy of the updated license to Gainwell Provider Enrollment (see address on checklist, below).

ATTENTION!!
Waiver service providers are required to comply with all requirements contained in:

1. The provider manuals located at:

https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

And
2. The information located on the LDH/OCDD website at

http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8

CHECKLIST OF FORMS TO BE SUBMITTED
For NOW Professional Waiver Services Program

The following checklist shows all documents that must be submitted to the Gainwell Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Individual NOW Professional provider:

Completed	Document Name
**	**1.** The NOW Professional Waiver Services Provider Enrollment Form (NOW-1).
**	**2.** 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.)** **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. **-or-** **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.
	3. Printout of online medical license verification from the governing license board of your profession. This verification must contain the license numbers, the effective date of issuance, and the current status of the license. A temporary permit is only good until the expiration date.
**	**4.** Completed Link/Unlink and Working Relationship Form.
	5. To report —Specialtyǁ for this provider type on Section A of the PE-50, please use Code 4R (Registered Dietician), 4D (Psychologist), 4E (Social Worker).

** Forms are 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:
Gainwell - Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Louisiana's Medicaid Program
NOW PROFESSIONAL WAIVER SERVICES

Provider Number: (Leave Blank If Applying For New Number)							
Individual Provider Name:							
National Provider Identifier:							
Provider Street Address:							
Provider City:							
Provider State:				Provider Zip:			
Provider Phone Number:	( ) -			Fax Number:	( ) -		
Social Security Number:							
Professional License Number: (attach copy of license)							
Specialty (refer to attached lists):	**Registered Dietician (4R)** ☐ **Psychologist (4D)** ☐ **Social Worker (4E)** ☐						
Requested Effective Date:							
Provider Signature:				Date of Signature:			

PROVIDER VERIFICATION FOR DELIVERY OF NOW WAIVER SERVICES

I hereby certify under oath that all statements I have made on this application and the attachments thereto are true and correct. I affirm I have a minimum of one-year post-licensure experience in my field of expertise and I hold a current Louisiana License for the Professional Type indicated:

Registered Dietician (4R) ☐ Psychologist (4D) ☐ Social Worker (4E) ☐

PROVIDER VERIFICATION FOR CONSULTATION SERVICE FOR NOW WAIVER PROGRAM

I hereby certify under oath that all statements I have made on this application and the attachments thereto are true and correct. I affirm I have a minimum of one-year post-licensure experience in my field of expertise and I hold a current Louisiana License for the Professional Type indicated:

Registered Dietician (4R) ☐ Psychologist (4D) ☐ Social Worker (4E) ☐

I hereby certify that all information is true and that I have a minimum of one-year experience in my field of expertise and hold a current Louisiana License.

Print Individual Provider's Name **Individual Provider's Signature** **Date**

Please submit all required documentation to:

Gainwell - Provider Enrollment Unit PO Box 80159
Baton Rouge, LA 70898-0159

(PT06)
Revised 05/10

Louisiana Medicaid
Group 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)		
☐ LINK	Effective Date:		☐ 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)		
☐ LINK	Effective Date:		☐ 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 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: Gainwell Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159