PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Optometrist (Individual)

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR THE INDIVIDUAL OPTOMETRIST PROVIDER TYPE

At the time of enrollment, if the Optometrist license is a temporary license, the provider will be enrolled but the provider file will expire on the date specified by the temporary license. To extend the provider file, the enrollee must fax a permanent license to Provider Enrollment (225-216-6392).

Individual Optometrists may link to the following group (as long as the group has a Louisiana Medicaid entity/business type Provider Number):

- Optometrist Group

Linkages of Professional Individuals to Groups – a professional individual's provider number can be "linked" to a group provider number for purposes of billing as an attending provider for the specified group.

- **Open professional individual providers require only Group Link/Unlink and Working Relationship Form.**
- **New, Inactive, or Closed professional individual providers require an entire enrollment application as well as the Group Link/Unlink and Working Relationship Form.**

The number of groups a professional individual can link to is limited. It is very important that all professional individuals terminating their relationship with a group notify Provider Enrollment. Provider Enrollment can then unlink the professional individual from the specified group, allowing the professional individual to be linked to other groups in the future.

Claims submitted under the group number, with a professional individual's number included as the attending provider, will be processed and the remittance will be sent directly to the group's mailing address. ***It is not necessary for the individual's mailing address to be the same as the Group's mailing address for these Remittance Advice notices to be sent to the group, if billed correctly.***

If a professional individual is linking to a group as an attending only (not being paid individually by Medicaid), then the EDI Contract, Direct Deposit Form, and voided check are not required.

Revised 06/10

Optometrist – Individual
CHECKLIST OF FORMS TO BE SUBMITTED

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 Optometrist provider:

Completed	Document Name
☐ *	1. Completed Individual Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
☐ *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	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.)** **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. **-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.
☐ *	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).
☐	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**).
☐	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**).
☐	8. Copy of current medical license from governing license board of your profession. If requesting retroactive coverage, a license must be submitted that covers that time period. A temporary permit is only good until the expiration date.
☐ **	9. Completed OFS Form 24, if applicable.
☐	10. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 88 (Optometrist).

For Group Linkages:

☐ **	1. Completed Group Link/Unlink and Working Relationship Form.

*These forms are available in the **Basic Enrollment Packet for Individuals**.

** Forms are included here.

Out of State Enrollment:

☐	1. Submit an original claim with the application for the initial date of service. This claim must meet timely filing guidelines. Subsequent claims must be submitted directly to Gainwell claims processing once the provider has received confirmation via mail of successful enrollment in Louisiana Medicaid.

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Dear Provider:

It is the policy of the Bureau of Health Services Financing that the Medicaid Program will only pay for in-office performance of certain laboratory and diagnostic services which are billed by physicians if the following conditions are met:

1. The physician has completed and has on file with Louisiana State Medicaid Program, Provider Enrollment Unit, a completed OFS Form 24.
2. The completed OFS Form 24 fully describes the laboratory or diagnostic equipment required to perform these tests.
3. The OFS Form 24 information is updated as needed.

Our policy towards laboratory or diagnostic services that are performed outside of a physician office remains unchanged. Physicians may not be reimbursed for laboratory or diagnostic services ordered for their patients if these services are performed outside of their office. Only the performer of a test may seek reimbursement for these services. Any interpretive service by the attending physician is reimbursed through the physician visit payment.

The OFS Form 24 requirements only pertain to: 1) those participating physicians who own or lease laboratory or diagnostic testing equipment that is located in their office or place of practice and 2) for which use the physician will be submitting a claim to the Medicaid program.

Example 1: Dr. Jones is an individual practitioner who owns or leases a SMA-12, EKG monitor and X-Ray equipment. Dr. Jones wishes to perform laboratory and diagnostic services on Medicaid patients in his office and bill the Medicaid Program for these laboratory or diagnostic services. Dr. Jones must complete the OFS Form 24.

Example 2: Drs. Smith, Jones, Doe, and Rae are a group practice. As a group they own or lease laboratory and diagnostic equipment. It is their desire to use this equipment in treating Medicaid recipients, and they will bill the Medicaid Program for these services. If each physician is individually enrolled in the Medicaid Program, each physician in the group must complete the OFS Form 24, even though the descriptive information will be identical. If the physicians are enrolling as a group, only one OFS Form 24 is required as long as all members of the group are indicated.

Example 3: An individual or group practitioner utilizes an external source for laboratory or diagnostic tests. The individual or group practitioner would not complete the OFS Form 24, as they would not bill the Medicaid Program directly.

A Louisiana OFS Form 24 is enclosed for completion and submittal where applicable. Return the completed form to:

Gainwell Provider Enrollment Unit,
P.O. Box 80159,
Baton Rouge, LA 70898-0159.

Sincerely,

Provider Enrollment Unit

Revised 09/09

Diagnostic and/or Laboratory Equipment

Provider Number (7 digits) | | | | | | | |

NPI (10 digits) | | | | | | | | | | |

Provider Name: _____

Provider Address: _____

_____

Diagnostic and/or Laboratory Equipment

Make	Model	Serial #	Capabilities

List names of individuals who will be performing the diagnostic and/or laboratory tests in the spaces below:

1.	2.

I certify that the above is a true and accurate listing of diagnostic and/or laboratory equipment in my office.

Signature* Date

* Acceptable signatures are as follows: individual professionals must sign their own forms. Only an authorized representative may sign for groups, businesses, or entities. Original provider signature is required (no stamps or initials)

COPY PAGE IF ADDITIONAL SPACE IS NEEDED

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Louisiana Medicaid
Link/Unlink and Working Relationship Form

If additional space is needed, please copy this form before filling it out.

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, if linking. **(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, 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 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