



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid)

Physical Therapist (Individual)

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION

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 an additional three-week turnaround period.

The enrollment begin effective date for Physical Therapists enrolling for ROW or Children's Choice Waiver Therapy Services only will be the date the enrollment 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 sent to the provider regarding the automatic closure.

Physical Therapy Assistants are not eligible to enroll in Louisiana Medicaid.

- Individual Physical Therapist Providers may enroll in Louisiana Medicaid for:
 - Early Steps Provider (see PT 29 Early Steps Provider Type Specific Checklist/Packet)
 - Medicare Crossover Payments
 - o Residential Options Waiver (ROW)
 - o Children's Choice Waiver Therapy Services
- Individual Physical Therapists may enroll and bill as an Individual Physical Therapist for the ROW program OR they may choose to link to and bill through the following Provider Type agencies:
 - o PT11 Shared Living
 - o PT84 Substitute Family Care
- If a professional Individual is linking to an Entity/Business as an 'Attending' only (not being paid individually by Medicaid), then the EDI Contract, Direct Deposit Form, and voided check are not required.
- Individual Physical Therapists may not link to any Medicaid enrolled Groups, Rural Health Clinics, Federally Qualified Health Centers, or any other program within Louisiana Medicaid (except for the specified Waiver provider type mentioned above for ROW or Children's Choice Waiver Services).

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

Physical Therapist 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 Physical Therapist provider:

Completed	Document Name					
*	Completed Individual Louisiana Medicaid PE-50 Provider Enrollment Form.					
*	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).					
*	Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.					
*	4. Completed Louisiana Medicaid Ownership Disclosure Information Form for Individual.					
	5. 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).					
	6. 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).					
	7. Printout of the online 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.					
	8. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 65 (Physical Therapy).					
For ROW S	ervices:					
**	9. Completed Link/Unlink and Working Relationship Form.					
**	10. Provider Verification Form for ROW Services.					
**	11. To report "Sub-specialty" for this provider type on Section A of the PE-50 please use Code 4W (Waiver Services).					
For Children's Choice Waiver Services:						
**	12. Provider Verification Form for Children's Choice Waiver Therapy Services.					
**	13. To report "Subspecialty" for this provider type on Section A of the PE-50, select all services you will provide of the following Subspecialty codes: Aquatic Therapy (7R), Art Therapy (7T), Music Therapy (7V), Art and Music Therapy (7U), Sensory Integration (7X), Therapeutic Horseback Riding (7Y), and/or Hippotherapy (7Z)					
	14. Submit a copy of the appropriate certification that supports the Subspecialty chosen from # 13 above.					

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

**
These 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 Medicaid Link/Unlink and Working Relationship Form

PURPOSE

This form is used when an individual provider is requesting to be linked to an Entity/Business. The form allows for the Linkage/ Unlinkage to two (2) separate Entities/Businesses. This form also serves as documentation that a working relationship exists between an individual and an Entity/Business. For this form to be valid, an **ORIGINAL SIGNATURE AND DATE ARE REQUIRED.**

Individual Provider Name:								
Individual Provider Number:			LA Medicaio	d Provider #	National Provide	er Identifier (NPI)		
Professional Group Name:								
Professional Group Provider Number:			LA Medicaio	d Provider#	National Provide	er Identifier (NPI)		
LINK	Effective Date:			UNLINK	Termination Date:			
Approximate Number of Hours Worked at this Group Per Week, if linking. (required)			NOT REQUIRED FOR PHYSICAL THERAPIST					
Profession	al Group Name	e:						
	al Group Namo		LA Medicaio	d Provider#	National Provide	er Identifier (NPI)		
Profession	· · · · · · · · · · · · · · · · · · ·		LA Medicaio	d Provider #	National Provide Termination Date:	er Identifier (NPI)		
Professiona Number: LINK	al Group Provi	der		UNLINK	Termination			
Professiona Number: LINK Approximate I Group Per We	al Group Provi Effective Date: Number of Hours teek, if linking. (received)	der Worked at this uired)		UNLINK	Termination Date:			
Profession: Number: LINK Approximate I Group Per We regarding to	al Group Provi Effective Date: Number of Hours teek, if linking. (received)	Worked at this juired)		UNLINK	Termination Date:			

I am an Individual currently enrolled or enrolling in Medicaid, who has a contractual agreement to see Medicaid Recipients for the above named Entity/Business. I understand that upon request I must provide DHH a copy of the written, contractual working agreement between the Individual and the Entity/Business listed above.

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

Original signature only - colored ink (please don't use black ink)

Provider Verification for Children's Choice Waiver Services

PURPOSE

This form confirms that the individual specified below wishes to provide Children's Choice Waiver Services to Louisiana Medicaid recipients, and attests that the individual has provided paid services to person(s) with developmental disabilities through the OCDD program for a minimum of one year as Occupational Therapist, Physical Therapist, Speech Therapist, Psychologist, and Certified Behavioral Analyst.

Additional documentation/ credentials required for Therapy Services: Certification/ Registration as Art Therapist, Certification/Registration as Aquatic Therapist, Certification/ Registration as Music Therapist, Certification/ Registration as Hippo Therapist, Certification/ Registration in Therapeutic Horseback Riding, Certification/ Registration in Sensory Integration, Psychologist Certification/ Registration in Applied Behavioral Analysis –based Therapy, Certified Behavioral Analyst with Certification/ Registration in Applied Behavioral Analysis –based Therapy.

Individual Provider Number:	LA Medicaid Provider # (leave blank if new applicant)		# National Provider Identifier (NPI)									
	(loave slaim ii lie											
Individual Provider Name:			1 1					1	1			<u> </u>
Physical Address:												
Professional Category (choose one):	ОТ 🗌 РТ	☐ ST		PSY [] CB/	A						
Contact Person for questions												
regarding this form: Contact Person Phone Number:	()	_										
 I hereby affirm under oath that all statements I have made on this application and the attachments thereto are: True and correct, and that I can receive reimbursement for services provided only to those persons within the Children's Choice Waiver (CCW), and that all Professional Services provided to Children's Choice Waiver (CCW) participants must be prior authorized before services are rendered, and that as a Professional providing services to Children's Choice Waiver (CCW) participants, I have one year paid experience working with people with developmental disabilities as outlined in the Children's Choice Waiver (CCW) Provider Manual, and I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid. THUS DONE AND PASSED BEFORE ME, Notary, in the City of							rized oaid					
of	on the _day	of				20	<u></u>					
Print Individual Provider's Name			Notary	Public	Signati	 ure						
			,		J							
			Notary	Seal c	or Notary	y Ident	tificati	ion N	umbe	r (req	uirea	1)
Individual Provider's Signature												
Original signature only – colored ink (please do	on't use black ink)											

Provider Verification for ROW Services

PURPOSE

This form confirms that the individual specified below wishes to provide ROW Services to Louisiana Medicaid recipients, and attests that the individual has provided paid services to person(s) with developmental disabilities through the OCDD program for a minimum of one year as a Dietician, Occupational Therapist, Physical Therapist, Psychologist, Speech Therapist, or Social Worker.

Individual Provider Number:	LA Medicaid Provider # (leave blank if new applicant)	National Provider Identifier (NPI)						
Individual Provider Name:								
Physical Address:								
Professional Category (choose one):	Dietician	PSY ST SW						
Contact Person for questions regarding this form:								
Contact Person Phone Number:	() -							
 True and correct, and that I can receive reimbursem Waiver (ROW), and that all Professional Services rendered, and that as a Professional providing people with developmental distribution of the in Medicaid. 	nent for services provided only provided to ROW participants and services to ROW participants sabilities as outlined in the RO this oath shall constitute cause	sufficient for the refusal or revocation of enrollment						
		ity of, State						
Print Individual Provider's Name	on the _ day of Nota	ry Public Signature						
Individual Provider's Signature Original signature only – colored ink (please do		ry Seal or Notary Identification Number (required)						

Complete this form in its entirety and mail the original to:

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