PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Mental Health Clinic

(Enrollment packet is subject to change without notice)

Mental Health Clinic
CHECKLIST OF FORMS FOR SUBMISSION

NOTE: Only Local Governing Entities (LGEs) can enrolled with Fee-For-Service Medicaid as a Mental Health Clinic (PT-74) – AND - only for Medicare Cross-overs and QMB Claims

The following checklist identifies the necessary documents needed to enroll in Louisiana Medicaid (Fee-For-Service), as a Mental Health Clinic:

Completed	Document Name
☐ *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. Completed PE-50 Addendum – Provider Agreement Form.
☐ *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.
☐ *	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 the Behavioral Health Service Provider License issued by the Health Standards section from Louisiana Department of Health.
☐	9. On **Section A** of the PE-50 Form, in the **Specialty Code** space write in **'70'** (Group/Clinic) and leave the **Subspecialty Code** space **'blank'**.
☐	10. On **Section D** of the PE-50 Form, in the **Provider Type Description** space write in '**Mental Health Clinic'** and in the **Provider Type Code** space write in '**74'.**
TO LINK INDIVIDUAL PROFESSIONALS	
☐ **	11. Completed Link/Unlink and Working Relationship Form for currently enrolled professional individuals needing to link to this Mental Health Clinic. The following individuals may link to a Mental Health Clinic – if their Specialty is Psychiatric: Doctor of Osteopathic Medicine (PT-19), Physicians (PT-20), Nurse Practitioner (PT-78), Psychologist or Medical Psychologist (PT-31) and Social Worker (PT-73). If any individual is not enrolled or active in Medicaid, then a full Individual Enrollment Application is required, in addition to the Group Link/Unlink form.

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

** Forms included here.

Please submit all required documentation to:

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

Louisiana Medicaid
Link/Unlink and Working Relationship Form

Copy this form for additional space as needed

PURPOSE

This form serves to link/unlink an Individual to or from an Entity, for Medicaid purposes. The form allows Link/Unlink of one Individual for two separate Entities. Estimate the number of hours the Individual will work for that specific provider Entity. The form also serves as documentation a working relationship exists between an Individual and the Entity. The Individual must sign and date this form.

Individual Provider Name:					
Individual Provider Number:	LA Medicaid Provider #		National Provider Identifier (NPI)		
Entity Name:					
Entity Provider Number:	LA Medicaid Provider #		National Provider Identifier (NPI)		
LINK	Effective Date:		UNLINK	Termination Date:	
Approximate Number of Hours Working at this Entity Per Week **(required)**					
Entity Name:					
Entity Provider Number:	LA Medicaid Provider #		National Provider Identifier (NPI)		
LINK	Effective Date:		UNLINK	Termination Date:	
Approximate Number of Hours Working at this Entity Per Week **(required)**					
Contact Person for questions regarding this form:					
Contact Person Phone Number:	( ) -				

WORKING RELATIONSHIP AGREEMENT

I am an Individual who has a contractual agreement with the above named Entity.
I have recorded the approximate number of hours I will be working per week for the entity.

Individual Provider Signature _____

Date of Signature _____

MAIL Completed Forms To:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159