



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

**Mental Health Rehabilitation Agency
(MHR)**

(Enrollment packet is subject to change without notice)

Mental Health Rehabilitation Agency (MHR)

CHECKLIST OF FORMS FOR SUBMISSION

NOTE: Mental Health Rehab Agencies (PT-77) may only in enroll in Louisiana Medicaid (Fee-For-Service) for Medicare Cross-overs and QMB Claims - so the MHR Entity must be enrolled with Medicare

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

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.
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.
<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 the Behavioral Health Service Provider License issued by the Health Standards section from Louisiana Department of Health.
<input type="checkbox"/>	9. On Section A of the PE-50 Form, in the Specialty Code space write in '78' (Mental Health Rehab) and leave the Subspecialty Code space 'blank' .
<input type="checkbox"/>	10. On Section D of the PE-50 Form, in the Provider Type Description space write in 'Mental Health Rehab' and in the Provider Type Code space write in '77' .
TO LINK INDIVIDUAL PROFESSIONALS	
<input type="checkbox"/> **	<p>11. Completed Link/Unlink and Working Relationship Form for currently enrolled professional individuals needing to link to this Mental Health Rehab Agency.</p> <p>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).</p> <p>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.</p>

* 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**