ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

(Louisiana Medicaid Program)

OPR

(Ordering, Prescribing, Referring)

Enrollment Packet

(All Inclusive Packet)

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR ORDERING, PRESCRIBING AND REFERRING (OPR) PROVIDERS

The Federal Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid Program to order, prescribe, and refer items or services for Medicaid beneficiaries, even when they do not submit claims to Medicaid themselves.

Practitioners that order, prescribe, or refer items or services for Medicaid beneficiaries, but who choose not to submit claims to Medicaid, are required to enroll with Fee-For-Service (FFS) Medicaid using this OPR packet.

Enrolling as a FFS Medicaid OPR Provider:

- Does not obligate you to see Medicaid patients;
- Does not mean you will be listed as a Medicaid provider for patient assignment or referral;
- Does not, at this time, require an annual renewal;
- Allows you to continue to see Medicaid patients without billing the Medicaid program if you so choose; and,
- Helps ensure that your orders, prescriptions, and referrals for Medicaid patients are accepted and processed appropriately
- Will not allow a claim to be paid under this provider type.

Statutorily Mandated Revisions to all Provider Agreements

The 1997 Regular Session of the legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437:14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between the Department of Health and Hospitals (DHH) and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

1) comply with all federal and state laws and regulations;
2) provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
3) have all necessary and required licenses or certificates;
4) maintain and retain all records for a period of at least five (5) years;
5) allow for inspection of all records by governmental authorities;
6) safeguard against disclosure of information in patient medical records;
7) bill other insurers and third parties – provider type PT PO is prohibited from billing Medicaid;
8) report and refund any and all overpayments;
9) agree to be subject to claims review;
10) the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
11) notification prior to any change in ownership;
12) inspection of facilities; and
13) posting of bond or letter of credit when required.

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

The provider agreement provisions of MAPIL also provide the DHH Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

Office for Civil Rights Policy Memorandum

The Department of Health and Human Services (DHHS), Office for Civil Rights, recently issued a policy memorandum regarding non-discrimination based on national origin as it relates to individuals who are limited-English proficient. Below is the Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Statement which expresses our Agency's commitment to ensuring that there is no discrimination in the delivery of health care services through CMS programs.

Louisiana Medicaid is in full compliance with the requirements contained in this policy statement. As a partner with the administration of the Medicaid program, a Medicaid provider is likewise obligated to comply with the statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The Office for Civil Rights of the DHHS has previously advised CMS that detailed implementation regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

Please share this policy statement with the healthcare providers and all others involved in the administration of CMS programs.

Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Policy Statement

The Centers for Medicare and Medicaid Services' vision in the current Strategic Plan guarantees that all beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all CMS program operations and activities. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all CMS operating components. Promoting attention to and ensuring CMS program compliance with civil rights laws are among the highest priorities for CMS, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of CMS programs.

CMS, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. CMS will, with the help of each Medicaid provider, continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

To achieve its civil rights goals, CMS will continue to incorporate civil rights concerns into the culture of its programs, and is requesting all partners do the same. Civil right concerns will be included in the regular program review and audit activities including: collecting data on access to, and the participation of minority and disabled persons in the programs; furnishing information to recipients and contractors about civil rights compliance; reviewing CMS publications, program regulations, and instructions to assure support for civil rights; and working closely with the DHHS, Office for Civil Rights, to initiate orientation and training programs on civil rights. CMS will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

DHHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, CMS will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

CMS's mission is to assure health care security for the diverse population that constitutes the nation's Medicare and Medicaid beneficiaries; i.e., the customers. Communications will be enhanced with constituents, partners and stockholders. Input from health care providers, states, contractors, and DHHS Office for Civil Rights, professional organizations, community advocates and program beneficiaries will be sought. Vigorous assurance that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability will be continued.

BHSF PE-50 Form Instructions for PT OPR (Ordering, Prescribing and Referring)

PREPARATION

Please read the instructions in its entirety before completing the form. Complete the form as an **original** document. It is recommended that the enrolling OPR provider keep a photocopy these forms for their records. Inaccurate/Incomplete forms will result in the entire application being returned for completion.

GENERAL INFORMATION

A Medicaid provider number will be issued to the individual whose name appears in Section A of this form. It is the responsibility of this individual to maintain accurate information on the Louisiana Medicaid provider file by submitting updates (as needed) to the Provider Enrollment Unit.

An Individual Medicaid provider number can have only one (1) mailing address. Therefore, this address **MUST** be the address the enrolling prescribing individual wishes to receive correspondence from LDH or Gainwell regarding their Medicaid application or provider number.

All fields on the PT PO (OPR) BHSF PE-50 Form **MUST** be completed unless labeled as optional.

Louisiana Medicaid Provider Number – enter the 7-digit Louisiana Medicaid provider number (if known). If this is a new enrollment, leave the boxes blank.

This enrollment packet is for –check the appropriate box.

Type 1 Individual National Provider Identifier (NPI) – enter the enrolling Prescriber provider's 10-digit NPI number. The NPI is a unique 10-digit identification number issued to healthcare providers by the Centers for Medicare and Medicaid Services (CMS). Visit https://nppes.cms.hhs.gov for more information on obtaining an NPI. A NPI number is required prior to being issued a Prescriber Only Medicaid provider number.

NPI Tie Breaker (Taxonomy or Zip + 4) – **NOTE: The current Louisiana Medicaid system will only allow the linkage of one unique NPI to one Medicaid provider number.** Thus, the recommendation is to obtain one NPI for each Medicaid ID number requested. The use of the same NPI to link to multiple Medicaid numbers requires a unique Tiebreaker each time that NPI is used in conjunction with a different provider number. Acceptable Tiebreakers are valid Taxonomy codes from NPPES or a ZIP Code + 4. The same NPI (or NPI with a Tiebreaker) indicated on the file for a given Medicaid provider number is the same NPI (or NPI with a Tiebreaker) that needs to be on claims.

Requested Enrollment Effective Date – requested date for the activation of the Medicaid provider number. In some instances, this date can be retroactive as long as it the meets the timely filing policy. Attach a valid license that covers the requested date of enrollment in addition to documentation providing your prescriptive authority.

SECTION A – INDIVIDUAL INFORMATION & PRACTICE LOCATION

Provider Type Description and Code (Required) – OPR (prefilled).

Provider Type Code – PT-PO OPR (prefilled).

Specialty (required) – 92 – OPR (prefilled).

Subspecialty (required) – refer to the list below and enter the correct subspecialty code in the field.

Code	Description
16	Certified Nurse Mid-Wife (CNM)
05	Certified Registered Nurse Anesthetist (CRNA)
01	Doctor of Osteopathic Medicine- DO (General Practice)
41	Doctor of Osteopathic Medicine-DO (Internal Medicine)
27	Doctor of Osteopathic Medicine-DO (Psychiatry)
66	Dentist
6G	Medical Psychologist (MP)
79	Nurse Practitioner (NP)
88	Optometrist (OD)
01	Physicians- MD (General Practice)
41	Physicians-MD (Internal Medicine)
26	Physicians – MD (Psychiatry)
2R	Physician Assistant (PA)
48	Podiatrist (DPM)
87	All Others

Name of enrolling Prescribing Individual – enter the individual's name in this field (must match the name on the license).
M.D., O.D., etc. – enter the abbreviation of the professional title held by the provider.
Area Code and Telephone # - enter the telephone number at the practice location where the enrolling prescribing individual can be reached.
Social Security Number (required) – enter the social security number of the enrolling prescribing individual.
Pursuant to Louisiana Medicaid rules and regulations and 42 U.S.C. § 1320a-3, social security numbers are required for each individual for enrollment in Louisiana Medicaid. Not having a Social Security number on the application will result in a rejected application, needing correction.
Has the enrolling Prescriber provider used or been known by another name? – check the appropriate box. If yes, check the appropriate type(s) of other name(s) and enter those name(s) used and known by.
Is the enrolling Prescriber provider a U.S. citizen? – check the appropriate box. If no, answer the "Does the enrolling Prescriber provider have legal status and work privileges in the U.S.?" question by checking the appropriate box.
Main Practice Street Address – enter the main practice location where the enrolling prescribing individual will be working. (For those providers who provide services at multiple locations, this address should be the address of the individual's main location.) Occasionally, there will be an instance when mail or a document or a correspondence may be sent to the Main Practice Street Address. If mail cannot be received at the Main Practice Street Address because there is no receptacle and the postal carrier will not bring the mail inside the building, include a brief note that explains the problem and provide an alternate delivery address for the physical location only.
Practice City – enter the city of the *Main Practice Street Address*.
Practice State – enter the state of the *Main Practice Street Address*.
Practice Zip Code – enter the zip code of the *Main Practice Street Address*.
Parish/County – enter the parish / county of the *Practice Street Address*, (for out-of-state providers, see county codes below).
Parish Code – enter the parish code of the physical location (see list below and enter appropriate code for the parish entered in the *Parish* field) – ***(continued on next page)***.

Acadia	01	E. Baton Rouge	17	Madison	33	St. Landry	49
Allen	02	E. Carroll	18	Morehouse	34	St. Martin	50
Ascension	03	E. Feliciana	19	Natchitoches	35	St. Mary	51
Assumption	04	Evangeline	20	Orleans	36	St. Tammany	52
Avoyelles	05	Franklin	21	Ouachita	37	Tangipahoa	53
Beauregard	06	Grant	22	Plaquemines	38	Tensas	54

Bienville	07	Iberia	23	Pointe Coupee	39	Terrebonne	55
Bossier	08	Iberville	24	Rapides	40	Union	56
Caddo	09	Jackson	25	Red River	41	Vermillion	57
Calcasieu	10	Jefferson	26	Richland	42	Vernon	58
Caldwell	11	Jefferson Davis	27	Sabine	43	Washington	59
Cameron	12	Lafayette	28	St. Bernard	44	Webster	60
Catahoula	13	Lafourche	29	St. Charles	45	W. Baton Rouge	61
Claiborne	14	LaSalle	30	St. Helena	46	W. Carroll	62
Concordia	15	Lincoln	31	St. James	47	W. Feliciana	63
DeSoto	16	Livingston	32	St. John	48	Winn	64

Out of State Providers (Use the chart below to determine the county/state codes)

Bordering states with counties identified as a “trade-area” to Louisiana have specific county codes that must be used, as follows:

Use the state code unless the practice location is in one of the trade-area counties. If the practice location is in one of the trade-area counties, be sure to use the appropriate county code (NOT the state code).

State	State Code	Trade-Area County	County Code
Texas	87	Cass, Harrison, Jefferson, Marion, Newton, Orange, Panola, Sabine, Shelby	90
Mississippi	88	Adams, Amite, Claiborne, Hancock, Issaquena, Jefferson, Marion, Pearl River, Pike, Walthall, Washington, Warren, Wilkinson	91
Arkansas	89	Ashley, Chicot, Columbia, Lafayette, Miller, Union	92
ALL OTHER STATES			**99**

State Status – check “In (0)” if the *Practice Street Address* is located within Louisiana or “Out (1)” if it is located outside Louisiana.
Location Type – check “Urban (1)” if the *Practice City* is an urban (city) location or “Rural (2)” if it is a rural (away from city centers) location.
Does the enrolling Prescriber provider currently hold (or have in the past held) a professional license in this or any other state? – check the appropriate box.
If yes, list the state, type of license, and license numbers. If necessary, attach additional pages to the BHSF PE-50 form. NOTE: License must cover the requested effective date of enrollment. Also, documentation verifying your prescriptive authority is required.
Date of Birth – enter the date of birth for the individual. This is a required field and the forms will be returned for correction if it is left blank.
UPIN (if known) – enter the Universal Provider Identification Number (UPIN) of the enrolling Prescriber provider, if applicable. The NPI has replaced the UPIN as the required identifier for Medicare services.
Board Certification # (optional) - enter the number relating to the Board Certification of the enrolling Prescriber provider– this number is issued by the certifying board and is included on the Board Certification certificate, optional. (Attach a copy of the certificate if this field is used).

SECTION B – CONTACT INFORMATION

Contact Name – enter the name of the person who may be contacted for additional information regarding this enrollment application.
Contact Phone # – enter the phone number of the person who may be contacted for additional information regarding this enrollment application.
Contact Fax # - enter the fax number of the person who may be contacted for additional information regarding this enrollment application.
Contact Email – enter the email address of the person who may be contacted for additional information regarding this enrollment application.

SECTION C – PROVIDER ATTESTATION OF INFORMATION

Read the information included in this section.
Printed Name of Individual Provider - print the name of the **individual provider** who is enrolling in Louisiana Medicaid.
Signature of Individual Provider – the individual provider who is enrolling in Louisiana Medicaid must sign the form.

> **NOTE: Signatures must be original and in blue ink (not BLACK) (stamped signatures and initials are not accepted). Office Manager signatures are not accepted.**

Date of Signature – enter the date this agreement was signed.

ALL PROVIDERS MUST COMPLETE THE PE-50 FORM IN ITS ENTIRETY – INACCURATE/INCOMPLETE FORMS WILL BE RETURNED TO THE MAILI NG ADDRESS FOR CORRECTION

BHSF PE-50 Form for PT PO OPR (Individual) Rev. 10/15

All fields must be completed unless labeled as optional

Louisiana Medicaid Provider # (if known)	This enrollment packet is for a ☐ New Enrollment ☐ Re-validation of existing enrollment ☐ Reactivation ☐ Other (Please specify):
Type 1 Individual NPI	NPI Tie Breaker (Taxonomy or Zip + 4) / Requested Enrollment Effective Date:

A Individual Information & Business Practice Location

See Provider Specialty Checklist

Provider Type Description (required)	Provider Type Code	Specialty Type (required)	Subspecialty (required)
Ordering, Prescribing and Referring Only	PT-PO	92 – OPR	

Name of enrolling Prescribing Individual (Last Name, First Name, Middle Name)	M.D., O.D., etc.	Area Code & Telephone #	Social Security # (required)
		( ) -	- -

Has the enrolling Prescriber provider used or been known by another name? ☐ Y ☐ N
☐ Former or Maiden Name ☐ Professional Name ☐ Other (Describe):
If yes, please enter name(s) here:

Is the enrolling Prescriber provider a U.S. citizen? ☐ Y ☐ N
If no, does the enrolling Prescriber provider have legal status and work privileges in the U.S.? ☐ Y ☐ N

Main Practice Street Address

Practice City	State	Zip Code + 4, if known

Parish/County	Parish/County Code	State Status	Location Type
		☐ In (0) ☐ Out (1)	☐ Urban (1) ☐ Rural (2)

Does the enrolling Prescriber provider currently hold (or have in the past held) a professional license and prescriptive authority in this or any other state? ☐ Y ☐ N
If yes, provide a copy in addition to listing the license #, type of license, state issued and prescriptive authority information below: (If necessary, attach additional page.)

License #: Type of License: State of Issuance: Prescriptive Authority:	Date of Birth	UPIN (if known)	Board Certification # (optional)

B Contact Information

The following person may be contacted for additional information regarding this enrollment application:

Contact Name:

Contact Phone #
( )

Contact Fax # ( )

Contact email:

C Provider Attestation of Information

The undersigned enrolling Prescriber provider certifies the following, that:

1. The contents of this completed Prescriber enrollment packet including the PE-50 Provider Agreement Addendum and the information contained herein is true, correct, and complete;
2. It is the enrolling Prescriber provider's responsibility to maintain current information on the Louisiana Medicaid file and failure to do so may result in closure of the Medicaid Provider Number;
3. The signature of the enrolling Prescriber provider legally binds this provider to this agreement; and
4. The Louisiana Medicaid files will be updated with information supplied on these forms.

Printed Name of Individual Provider	**Signature of Individual Provider** ***(Sign in blue ink only)***	**Date of Signature**

PT PO OPR (Ordering, Prescribing and Referring) PE-50 PROVIDER AGREEMENT ADDENDUM

Provider Name			
Business Practice Location			
NPI		SSN/Tax ID	Provider Type

I, the undersigned, certify and agree to the following:

Enrollment in Louisiana Medicaid

1. I have read the contents of this Louisiana Medical Assistance Program Enrollment Packet and the information supplied herein is true, correct and complete;
2. I understand that it is my responsibility to ensure that all information is kept up to date on the Louisiana Medicaid Provider File;
3. I understand that failure to maintain current information may result in the closure of my Medicaid provider number;
4. I understand that if my number is closed due to inaccurate information, I will have to complete a new enrollment packet in its entirety to reactivate my provider number. A new application fee may be required for certain provider types.
5. I attest that I am a U.S. citizen or that I have legal status and work privilege in the U.S.
6. I understand that it is my responsibility to ensure that all my employees and/or authorized representatives are U.S. citizens or have legal status and work privilege in the U.S.
7. I understand that individuals who meet one or more of the following conditions may not be eligible to participate in the Medicaid program. I understand that it is my responsibility to immediately report to the Program Integrity Section at DHH if I, or any owners, managing employees or agents meet one or more of the noted conditions upon discovery of such information.
   - denied enrollment;
   - suspended, or excluded from Medicare, Medicaid or other Health Care Programs in any state;
   - employed by a corporation, business, or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or other Health Care Programs in any state;
   - convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs or any offense delineated in the Louisiana Medical Assistance Programs Integrity Law; 42 CFR 455.106
8. I understand that, as part of the Louisiana Medicaid enrollment/re-enrollment process, the Social Security Numbers of any person with an ownership or control interest in the disclosing entity, any managing employees or any agents must be disclosed; 42 CFR 455.104
   - I understand that failure to provide the Social Security Numbers will result in the rejection of my enrollment or re- enrollment request.
9. I acknowledge that I have read and am familiar with LA R.S. 46:437.10. A&B – Continuing Liability; assumption of liability by the seller and buyer. Both parties are responsible for recoverable obligations.

Providing Services to Louisiana Medicaid Recipients

10. I agree to conduct my activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL Louisiana R.S. Title 46, Chapter 3, Part VI-A) as required to protect the fiscal and programmatic integrity of the medical assistance programs;
11. I understand that the Medicaid Provider Agreement is voluntary between the DHH and the health care provider and shall be effective for a stipulated period of time;
    - This agreement may be terminated by the DHH for cause without notice;
    - Either party shall terminate the agreement for no cause 30–days after written notice; and
    - The agreement shall be renewable upon mutual agreement.
12. I understand that services and/or supplies provided by me must be medically necessary and medically appropriate for each individual patient based on needs presented on the date the service is provided and/or delivered;
13. I agree to charge no more for services to eligible recipients than is charged on the average for similar services to others;
14. I understand that as the provider, I am held responsible for any and all claims associated under the Louisiana Medicaid provider number issued to me;
15. I agree to maintain all records necessary for full disclosure of services provided to individuals under the program and to furnish, at no cost, information regarding those records as well as payments claimed/received for providing such services that DHH, the DHH Secretary, the Louisiana Attorney General, or the Medicaid Fraud Control Unit may request for five years from the date of service;
16. I agree to submit all requested medical records within the time frames allowed to the CMS Payment Error Rate Measurement (PERM) contractor if/when claims are selected in a random sample. Failure to do so may result in sanctions;

17. I agree to report and refund any discovered overpayments within sixty (60) days of discovery;
18. I agree to adhere to the published regulations of the DHH Secretary and the Bureau of Health Services Financing, including, but not limited to, those rules regarding recoupment and disclosure requirements as specified in 42 CFR 455, Subpart B;
19. I agree to adhere to the federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the federal DHHS, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA;
20. I understand the Louisiana Medicaid Program must comply with DHHS regulations promulgated under Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; and the American Disabilities Act of 1990 which require that:
    - No person in the United States shall be excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of age, color, handicap, national origin, race or sex under any program or activity receiving Federal financial assistance.

    Under these requirements, Louisiana's DHH, Bureau of Health Services Financing cannot pay for medical care or services unless such care and services are provided without discrimination based on age, color, handicap, national origin, race or sex. Written complaints of non-compliance should be directed to Secretary, Department of Health and Hospitals, PO Box 91030, Baton Rouge, LA 70821-9030 or DHHS Secretary, Washington, DC or both.
21. The Deficit Reduction Act of 2005, Section 6032 Implementation: As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, I agree to comply with the False Claims Act employee training and policy requirements in 1902(a)(68) of the Social Security Act, set forth in that subsection and as the Secretary of the US DHHS may specify. As an enrolled provider/entity, I understand that it is my obligation to inform all of my employees and affiliates of the provisions of the Federal False Claims Act, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. When monitored or audited, I will be required to show evidence of compliance with this requirement.
22. The Anti-Trust Assignment: The provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed by the State and/or its offices, agencies, departments or political subdivisions through any programs or payment mechanisms. For purposes of this assignment clause, the "provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

Printed Name of Individual Provider

Signature of Individual Provider

Date of Signature

Instructions for Louisiana Medicaid Ownership Disclosure Information
PT PO OPR-Ordering, Prescribing and Referring (Individual)

This is a multi-page form. Please review the instructions in their entirety before completing the form. ***Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.***

Please refer to the web sites listed on the page following these instructions for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Please enter your Provider Name at the top of each page in the space provided.

SECTION I – ENROLLING PRESCRIBING INDIVIDUAL INFORMATION

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number. If this application is for a new Medicaid provider number, leave this field blank.
NPI Type 1 – Individual – Enter your ten (10) digit Type 1 (Individual) National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
Taxonomy/Tie Breaker, if applicable – Enter your Taxonomy Code or your ZIP+4 Tie Breaker, if applicable.
NPI Type 2 – Organizational, if applicable – Enter your ten (10) digit Type 2 (Organizational) NPI, if necessary.
Federal Employer Tax ID Number (FEIN) – Enter the nine (9) digit Tax ID number for this self-incorporated provider. If not self-incorporated, leave blank.
Social Security Number of Individual (required) – Enter the social security number of the enrolling prescribing individual.
Date of Birth – Enter the date of birth of the enrolling prescribing individual in the space provided.
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Re-validation of existing enrollment, or Re-Enrollment.
Provider Type – enter the Louisiana Medicaid Provider Type for the enrolling prescribing individual.
Enrolling Prescribing Individual Provider Information – Enter the following in the spaces provided for the enrolling prescribing individual.

- First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable).
- Telephone Number
- Email Address
- Fax Number
- Provider's telephone number to request medical records
- Main Practice Location Address
- Mailing Address/PO Box of Main Practice Location

Is the enrolling prescribing individual a U.S. citizen? – Check the appropriate box. If no, provide the Alien Verification number.
Do you practice in any location other than the one listed above? – Check the appropriate box. If yes, provide the following information for each practice location:

- DBA Name of practice location
- Medicaid Provider number
- Second Practice Mailing Address/PO Box
- Second Practice Location Address
- Second Practice Location phone number
- Second Practice Location fax number
- Second Practice Location Email address
- Repeat the information above for third, fourth and fifth practice locations, if applicable. If more practice locations exist, attach additional pages.

SECTION II – ENROLLING PRESCRIBING INDIVIDUAL ADDITIONAL INFORMATION

Has the enrolling prescribing individual listed in Section I ever:

A. Held a professional license in any state other than Louisiana? – Check the appropriate box. If yes, list the state(s) and Professional License Numbers in the spaces provided.

B. Practiced as a Medicare/Medicaid healthcare provider in any state other than Louisiana? – Check the appropriate box. If yes, list the state(s), Medicare Provider Numbers, and the Medicaid Provider Numbers in the spaces provided. Attach additional pages if needed.

C. Used or been known by any other name including married, maiden, hyphenated, or alias? – Check the appropriate box. If yes, enter the names in the spaces provided. Attach additional pages if needed.

D. Used or been known by any other incorporated or Doing Business As (DBA) names? – Check the appropriate box. If yes, list all DBA names, Legal Names and Tax IDs in the spaces provided. Attach additional pages if needed.

SECTION III – ENROLLING PRESCRIBING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE

Has the enrolling prescribing individual owner named in Section I (ever) – Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

SECTION IV – ENROLLMENT IN HEALTHCARE PROGRAMS

A. Is the Social Security Number and/or Tax ID number(s) listed in Section I currently enrolled in any other Federal/State funded healthcare programs? – Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name and address, the Tax ID number/Social Security number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION V – OWNERSHIP OF ENTITIES/BUSINESSES ENROLLED IN FEDERAL/STATE FUNDED HEALTHCARE PROGRAMS

A. Does the enrolling prescribing individual have any direct, indirect or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in a Federal/State funded healthcare program(s)? – Check the appropriate box. If yes, identify the applicable plan(s) and list the DBA Name(s) and address(es), the Tax ID(s), the Social Security Number(s), % ownership, the location (state) and the Plan Number(s) in the spaces provided.

B. Is the enrolling prescribing individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed in item A above? – Check the appropriate box. If yes, enter the names of each individual, the relationship to the enrolling prescribing individual (i.e., spouse, parent, child, sibling), percentage of ownership, date of birth and social security number.

SECTION VI – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

Enter the following in the spaces provided for the preparer of this application.

- First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable)
- Social Security Number
- Date of Birth
- Job Title
- Indicate if the person completing the form is self, staff, third party/independent agent or other. If other, please explain further.
- Physical Location Address
- Telephone Number - indicate the type of telephone number provided: work, home or cell
- Email Address
- Additional Telephone Number
- Additional Email Address

SECTION VII – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

If the enrolling prescribing individual is also the owner of the business/entity identified as the Provider Pay-to name and Tax ID in Section B on the form PE-50-I, this section must be completed.

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

A separate VII form is required for each agent or managing employee, therefore, please make the necessary copies as a list of all managing employees and/or agent names will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith;* or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Managing employee is defined as a general manger, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.

Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider. See Federal Regulation 42 CFR § 455.101.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Managing employee/agent
- Officer
- Trustee

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

Section VII Instructions:

A. **Does this enrolling prescribing individual employ any Agents or Managing employees? –** Check the appropriate Box. If yes, make one photocopy of Section VII for each agent or managing employee you report. If no, proceed to Section VIII.

B. **AGENT – or – MANAGING EMPLOYEE–** Check on a box to specify whether the person is a Managing employee or an Agent. Enter the managing employee/agent's First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable), Title/ Job Position, Social Security Number, Date of Birth, current mailing address, telephone number, email address, primary physical location address and additional business location addresses and mailing addresses in the spaces provided. Attach additional sheets if needed.

C. **Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? –** Check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional sheets if needed.

D. **Is this agent or managing employee a U.S. citizen? –** Check the appropriate box. If no, provide Alien Verification number.

E. **Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related in the spaces provided. Attach additional pages if needed.

F. **Has the agent or managing employee named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

G. **Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

Reference Material for
Louisiana Medicaid Ownership Disclosure Information
For a PT PO OPR (Ordering, Prescribing and Referring) Individual

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address**:** http://www.ecfr.gov/cgi-bin/text/Title42_Volume 4_Chapter IV_430-481

MAPIL Louisiana R.S., Title 46:437.1-14. http://www.legis.la.gov/legis/Law.aspx?d=100852

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://www.doa.la.gov/Pages/osr/reg/register.aspx

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at www.lamedicaid.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: http://www.gpo.gov/fdsys/granule/USCODE-2010-title42/USCODE-2010-title42-chap7-subchapXI-partA-sec1320a-3

Social Security Act 1128 a: http://www.ssa.gov/OP_Home/ssact/title11/1128A.htm

Provider Name: _____

LOUISIANA MEDICAID PT PO OWNERSHIP DISCLOSURE INFORMATION – OPR (Ordering, Prescribing and Referring Only)

Must be completed in its entirety. Refer to Instructions found at www.lamedicaid.com

SECTION I – ENROLLING PRESCRIBING INDIVIDUAL INFORMATION

Louisiana Medicaid Provider Number **(Leave blank if applying for new number)**							

NPI Type 1 – Individual										
Taxonomy/Tie Breaker (if applicable)										

NPI Type 2 – Organizational **(if applicable)**										

Federal Employer Tax ID Number (FEIN)									

Social Security # of Individual (required)									

Date of Birth (required)			/			/				

This enrollment packet is for a ☐ New Enrollment ☐ Re-validation of existing enrollment ☐ Re-Enrollment	**Provider Type:**

A. ENROLLING PRESCRIBING INDIVIDUAL PROVIDER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Telephone Number of Enrolling prescribing individual - -	Email Address		
Fax Number - -	Provider's telephone number to request medical records - -		
Main Practice Location Address	City	State	Zip
Mailing Address/PO Box of Main Practice Location	City	State	Zip

B. ☐ **Yes** ☐ **No Is the enrolling prescribing individual a U.S. Citizen? If no, provide Alien Verification #**

_____

Provider Name: _____

Make a photocopy of this page if more space is needed to list additional locations

C. ☐ Yes ☐ No Do you practice in any location other than the one listed on the previous page?

If yes, complete the section below for each location.

DBA Name of second practice location	Medicaid Provider #		
Second Practice Mailing Address/PO Box	City	State	Zip
Second Practice Location Address	City	State	Zip
Second Practice Location Phone Number - -	Second Practice Location Fax Number - -		
Second Practice Location Email address			

DBA Name of third practice location	Medicaid Provider #		
Third Practice Mailing Address/PO Box	City	State	Zip
Third Practice Location Address	City	State	Zip
Third Practice Location Phone Number - -	Third Practice Location Fax Number - -		
Third Practice Location Email address			

DBA Name of fourth practice location	Medicaid Provider #		
Fourth Practice Mailing Address/PO Box	City	State	Zip
Fourth Practice Location Address	City	State	Zip
Fourth Practice Location Phone Number - -	Fourth Practice Location Fax Number - -		
Fourth Practice Location Email address			

DBA Name of fifth practice location	Medicaid Provider #		
Fifth Practice Mailing Address/PO Box	City	State	Zip
Fifth Practice Location Address	City	State	Zip
Fifth Practice Location Phone Number - -	Fifth Practice Location Fax Number - -		
Fifth Practice Location Email address			

Provider Name: _____

**Make a photocopy of this page if more space is needed to respond to all items below **

SECTION II – ENROLLING PRESCRIBING INDIVIDUAL ADDITIONAL INFORMATION

Has the enrolling prescribing individual listed in Section I ever:

A. ☐ **Yes** ☐ **No** **Held a professional license in any state other than Louisiana?**

B. ☐ **Yes** ☐ **No** **Practiced as a Medicare/Medicaid healthcare provider in any state other than Louisiana?**

If yes to either item A or B, complete the section below.

Domicile State:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #:

C. ☐ **Yes** ☐ **No** **Used or been known by any other name including married, maiden, hyphenated, or alias?**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

D. ☐ **Yes** ☐ **No** **Used or been known by any other incorporated or Doing Business As (DBA) names?**

If yes, list all names and Tax IDs below. Attach additional pages if needed.

1. DBA Name	Legal Name	Tax ID
2. DBA Name	Legal Name	Tax ID
3. DBA Name	Legal Name	Tax ID
4. DBA Name	Legal Name	Tax ID

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to Section IV below

SECTION III – ENROLLING PRESCRIBING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

Has the enrolling prescribing individual named in Section I (ever):

☐ Yes ☐ No	Been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Had any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Been denied malpractice insurance?
☐ Yes ☐ No	Has or had any type of felony conviction(s)?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

- **SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.**
- **ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.**

SECTION IV – ENROLLMENT IN HEALTHCARE PROGRAMS

☐ **Yes** ☐ **No** **Is the Social Security Number and/or Tax ID number(s) listed in Section I currently enrolled in any other Federal/State funded healthcare programs?**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID/SSN	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to items A and B below

SECTION V – OWNERSHIP OF ENTITIES/BUSINESSES ENROLLED IN FEDERAL/STATE FUNDED HEALTHCARE PROGRAMS

A. ☐ Yes ☐ No Does the enrolling prescribing individual have any direct, indirect or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in a Federal/State funded healthcare program(s)?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name and Address	Tax ID/SSN	% ownership	Plan Numbers for Enrollments	
				State	ID#

B. ☐ Yes ☐ No Is the enrolling prescribing individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed in item A above?

If yes, list all individuals and how they are related (i.e., spouse, parent, child, sibling) below.
Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:		% ownership	Date of Birth		Social Security #
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:		% ownership	Date of Birth		Social Security #
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:		% ownership	Date of Birth		Social Security #
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:		% ownership	Date of Birth		Social Security #

Provider Name: _____

SECTION VI – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Social Security Number	Date of Birth	Job Title

The person completing this form is (please check one):

☐ Self ☐ Staff ☐ Third Party/Independent Agent ☐ Other (explain) _____

Physical Location Address	City	State	Zip

Telephone Number ☐ Work ☐ Home ☐ Cell	Email Address

Additional Telephone Number ☐ Work ☐ Home ☐ Cell	Additional Email Address

Provider Name: _____

Make photocopies of the next 2 pages to complete Section VII for each agent or managing employee AND make a photocopy of this page if more space is needed to respond to items C and E below

SECTION VII – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ Yes ☐ No Does this enrolling prescribing individual employ any Agents or Managing employees?
If yes, complete the following information for each agent or managing employee.
If no, proceed to Section VIII.

B. ☐ AGENT – or – ☐ MANAGING EMPLOYEE

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Title/Job Position within this entity/business	Social Security Number (required) - -	Date of Birth (required) / /

Mailing Address/PO Box	City	State	Zip Code
Physical Address	**City**	**State**	**Zip Code**

Telephone Number - -	Email Address

Additional business location address	City	State	Zip
Mailing address for above location	City	State	Zip
Additional business location address	City	State	Zip
Mailing address for above location	City	State	Zip

C. ☐ Yes ☐ No Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias?
If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

D. ☐ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification #_____

E. ☐ Yes ☐ No Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business?
If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item G below

Name of Agent or Managing Employee: _____

Check the appropriate yes or no box regarding the questions below. Every item needs to have either a yes or no check. Do not leave any blanks.	
F. Has the agent or managing employee named above (ever):	
☐ Yes ☐ No	Convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program.
☐ Yes ☐ No	Has any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification?
☐ Yes ☐ No	Been denied enrollment, suspended or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any State or U.S. Territory?
☐ Yes ☐ No	Has a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Yes ☐ No	Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency.
☐ Yes ☐ No	Currently have any open or pending healthcare court cases?
☐ Yes ☐ No	Denied malpractice insurance?
☐ Yes ☐ No	Has a felony conviction(s) of any type?

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

- **SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES**
- **ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.**

G. ☐ Yes ☐ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID#

Provider Name: _____

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That I have disclosed all necessary information;
2. That I am the individual identified in Section I and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That I have reviewed the information on this Individual Disclosure form and attest that it is true, accurate and complete;
4. That I understand that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the individual already participates, a termination of the provider agreement or contract with DHH or the Secretary, as appropriate;
5. That I understand that a denial or termination of the provider agreement or contract with DHH or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That I understand that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to DHH or the Secretary may be prosecuted under applicable federal or state laws;
7. That I understand it is my responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That I understand that the failure to maintain current and correct information may result in closure of my Medicaid provider number;
9. That I understand if my number is closed due to inaccurate information, I will have to complete a new Provider Enrollment Packet in its entirety to reactivate my provider number;
10. I understand that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, I must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US and I understand that it is my responsibility to ensure that all my managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
13. I understand that it is my responsibility to ensure that I have disclosed on this form if I, or any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
14. I understand that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), I am required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
15. I understand that I shall report any of the above conditions to the Department of Health and Hospitals (DHH), and once enrolled, I understand that upon discovery of any of the above conditions, it is my responsibility to report them immediately in writing to DHH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
16. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any federally funded healthcare program, I am required to submit this information and the requested documentation.
17. I understand that I am being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." I understand that this criminal statute means that if I, or any managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or been terminated from participation in the Medicare, Medicaid, or any other Federally or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. I also understand that "participation" includes providing any services which will be billed, directly or indirectly, to Medicaid, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to Louisiana's Medicaid Program. I also understand that this new crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

_____
Printed Name of Individual Provider

_____
Signature of Individual Provider
(sign in blue ink)

_____
Date of Signature