PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Physician (Individual)

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR THE INDIVIDUAL PHYSICIAN PROVIDER TYPE

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

- Physician Group
- Rural Health Clinics
- Federally Qualified Health Centers
- School Based Health Centers

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's NPI, with a professional individual's NPI 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.

If you plan to prescribe Buprenorphine and/or Buprenorphine-Naloxone containing products, it will be necessary for you to also submit a copy of your "X" DEA registration. Otherwise prescriptions for these products will not be payable in the Pharmacy program.

Physician – 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 Physician provider:

Completed	Document Name
☐ *	1. Completed Individual 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 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. To prescribe Buprenorphine and/or Buprenorphine-Naloxone containing products, copy of Controlled Substance Registration Certificate showing the X-DEA number. (Otherwise, prescriptions for these products will not be payable in the Pharmacy program)
☐ **	10. Completed OFS Form 24, if applicable.
☐	11. Copy of CLIA certificate, if applicable.
☐ **	12. To report "Specialty" for this provider type on Section A of the PE-50, please refer to the attached listing of recognized physician specialties for Louisiana Medicaid. Choose a specialty from the list provided (below) that best matches your area of expertise.

For Group Linkages:

☐ **	1. Completed Link/Unlink and Working Relationship Form. Must complete number of working hours per week on this 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

Specialties and Subspecialties For
Physicians ONLY

Code	Specialty Description		Code	Specialty Description
01	General Practice			1F Pediatric Emergency Med.
02	General Surgery			1G Pediatric Endocrinology
03	Allergy			1H Pediatric Gastroenterology
04	Otology, Laryngology, Rhinology (ENT)			1I Pediatric Hematology – Oncology
05	Anesthesiology			
06	Cardiovascular Disease			
07	Dermatology			1J Pediatric Infectious Disease
08	Family Practice			1K Pediatric Nephrology
10	Gastroenterology			1L Pediatric Pulmonology
13	Neurology			1M Pediatric Rheumatology
14	Neurological Surgery			1N Pediatric Sports Medicine
16	Obstetrics & Gynecology (see subspecialty below)			1P Pediatric Surgery
	Subspecialty			1Q Pediatric Neurology
	3A Critical Care Medicine			1R Pediatric Genetics
	3B Gynecologic Oncology			1U Pediatric Developmental Behavioral Health
	3C Maternal & Fetal Medicine		38	Geriatrics
18	Ophthalmology		39	Nephrology
1T	Emergency Medicine / Emergency Room		40	Hand Surgery
20	Orthopedic Surgery		41	Internal Medicine (see subspecialty below)
22	Pathology			**Subspecialty**
24	Plastic Surgery			2A Cardiac Electrophysiology
25	Physical Medicine Rehabilitation			2B Cardiovascular Disease
26	Psychiatry			2C Critical Care Medicine
28	Proctology			2D Diagnostic Lab Immunology
29	Pulmonary Diseases			2E Endocrinology & Metabolism
2Q	Nuclear Medicine			2F Gastroenterology
30	Radiology			2G Geriatric Medicine
33	Thoracic Surgery			2H Hematology
34	Urology			2I Infectious Disease
37	Pediatrics (see subspecialty below)			2J Medical Oncology
	Subspecialty			2K Nephrology
	1A Adolescent Medicine			2L Pulmonary Disease
	1B Diagnostic Lab Immunology			2M Rheumatology
	1C Neonatal Perinatal Medicine			2N Surgery-Critical Care
	1D Pediatric Cardiology			2P Surgery-General Vascular
	1E Pediatric Critical Care Med.		49	Miscellaneous (Admin Medicine)

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 07/09

Diagnostic and/or Laboratory Equipment

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

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

Provider Name: ______________________________

Provider Address: ______________________________

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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:

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

Revised 06/10

Louisiana Medicaid
Link/Unlink and Working Relationship Form

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

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