PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

PHARMACY

(Enrollment packet is subject to change without notice)

Pharmacy

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 a Pharmacy provider:

Completed	Document Name
All Providers	
☐ *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
☐ *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
☐ *	4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. **(Only the Disclosure of Ownership portion of this enrollment packet can be done by choosing Option 1.)** **Option 1** (preferred): Provider Ownership Enrollment Web Application. Go to www.lamedicaid.com and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist. **-or-** **Option 2** (not recommended): If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy 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 Pharmacy license issued by the State Board of Pharmacy.
☐	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 87 (Other).
☐ **	10. Completed Point of Sale Forms (5 pages).
Out-of-State Providers **(Additional Document Requirements)**	
☐ **	11. Complete Out-of-State Pharmacy Enrollment Amendment
☐	12. Submit justification that supports the criteria selected on the Out-of-State Pharmacy Enrollment Amendment.
☐	13. If applying for Medicare Crossovers, submit the Medicare confirmation letter.

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

**Forms 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

Provider Name

Provider # (for Gainwell Use only)

POINT-OF-SALE CERTIFICATION

I certify that all Point of Sale claims are rendered by a legally qualified person, that the charge is within the Department's prescription package policy and that the payment has not been previously received.

I have retrieved the online Provider Manual at www.lamedicaid.com, have read and understand all published regulations, Prescription Drug Services Manual and Provider Updates concerning pharmaceutical payments and agree that all point of sale services adhere to those regulations.

I also agree to keep such records as are necessary or required to disclose fully the extent of Point-of-Sale services provided to individuals under the State's Title XIX plan and to furnish all information regarding any payments claimed for providing such Point of Sale services as the state agency or the Medicaid Fraud Control Unit may request for five (5) years from the date of services.

With my signature below, I attest that I am an authorized representative of this entity and, as such, have the authority to enter into a provider agreement with Louisiana Medicaid.

According to the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS-46:437, I will notify Louisiana Medicaid Provider Enrollment prior to any change in ownership.

I understand that payment and satisfaction of the claims will be from federal and state funds and that any false or misleading claim statements, documents or concealment of material fact, may be prosecuted under applicable federal and state laws.

ALL SIGNATURES MUST BE ORIGINAL AND IN BLUE INK.

Authorized Representative (print)

Authorized Representative Title

Authorized Representative Signature

Date of Signature

Pharmacist-in-Charge Signature

PIC License Number

(If the provider is a corporation or partnership, a statement certifying the above authorized representative must be attached to the Point-of-Sale Certification and Enrollment Amendment)

Provider Name

Provider # (for Gainwell Use only)

STATE OF LOUISIANA
MEDICAID PHARMACY POINT-OF-SALE AGREEMENT

This Pharmacy Point of Sale Agreement (hereinafter Agreement), made and entered into this _____ day of _____, 20___, by and between the Louisiana Department of Health and Hospitals (Hereinafter Agency), acting in its own right as the Agency responsible for administering the Medicaid Assistance Program (Title XIX) In and by _____(hereinafter Provider).

In consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the pharmacy agrees to provide said services in accordance with the following terms and conditions.

1. This Agreement is in addition to the Provider Enrollment Application between the Agency and Provider, including, but not limited to the right of the Agency or its representatives to perform audit functions or the requirement that the Provider maintain the original prescription on file.

2. Provider shall submit to the Agency, through the fiscal agent (hereinafter Agent), for Louisiana Medicaid, via a Point of sale (POS) device, claims for prescriptions dispensed to Louisiana Medicaid recipients.

3. The Provider shall safeguard the Medicaid program against abuse in its utilization of claims entry through the POS system.

4. The Provider shall correctly enter the claims data, monitor the data and certify that the data entered is correct.

5. The Provider shall reverse any claim which is adjudicated (submitted for payment) and then not dispensed to a Medicaid recipient.

6. The Provider shall allow the Agency access to claims data and assure that transmission of claims data is restricted to authorized personnel so as to preclude erroneous payment by the Agent resulting from carelessness or fraud.

7. The Provider shall allow the Director of the Agency or any of its designees and representatives of the Office of the Attorney General Medicaid Fraud Control Unit to review and copy all records free of charge.

8. The Provider shall abide by all Federal and State statutes, rules, regulations and manuals and provider updates governing the Louisiana Medicaid Program and those conditions as set out in the State of Louisiana, Department of Health and Hospitals Medicaid Provider Agreement entered into previously.

9. The Provider agrees to charge no more for Medicaid services than is charged to the general public.

ALL SIGNATURES MUST BE ORIGINAL AND IN BLUE INK.

Authorized Representative (print)

Authorized Representative Title

Authorized Representative Signature

Date of Signature

(If the provider is a corporation or partnership, a statement certifying the above authorized representative must be attached to the Point-of-Sale Certification and Enrollment Amendment)

Provider Name _____ Provider # (for Gainwell Use only) _____

PHARMACY POINT-OF-SALE AMENDMENT

INDEPENDENT PHARMACY OWNERSHIP INFORMATION

(less than 15 Medicaid enrolled pharmacies under common ownership)

Summary of Ownership Information

*If the pharmacy is owned by a corporation, please list the individual owners of the corporation and their percentage of interest in the corporation.

Owner Name	% Ownership

(Please attach additional pages if needed.)

Please note that if there has been a 50% or more change in ownership since the Board of Pharmacy issued your original permit, a new Board of Pharmacy permit and Louisiana Medicaid provider number are required!

Owner Contact Information

Owner 1
Name _____ Phone _____
Address _____ Fax _____
City, State, Zip _____ Email _____

Owner 2
Name _____ Phone _____
Address _____ Fax _____
City, State, Zip _____ Email _____

Owner 3
Name _____ Phone _____
Address _____ Fax _____
City, State, Zip _____ Email _____

Owner 4
Name _____ Phone _____
Address _____ Fax _____
City, State, Zip _____ Email _____

Owner 5
Name _____ Phone _____
Address _____ Fax _____
City, State, Zip _____ Email _____

Provider Name

Provider # (for Gainwell Use only)

PHARMACY POINT-OF-SALE AMENDMENT

CHAIN PHARMACY OWNERSHIP INFORMATION

(15 or more Medicaid enrolled pharmacies under common ownership)

Corporate Information:

Corporate Name	
Address 1	
Address 2	
City	
State	
Zip	

Financial Contact:

Name	
Pone	
Fax	
Email	

Provider Name _____ Provider # (for Gainwell Use only) _____

PHARMACY POINT-OF-SALE AMENDMENT

LA Pharmacy Permit # _____ *PLEASE ATTACH A CURRENT COPY OF THE PERMIT*

*Out-of-state pharmacies that DO NOT mail or deliver to the state of Louisiana- please submit the pharmacy permit of your home state.

**Out-of-state pharmacies that DO mail and/or deliver to the state of Louisiana- please submit copies of both your Louisiana permit and the permit of your home state.

Medicare # _____ Tax ID # _____
NPI # _____ NCPDP # _____

Contact Information

Store Phone _____ Store Fax _____
Store Email _____ Disaster Phone _____

Physical Address	Billing Address	Mailing Address

Services Provided (check all that apply):

☐ Retail ☐ IV Therapy ☐ Group Home ☐ Nursing Home
☐ IV Exclusive ☐ Group Home / ICF / MR ☐ Nursing Home Exclusive

Please list below all nursing homes, group homes, ICF/MR facilities that your pharmacy services:

Facility 1
Name _____ Approx. # Medicaid Recipients _____
Address _____ Consultant PD _____
City, State, Zip _____

Facility 2
Name _____ Approx. # Medicaid Recipients _____
Address _____ Consultant PD _____
City, State, Zip _____

Facility 3
Name _____ Approx. # Medicaid Recipients _____
Address _____ Consultant PD _____
City, State, Zip _____

Facility 4
Name _____ Approx. # Medicaid Recipients _____
Address _____ Consultant PD _____
City, State, Zip _____

Provider Name _____ Provider # (for Gainwell Use only) _____

PHARMACY POINT-OF-SALE AMENDMENT

In the past twelve (12) months, as there been a change of ownership for your pharmacy?
☐ Yes (attach Disclosure of Ownership Information) ☐ No

Please list ownership interest in any other pharmacies. (Attach additional pages if necessary)
☐ Not applicable

Owner Name	Pharmacy Name	Pharmacy Address	Medicaid Provider #

340 B

☐ Yes ☐ No Is the Medicaid Provider number listed above a 340 B contracted pharmacy?
If yes, does your pharmacy carve out Medicaid recipients? ☐ Yes ☐ No

Technology / Services Provided

Software Vendor _____ Electronic Switch Vendor _____

☐ Yes ☐ No Does your pharmacy use Bar Code technology to scan drugs before being dispensed / filled?
☐ Yes ☐ No Does your pharmacy provide drugs via mail order if requested by the recipient?
☐ Yes ☐ No Does your pharmacy provide a delivery service?
☐ Yes ☐ No Is your pharmacy capable of accepting electronic prescriptions (excluding faxes)?
☐ Yes ☐ No Is this pharmacy provider associated with the sole distribution of a drug?

If yes, please list:_____

Percentage of Business

_____ Approximately what percentage of your total business is Medicaid (FFS, Community Health Solutions, & United Healthcare)?
_____ Approximately what percentage of your total business is provided to Medicaid Managed Care Organizations (Amerigroup Caritas, & Louisiana Healthcare Connections)?
_____ What is the total number of prescriptions dispensed from July 1, 2013 to June 30, 2014 (including Medicaid, cash, and other payors?

Wholesalers
Please list the wholesaler(s) you use. MUST BE COMPLETED.
1. _____
2. _____
3. _____

Store Hours

Monday-Friday	am	to	pm	☐ closed	Other (ex. 24 hr? available prn?) Please explain:
Saturday	am	to	pm	☐ closed	
Sunday	am	to	pm	☐ closed	

Provider Name

Provider # (for Gainwell Use only)

PHARMACY POINT-OF-SALE AMENDMENT

Employee Information
Please provide full-time and part-time employee information that is current as of today's date.
Attach additional pages as needed.

Pharmacist in Charge

Name		License #	
Pharmacist Medicaid #		Pharmacist NPI	
Medication Admin Registration #		Disease State Certification & Date of Certification	

Pharmacist 1

Name		License #	
Pharmacist Medicaid #		Pharmacist NPI	
Medication Admin Registration #		Disease State Certification & Date of Certification	

Pharmacist 2

Name		License #	
Pharmacist Medicaid #		Pharmacist NPI	
Medication Admin Registration #		Disease State Certification & Date of Certification	

Pharmacist 3

Name		License #	
Pharmacist Medicaid #		Pharmacist NPI	
Medication Admin Registration #		Disease State Certification & Date of Certification	

Pharmacist 4

Name		License #	
Pharmacist Medicaid #		Pharmacist NPI	
Medication Admin Registration #		Disease State Certification & Date of Certification	

Pharmacy Technicians

Name	License #

Remittance Advice Reviewer

Name	
Title	
Phone	
Fax	
Email	

Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana
Department of Health and Hospitals
Bureau of Health Services Financing

January 3, 2014

MEMORANDUM

Re: Louisiana Medicaid Pharmacy Benefits Management Program
Out-of-State Pharmacy Enrollment

In accordance with Louisiana Administrative Code 50:701(B), out-of-state pharmacies may enroll as Medicaid providers to secure reimbursement for a specific claim or claims under the following circumstances ONLY:

1. Where an emergency arises from an accident or illness
2. Where the health of the individual would be endangered if he undertook travel or if care and services are postponed until he returns to the state of Louisiana
3. When it is the general practice for residents of a particular locality to use medical resources in the medical trade areas outside the state
4. When the medical care and services or needed supplementary resources are not available within the state. Prior authorization is required for out-of-state care.

If services are provided to a Louisiana Medicaid recipient in accordance with the criteria detailed above, enrollment will be allowed to obtain a Medicaid provider number to secure payment of the claim. However, this Medicaid provider number will only be active to finalize the claim at issue, not to allow the out-of-state pharmacy to maintain continuous and active enrolled provider status. In no event can an out-of-state Medicaid provider number be active for more than thirteen months to secure payment of a single claim.

Medicare Crossover Claims

Please note that the enrollment criteria outlined above *does not apply* to Medicare crossover claims: out-of-state Pharmacy providers will be allowed continuous Medicaid enrollment for Crossover claims only. The out-of-state pharmacy must be enrolled in Medicare prior to enrolling in Louisiana Medicaid. When enrolling in the Medicaid program, the out-of-state Pharmacy must indicate that crossover billing is requested and submit a copy of their Medicare certification letter.

Enrollment

In order to enroll for the payment of a claim or claims that meet the above-referenced criteria or for the payment of Medicare crossover claims, please visit the Provider Enrollment section of *www.lamedicaid.com* and complete the "Basic Provider Enrollment Packet for Entities/Businesses" and the provider type-specific packet "26 Pharmacy."

If you have any questions regarding this policy, please contact Gainwell Provider Enrollment at 225-216-6370.

Mary TC Johnson Medicaid
Deputy Director
MTCJ/mbw/deph

Provider Name: _____

OUT-OF-STATE PHARMACY ENROLLMENT AMENDMENT

Louisiana Medicaid will not routinely enroll an out-of-state pharmacy. There are set criteria that must be met for an out-of-state pharmacy to be enrolled in Louisiana Medicaid.

Enrollment Criteria

Please indicate the reason for requesting enrollment in Louisiana Medicaid and submit the documentation indicated:

☐ To receive reimbursement for Medicare crossover claims. Submit a copy of the Medicare Certification eligibility notice.

☐ It is the general practice for residents of a particular locality to use medical resources in the medical trade areas outside the state (Please indicate appropriate state and county codes on PE-50 page 1).

☐ Services or supplementary resources rendered that were not / are not available in Louisiana. Submit a letter explaining / describing the care, service, or resource in detail.

☐ Prescriptions filled on an emergency basis due to an accident or illness Submit a letter explaining / describing the care, service, or resource in detail.

☐ The health of the recipient would be endangered if he undertook travel or if care and services are postponed until he returns to the state of Louisiana. Submit a letter explaining / describing the care, service, or resource in detail.

Recipient Verification

This information will be used to verify that the recipient was enrolled in Louisiana Medicaid at the time the services were rendered and to help determine if the services provided meet the out-of-state enrollment criteria.

Recipient Name	Recipient Medicaid ID	Date of Service

Print Name Authorized Representative

Title of Authorized Representative

Signature of Authorized Representative

Date of Signature