



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

PHARMACY

(Enrollment packet is subject to change without notice.)

Pharmacy REQUIRED DOCUMENTS FOR ENROLLMENT

The following checklist shows all required documents that MUST be submitted to enroll with Fee For Service (FFS) Louisiana Medicaid. Please make certain to complete each required form in its entirety to avoid processing delays.

 $[\]begin{tabular}{ll} \begin{tabular}{ll} \beg$

Completed	Document Name
All Provider	
*	1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
*	2. PE-50 Addendum – Provider Agreement Form (three pages).
*	3. Medicaid Direct Deposit (EFT) Authorization Agreement Form.
*	4. Louisiana Medicaid Ownership Disclosure Information Forms.
*	(If submitting claims electronically) 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). NOTE: The EDI forms are only required if the Pharmacy will be processing claims for Durable Medical
	Equipment (DME) services.
	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).
	 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 Louisiana Board of Pharmacy. (In-state providers only)
	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 87 (Other).
**	10. Point-of-Sale Forms (7 pages).
Out-of-Stat	Providers (Additional Document Requirements)
**	11. Out-of-State Pharmacy Enrollment Amendment (two pages).
	12. Submit justification that supports the criteria selected on the Out-of-State Pharmacy Enrollment Amendment.
	 If applying for Medicare Crossovers, the provider must be enrolled with Medicare prior to requesting enrollment with Louisiana Medicaid.
	14. Copy of Nonresident Louisiana Pharmacy Permit, if applicable.
	15. Copy of pharmacy permit from home state.

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

 $[\]mbox{\ensuremath{\bigstar}}$ Form is included in the Basic Enrollment Packet for Entities/Businesses.

Provider Name	Provider # (for Gainwell Use only)		
POINT-O	DF-SALE CERTIFICATION		
	ed by a legally qualified person, that the charge is within the age policy, and that the payment has not been previously received.		
	ww.lamedicaid.com, have read and understand all published nd Provider Updates concerning pharmaceutical payments and nents.		
I also agree to keep such records as are necessary or required to disclose fully the extent of POS services provide to individuals under the State's Title XIX plan and to furnish all information regarding any payments claimed for providing such POS services as the Louisiana Department of Health 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 authauthority to enter into a provider agreement with	horized representative of this entity and, as such, have the Louisiana Medicaid.		
According to the Medical Assistance Program Inte- Louisiana Medicaid Provider Enrollment prior to	egrity Law (MAPIL) cited as La. R.S. 46:437, I will notify any change in ownership.		
	e claims will be from federal and state funds and that any false or acealment of material fact, may be prosecuted under applicable		
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 POS Certification and Enrollment Amendment)

PIC License Number

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Pharmacist-in-Charge Signature

Pro	ovider Name Provider # (for Gainwell Use only)
	STATE OF LOUISIANA
	MEDICAID PHARMACY POINT-OF-SALE AGREEMENT
	s Pharmacy Point-of-Sale (POS) Agreement (hereinafter Agreement), made and entered into this day of, 20, by and between the Louisiana Department of Health (hereinafter Agency), acting in its own right as the ency responsible for administering the Medical Assistance Program (Title XIX of the Social Security Act) In and by(hereinafter Provider).
	consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the pharmacy ees 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 POS device, claims for prescriptions dispensed to Louisiana Medicaid beneficiaries.
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 beneficiary.
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 Medicaid Provider Agreement entered into previously.
9.	The Provider agrees to charge no more for Medicaid services than is charged to the general public.
	Original Signatures Required – Please Do NOT Use Black Ink
	Please submit all required documentation to: Gainwell Provider Enrollment Unit PO Box 80159 Baton Rouge, LA 70898-0159 225-216-6370
	Authorized Representative (print) Authorized Representative Title

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

Date of Signature

to

Authorized Representative Signature

Provider Name	Provider # (for Gainwell Use only)

PHARMACY POINT-OF-SALE AMENDMENT

INDEPENDENT PHARMACY OWNERSHIP INFORMATION

(Less than 10 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 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!
(Please attach additional pages if needed.)		
Owner Contact Information		
Owner 1		
Name	Phone —	
Address	Fax	
City, State, Zip	Email ————	
Owner 2		
Name	Phone	
Address	Fax	
City, State, Zip	Email	
Ourse 2		
Owner 3 Name	Phone	
Address	Fax	
City, State, Zip	Email	
Owner 4 Name	Phone	
Address	Eav	
City, State, Zip	Email	
Owner 5		
Name Address	Phone Fax	
City, State, Zip	Email	
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Provider Name	Provider # (for Gainwell Use only)
	PHARMACY POINT-OF-SALE AMENDMENT
	CHAIN PHARMACY OWNERSHIP INFORMATION
	(10 or more Medicaid enrolled pharmacies under common ownership)
Corporate Information:	
Corporate Name	
Address 1	
Address 2	
City	
State	
Zip	
Financial Contact:	
Name	
Phone	
Fax	
Email	

Provider Name	Provider # (for Gair	nwell Use only)		
	PHARMACY POINT-OF-SALE AMENDME	ENT		
'Out-of-state pharmacies that DO NC nome state.	PLEASE ATTACH A CURRENT COPY OT mail or deliver to the state of Louisiana - please nail and/or deliver to the state of Louisiana - pleas our home state.	submit the pharmacy permit of your		
Medicare # NPI #	Tax ID # NCPDP #			
Contact Information Store Phone Store Email	Store Fax Disaster Phone			
Physical Address	Billing Address	Mailing Address		
ervices Provided (check all that appl		Specialty Compound		
☐ IV Exclusive ☐ Group		Specialty Exclusive		
acility 1 lame ddress ity, State, Zip	Approx. # Medicaid Beneficial Consultant PD	ries		
acility 2 lame ddress ity, State, Zip	Approx. # Medicaid Beneficial Consultant PD	ries		
	Approx. # Medicaid Beneficial Consultant PD	ries		
Facility 4 Name Address	Approx. # Medicaid Beneficial	Approx. # Medicaid Beneficiaries Consultant PD		

Provider Name						Provider # (for Gainwell Use or	nly)	
			PHARM	AC	Y POINT-	OF-SALE AMENDMENT		
In the past twelve ((12) months, l	has th	iere been a ch	ang	ge of own	ership for your pharmacy?		
☐ Yes (attach Discl	losure of Own	ershi	p Information)		No		
	nip interest in	any c	ther pharma	cies	. (Attach	additional pages if necessary)		
☐ Not applicable Owner Name		Pha	rmacy Name			Pharmacy Address	Medicaid P	rovider#
			•					
340 B								
Yes No						ontracted pharmacy?		
If yes, does your ph					∐ Yes	∐ No		
(Medicaid policy do		B con	ract pharmacies	to su	IDMIT 340 B	ciaims.)		
Technology / Services P	rovided							
Software Vendor					Electroni	c Switch Vendor		<u></u>
Yes No						can drugs before being dispensed / filled? if requested by the beneficiary?		
Yes No	Is your ph	armac		oting	electronic p	prescriptions (excluding faxes)?		
Yes No	Is your ph	armac	y associated with	the	sole distribu	tion of a drug?		
If yes, please list:								
Percentage of Business								
Annrovim	ately what nerce	ntage	of your total busin	occ i	is Foo for So	nice Medicaid?		
	, .		•					
		_	-			Managed Care Organizations (Aetna Better care Connections, and United Healthcare Co		
What is th payors)?	ne total number o	f preso	riptions dispense	d du	ring the pri	or State Fiscal Year (July – June) (including N	ledicaid, cash, and o	ther
Wholesalers Please list the wholesale	er(s) your pharma	ıcv use	s. MUST BE COM	PLET	ED.			
1. 2.	(-, ,				-			
3.					- -			
Chara Harris								
Store Hours Monday-Friday	am	to	pm		closed	Other (ex. 24 hr? available prn?)		
Saturday	am	to	pm		closed	Please explain:		
Sunday	am	to	pm		closed			

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Provider Name		Pi	rovid	er # (for Gainwell Use	only)	_
Employee Information	PHARMACY POIN	NT-OF-SAL	E AN	IENDMENT		
Please provide full-time and part-time emadditional pages as needed.	ployee information that is cu	rrent as of tod	day's da	ite. Attach		
Pharmacist in Charge						
Name			Board	of Pharmacy License #		
Pharmacist Medicaid #			Pharn	nacist NPI #		
Medication Admin Registration #				se State Certification # e of Certification		
negisti ation #			Q Dat	e or certification	I	
Pharmacist 1						
Name			Board	of Pharmacy License #		
Pharmacist Medicaid #			Pharn	nacist NPI#		
Medication Admin Registration #			Diseas	se State Certification # e of Certification		
			Q Dat	e or certification		
Pharmacist 2						
Name			Board	of Pharmacy License #		
Pharmacist Medicaid #				nacist NPI#		
Medication Admin Registration #				se State Certification # e of Certification		
Pharmacist 3						
Name			Board	of Pharmacy License #		
Pharmacist Medicaid #			Pharn	nacist NPI #		
Medication Admin			Diseas	se State Certification # e of Certification		
Registration #			& Dat	e or certification		
Pharmacist 4						
Name			Board	of Pharmacy License #		
Pharmacist Medicaid #				nacist NPI#		
Medication Admin Registration #				se State Certification # e of Certification		
Pharmacy Technicians			ance A	dvice Reviewer		
Name	Board of Pharmacy License #	Name				
		Title				
		Phone				
		Fax				
		Email				

Drovi	dar Namar						
Provi	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.						
	nent Criteria						
Please	indicate the reason(s) for requesting enrollment in Louisiana Medicaid and submit the documentation indicated:						
enrollr Medica	-state Pharmacy providers will be allowed continuous Medicaid enrollment for Crossover claims if the out-of-state nent criteria is not met. The out-of-state pharmacy must be enrolled in Medicare prior to enrolling in Louisiana aid. When enrolling in the Medicaid program, the out-of-state Pharmacy must indicate that crossover billing is ted and submit a copy of their Medicare certification letter. This is # 1 below.						
pharm Medica contin	ces are provided to a Louisiana Medicaid beneficiary in accordance with the criteria 2 and 3 detailed below, the acy provider will be allowed to obtain a Medicaid provider number to secure payment of the claim. However, this aid provider number will only be active to finalize the claim at issue, not to allow the out-of-state pharmacy to maintain yous and active enrolled provider status. In no event can an out-of-state Medicaid provider number be active for more nirteen months to secure payment of a single claim.						
	uous enrollment will be allowed with the criteria 4 and 5 detailed below when services are not available in Louisiana or eviously enrolled provider.						
□ 1.	To receive reimbursement for Medicare crossover claims. Submit a copy of the Medicare Certification eligibility notice.						
□ 2.	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).						
□ 3.	The health of the beneficiary would be endangered if he undertook travel or if care and services are postponed until he/she returns to the state of Louisiana. Submit a letter explaining / describing the care, service, or resource in detail.						
□4.	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.						
□ 5.	Prescriptions filled on an emergency basis due to an accident or illness. Submit a letter explaining / describing the						

Beneficiary Verification

This information will be used to verify that the beneficiary was enrolled in Louisiana Medicaid or a Louisiana Medicaid Managed Care Organization (MCO) at the time the services were rendered and to help determine if the services provided meet the out-of-state enrollment criteria.

Beneficiary Name	Beneficiary Medicaid ID#	Date of Service	

ovider Name:	
OUT-OF-STATE PH	ARMACY ENROLLMENT AMENDMENT
Authorized Representative (print)	Authorized Representative Title
Authorized Representative Signature	Date of Signature

Original Signatures Required – Please Do NOT Use Black Ink

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