ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid Program)

PSYCHOLOGIST

(Enrollment packet is subject to change without notice)

(PT 31)
Revised 11/2020

PSYCHOLOGICAL SERVICES UNDER MEDICAID

PLEASE REVIEW THIS PAGE TO DETERMINE WHAT TYPE OF PSYCHOLOGICAL SERVICES FOR WHICH YOU WISH TO ENROLL BEFORE PROCEEDING WITH THE APPLICATION PROCESS.

Psychological services under the Medicaid program are available to eligible Medicaid recipients under the following programs:

1) **Medicare "Cross-Over" Claims**
   These services are provided to individuals who are dually eligible for both Medicare and Medicaid.

2) **Applied Behavior Analyst Services (ABA)**

3) **Residential Option Waiver (ROW)**

4) **Greater New Orleans Community Healthcare (GNOCHC)**

HELPFUL INFORMATION

To provide services under this program, Medicaid eligibility of the recipient must be verified through the following:

Verification of Medicaid eligibility may be obtained through the Recipient Verification System (REVS) by calling 800/776-6323, by eMEVS using a web application accessed through www.lamedicaid.com, or by using the automated Medical Eligibility Verification System (MEVS). Use of MEVS system requires additional hardware.

NOTE: The recipient's name, Medicaid number, and date of birth are required to obtain eligibility verification.

PSYCHOLOGIST
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 Psychologist provider under one of the following programs:

Completed	Document Name
☐	1. Completed Individual 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. Completed Louisiana Medicaid Ownership Disclosure Information Forms* for Individuals (eight pages).
☐	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 – not required for crossovers only).
☐	6. **(If requesting new submitter number)** EDI Annual Certification Of Electronically-Submitted Medicaid Claims Form.* (not required for crossovers only).
☐	7. Copy of voided check or letter from the bank on bank letterhead for the account to which you wish to have your funds electronically deposited (**deposit slips are not accepted**).
☐	8. 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**).
☐	9. 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.
☐	10. Identify your specialty(s) from one of the following: 62 Medicare Crossover Only, 6U Applied Behavior Analyst Services, 4W ROW, 6J GNOCHC
☐ **	11. If enrolling to provide ROW services, the Provider Verification for ROW Services Form (included in this packet) is to be notarized and mailed to OCDD. Verification of OCDD's approval is required prior to enrollment.

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.**

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 Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Louisiana Medicaid
Link/Unlink and Working Relationship Form

If additional space is needed, please copy this form before filling it out.

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

Provider Verification for ROW Services

PURPOSE

This form confirms that the individual specified below wishes to provide ROW Services to Louisiana Medicaid recipients, and attests that the individual has provided paid services to person(s) with developmental disabilities through the OCDD program for a minimum of one year as a Dietician, Occupational Therapist, Physical Therapist, Psychologist, Speech Therapist, or Social Worker.

Individual Provider Number:	**LA Medicaid Provider #** (leave blank if new applicant)		**National Provider Identifier (NPI)**
Individual Provider Name:			
Physical Address:			
Professional Category (choose one):	Dietician ☐ OT ☐ PT ☐ PSY ☐ ST ☐ SW ☐		
Contact Person for questions regarding this form:			
Contact Person Phone Number:	( ) -		

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct, and
- that I can receive reimbursement for services provided only to those persons within the Residential Options Waiver (ROW), and
- that all Professional Services provided to ROW participants must be prior authorized before services are rendered, and
- that as a Professional providing services to ROW participants, I have one year paid experience working with people with developmental disabilities as outlined in the ROW Provider Manual, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of ____________________, State

of _________________________on the _ day of ____________________, 20____.

Print Individual Provider's Name

Notary Public Signature

Notary Seal or Notary Identification Number (required)

Individual Provider's Signature

Original signature only – colored ink (please don't use black ink)

Complete this form in its entirety and mail the original to:

Office for Citizens with Developmental Disabilities, ROW Program Manager
P O Box 3117, Baton Rouge, LA 70821-3117