



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

**Registered Dietician
(Individual)**

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION REGARDING WAIVER ENROLLMENTS

- The effective date is the date of enrollment approval.
- Non active billing will result to deactivation of the Medicaid provider number. To be reinstated, a provider must meet all enrollment requirements.
- An updated license must be obtained and submitted to Provider Enrollment for physical address changes.
- Individual Registered Dietician providers may enroll in Louisiana Medicaid for:
 - NOW Professional Provider (see PT 06 – NOW Professional Provider Type Specific Checklist/Package)
 - Residential Options Waiver (ROW)
- Registered Dieticians may enroll and bill as an Individual Registered Dietician for the ROW program or they may choose to link to and bill through the following Provider Type agencies:
 - PT11 – Shared Living
 - PT84 – Substitute Family Care – Waiver (Host Home)
- Individual Registered Dieticians may not link to any Medicaid-enrolled Groups, Rural Health Clinics, Federally Qualified Health Centers, or any other program within Louisiana Medicaid (except in the case of ROW services).
- **Assistants are not eligible to enroll in Louisiana Medicaid.**

GENERAL POLICY INFORMATION:

Waiver service providers are required to comply with both policy and program requirements located on the Louisiana Department of Health (LDH) Office for Citizens with Developmental Disabilities (OCDD) website and the Louisiana Medicaid provider manuals linked below.

Louisiana Medicaid Provider Manuals:

<https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm>

LDH/OCDD website:

<https://ldh.la.gov/OCDD>

Please note Louisiana Medicaid will not reimburse you for waiver services provided to recipients who are not enrolled in one of the waiver programs.

Registered Dietician

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.

*Form is included in the **Basic Enrollment Packet for Individuals**.

**Forms are included here.

Completed	Document Name
*	1. Individual 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.
	5. 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) .
	6. 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) .
	7. Printout of online license verification from the governing license board of your profession. This verification must contain the license numbers, the effective date of issuance, and the current status of the license.
	8. To report “Specialty” for this provider type on Section A of the PE-50, please use Code 4R (Registered Dietician).

For ROW Services:

**	9. Link/Unlink and Working Relationship Form.
**	10. Provider Verification Form for ROW Services.
**	11. To report “Sub-specialty” for this provider type on Section A of the PE-50 please use Code 4W (ROW).

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

Louisiana Medicaid Link/Unlink and Working Relationship Form

Copy this form for additional space as needed.

PURPOSE

This form allows one individual to link to and/or unlink from two (2) separate entities/businesses. This form also serves as documentation that a working relationship exists between an Individual and an Entity.

Individual Provider Name:			
Individual Provider Number	LA Medicaid Provider #	National Provider Identifier (NPI)	
Entity Name:			
Entity Provider Number	LA Medicaid Provider #	National Provider Identifier (NPI)	
LINK	Effective Date:	UNLINK	Termination Date:
Approximate Number of Hours Working at this Entity Per Week (required)			
Entity Name:			
Entity Provider Number	LA Medicaid Provider #	National Provider Identifier (NPI)	
LINK	Effective Date:	UNLINK	Termination Date:
Approximate Number of Hours Working at this Entity Per Week (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-identified entity(s). I recorded the approximate number of hours working per week for the entity(s) identified above. I understand that upon request I must provide LDH a copy of the written contractual agreement.

Print Individual Provider’s Name

Individual Provider’s Signature

Date of Signature

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
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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 # <small>(leave blank if new applicant)</small>	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

Individual Provider's Signature

Notary Seal or Notary Identification Number (required)

Original Signatures Required – Please Do NOT Use Black Ink

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