PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Registered Dietician (Individual)

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION

Provider Enrollment works on a three-week turnaround time frame. If enrollment requirements are not met, the entire application will be returned for correction and would need to be re-submitted once the corrections are made. Any re-submission of the enrollment packet is subject to additional three-week turnaround period.

Effective date of enrollment for ROW services will be the date the application is actually worked up by Provider Enrollment.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be made to the provider regarding automatic closure.

If at any time during enrollment as a Waiver Medicaid provider, the provider has a change of physical address, then the provider must first obtain an updated license indicating the new address, and then submit notification of the change of address along with a copy of the updated license to Gainwell Provider Enrollment (see address on checklist, below).

Assistants are not eligible to enroll in Louisiana Medicaid.

- Individual Registered Dietician providers may enroll in Louisiana Medicaid for:
    - NOW Professional Provider (see PT 06 – NOW Professional Provider Type Specific Checklist/Packet)
    - 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).

ATTENTION!!
Waiver service providers are required to comply with all requirements contained in:

1. The provider manuals located at:

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

And
2. The information located on the LDH/OCDD website at

http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8

Registered Dietician

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 Registered Dietician provider:

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. Louisiana Medicaid Ownership Disclosure Information Forms for Individual. **(Only the Disclosure of Ownership portion of this enrollment packet can be done online 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 Individual.
	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:

**	1. Completed Link/Unlink and Working Relationship Form.
**	2. Provider Verification Form for ROW Services.
**	3. To report "Sub-specialty" for this provider type on Section A of the PE-50 please use Code 4W (ROW).

*These forms are available in the **Basic Enrollment Packet for Individuals**.

** Forms are 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

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) or entity. 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)

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

Individual Provider's Signature

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

Notary Seal or Notary Identification Number (required)

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

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