LOUISIANA DEPARTMENT OF HEALTH

gainwell

PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Certified Registered Nurse Anesthetist (CRNA) (Individual)

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR THE INDIVIDUAL CRNA PROVIDER TYPE

- An individual CRNA holding a temporary permit cannot be enrolled until the permanent license is received.

Individual CRNA providers may link to the following groups:

- CRNA Group
- Physician Group

Linkages of Professionals to Groups – an individual's provider number can be "linked" to a group provider number for purposes of billing as an attending provider for the specified group.

- **Active providers only require Group Link/Unlink and Working Relationship Form.**
- **New/Inactive/closed providers require a completed application and the Group Link/Unlink and Working Relationship Form.**

Claims submitted under the group number, with an individual's number included as the attending provider, will be processed and the remittance will be sent directly to the group's mailing address. ***It is not necessary for the individual's mailing address to be the same as the Group's mailing address for these Remittance Advice notices to be sent to the group, if billed correctly.***

Revised 01/10

CRNA
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 CRNA 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**: 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**: If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Individual (two 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).
☐	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. Printout of online medical license verification from the governing license board of your profession. This verification must contain the license numbers (RN and APRN), the effective date of issuance, and the current status of the license.
☐	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 05 (Anesthesia).

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

For Group Linkages:

☐ **	1. Completed Group Link/Unlink and Working Relationship Form.

** Forms are included here.

Out of State Enrollment:

☐	1. Submit an original claim with the application for the initial date of service. This claim must meet timely filing guidelines or attach proof of timely filing. Subsequent claims must be submitted directly to Gainwell claims processing once the provider has received confirmation via mail of successful enrollment in Louisiana Medicaid.

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

Revised 06/09

Louisiana Medicaid
Group 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 written 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