PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Physician Assistant (Individual)

(Enrollment packet is subject to change without notice)

(PT94)
Revised 11/2020

GENERAL INFORMATION FOR THE INDIVIDUAL PHYSICIAN ASSISTANT PROVIDER TYPE

Individual Physician Assistants must link to one of the following groups (as long as the group has a Louisiana Medicaid business/entity type Provider Number):

- Doctor of Osteopathic Medicine Group
- Physician Group
- Rural Health Clinics
- Federally Qualified Health Centers

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

- **Open professional individual providers require only Group Link/Unlink and Working Relationship Form.**
- **New, Inactive, or Closed professional individual providers require an entire enrollment application as well as the Group Link/Unlink and Working Relationship Form.**

The number of groups a professional individual can link to is limited. It is very important that all professional individuals terminating their relationship with a group notify Provider Enrollment. Provider Enrollment can then unlink the professional individual from the specified group, allowing the professional individual to be linked to other groups in the future.

Claims submitted under the group's NPI, with a professional individual's NPI included as the attending provider, will be processed under the group's Remittance Advice.

It is not necessary for the individual's mailing address to be the same as the Group's mailing address for the services to be allocated to the group's Remittance Advice notices.

If a professional individual is linking to a group as an attending only (not being paid individually by Medicaid), then the EDI Contract, Direct Deposit Form, and voided check are not required.

If you plan to prescribe Buprenorphine and/or Buprenorphine-Naloxone containing products, it will be necessary for you to also submit a copy of your "X" DEA registration. Otherwise prescriptions for these products will not be payable in the Pharmacy program.

Physician Assistant
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 Physician Assistant provider:

Completed	Document Name
☐ *	1. Completed Individual Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. Completed PE-50 Addendum – Provider Agreement Form.
☐ *	3. 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.)**
☐	4. 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**).
☐	5. 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.
☐	6. Verification of prescriptive authority, if applicable, with either a copy of the Certificate of Limited Prescriptive Authority or a copy of the Letter of Notice of Limited Prescriptive Authority.
☐	7. To prescribe Buprenorphine and/or Buprenorphine-Naloxone containing products, copy of Controlled Substance Registration Certificate showing the X-DEA number. (Otherwise, prescriptions for these products will not be payable in the Pharmacy program)
☐	8. The following documentation must be made available for review on request: protocols, delegation, supervision, education and/or training.
☐	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 2R (Physician Assistant).
☐ **	10. 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**.

** 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

Revised 06/10

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). 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

(PT94)
Revised 3/2018