



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid)

Physical Therapist (Individual)

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR PROVIDER ENROLLMENT

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.

The effective date for this enrollment will be the day the application is actually worked 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.

OCDD Waiver Service Providers must submit additional documentation to be placed on what is called the Freedom of Choice listing. This documentation is to be downloaded from the web after receiving the letter confirming enrollment in Louisiana Medicaid. The additional documentation required is a Medicaid Freedom of Choice Request Form which is found on the DHH website at: <http://new.dhh.louisiana.gov/index.cfm/page/141>. (The link to this form is located just above the map of Louisiana).

Upon completion of the Medicaid enrollment process, some providers of other Medicaid services will automatically be added to a Freedom of Choice listing in a web-based program called Provider Locator Tool. This enables public users to search for Medicaid and/or Home and Community Based Service providers who accept Louisiana Medicaid.

Assistants are not eligible to enroll in Louisiana Medicaid.

- Individual Physical Therapist Providers may enroll in Louisiana Medicaid for:
 - Early Steps Provider (see PT 29 – Early Steps Provider Type Specific Checklist/Packet)
 - Medicare Crossover Payments
 - Residential Options Waiver (ROW)
 - Both Medicare Crossover Payments and ROW
- Physical Therapists may enroll and bill as Individual Physical Therapist 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
- Individual Physical Therapists, enrolling for Medicare crossovers only, may not bill Louisiana Medicaid as a primary provider. Medicare would be the primary payer in this case, and Medicaid the secondary payer.
- Individual Physical Therapists 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).

NOTICE TO WAIVER SERVICE PROVIDERS

Please note that Louisiana Medicaid will only reimburse for waiver services rendered to Medicaid recipients who are enrolled in a waiver program (New Opportunities Waiver (NOW), Children's Choice Waiver, Supports Waiver, Residential Options Waiver (ROW), Adult Day Health Care (ADHC) Waiver and Community Choices Waiver). Medicaid will not reimburse for waiver services provided to recipients who are not enrolled in one of the waiver programs.

ATTENTION!!

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

- 1. The provider manuals located at <http://www.lamedicaid.com>**

And

- 2. The information located on the DHH/OCDD website at <http://new.dhh.louisiana.gov/index.cfm/subhome/11/n/8>**

Physical Therapist CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Molina Medicaid Solutions Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Individual Physical Therapist provider:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Individual Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/> *	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	<p>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.)</p> <p>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.</p> <p>-or-</p> <p>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.</p>
<input type="checkbox"/>	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).
<input type="checkbox"/>	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).
<input type="checkbox"/>	7. Printout of online medical 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. If requesting retroactive coverage, a license must be submitted that covers that time period. A temporary permit is only good until the expiration date.
<input type="checkbox"/>	8. Copy of the Medicare certification from CMS (required if requesting Medicare Crossover services).
<input type="checkbox"/>	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 65 (Physical Therapy).
For ROW Services:	
<input type="checkbox"/> **	10. Completed Link/Unlink and Working Relationship Form.
<input type="checkbox"/> **	11. Provider Verification Form for ROW Services.
<input type="checkbox"/> **	12. To report "Sub-specialty" for this provider type on Section A of the PE-50 please use Code 4W (Waiver Services).

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

** These 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 the appropriate address shown below:	
Enrollment for ROW only or both ROW & Crossover: Office for Citizens with Developmental Disabilities ROW Program Manager P.O. Box 3117 Baton Rouge, LA 70821-3117	Enrollment for Non ROW (Crossovers only): Molina Medicaid Solutions 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)																		
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Individual Provider Name:																				
Physical Address:																				
Professional Category (choose one):	Dietician <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> PSY <input type="checkbox"/> ST <input type="checkbox"/> SW <input type="checkbox"/>																			
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.

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