



**PROVIDER TYPE SPECIFIC
PACKET/CHECKLIST
(Louisiana Medicaid Program)**

**MENTAL HEALTH
REHABILITATION**

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR THE MENTAL HEALTH REHABILITATION PROVIDER TYPE

Prior to submitting this packet, it is required that prospective Medicaid Mental Health Rehabilitation providers achieve certification by the Medicaid Behavioral Health Section and receive an approval letter to include with this packet. Contact Medicaid Behavioral Health Section at 225-342-1203 to obtain a certification application.

MHR Provider Type

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 MHR provider:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business 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 Entity/Business. (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 style="text-align: center;">-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 Entity/Business.</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. Approval letter from Medicaid Behavioral Health Section.
<input type="checkbox"/> **	8. Completed Link/Unlink and Working Relationship Form for a Medicaid-enrolled psychiatrist, or the completed full application of a non-enrolled psychiatrist.
<input type="checkbox"/>	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 78 (MHR).

* These forms are available in the **Basic Enrollment Packet for Entities/Businesses**.

** The Link/Unlink and Working Relationship form is available here. (A full application is required if the linking psychiatrist is not currently enrolled in Louisiana Medicaid.) For the full application, please refer to the Basic Enrollment Packet for Individuals and the Provider Type Specific Checklist available at www.lamedicaid.com.

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:
Molina Provider Enrollment
P.O. Box 80159
Baton Rouge, LA 70898-0159

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)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> 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)					
<input type="checkbox"/> LINK	Effective Date:					<input type="checkbox"/> 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)