



Louisiana Medicaid Management Information System (LMMIS)

Provider Enrollment Portal Application User Manual For MCO Individual

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Prepared By Technical Communications Group

PROJECT INFORMATION

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1.0 OVERVIEW

The Provider Enrollment Portal is designed to meet Centers for Medicare and Medicaid Services (CMS) requirements for screening and enrolling Medicaid Providers and must be used by all Medicaid Providers, including those who do not participate in fee-for-service.

2.0 Accessing the Application

2.1 Louisiana Web Site Registration

Before a Provider can access the Provider Enrollment Portal, registration is required. In order to register, follow the instructions located here:

https://www.lamedicaid.com/Provweb1/Provweb Enroll/Web Registration.pdf

Please validate that the enrolling Provider's email given in the registration process is correct, as all correspondence will go to the registration email for the enrollment process.

Once registration is complete, you are enabled to login here:

https://www.lamedicaid.com/account/login.aspx

2.2 Log In

Detailed instructions for logging in are provided here:

https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid Provider Login PE Ins tructions User Manual.pdf

After login, look for the Provider Enrollment Portal Application, as shown below:



3.0 Start Page

Name: Provider ID: Provider NPI: 20 - PHYSICIAN (IND & GP) None Provider NPI: Provider Specialty: Current Status: Provider Loaded to web, not logged in We recognize that you are an MCO provider (enrolled with one of the Healthy Louisiana plans, Dental Benefits Program Manager plans, and/or the Coordinated System of Care plan). We recognize that you are an MCO provider (enrolled with one of the Healthy Louisiana plans, Dental Benefits Program Manager plans, and/or the Coordinated System of Care plan). Documentation for the Provider Enrollment web applications can be found by clicking here. Vising this web app, we will ask you to perform and verify these items: • Your taxonomy values • Your SSN and mail-to • Your disclosure of ownership information with stretistion Then we will ask you to review the coulsiana Medicaid Provider Participation Agreement and confirm your agreement.	Start	Taxonomy	Practice Address	Other Addresses	Mailing Address	Ownership Disclosure	Ownership Attestation	Other Programs	Participation Agreement	Review & Submit
We recognize that you are an MCO provider (entrolled with one of the Healthy Louisiana plans, Jental Benefits Program Manager plans, and/or the Coordinated System of Care plan). Documentation for the Provider Enrollment web applications can be found by clicking here. Using this web app, we will ask you to perform and verify these items: • Your taxonomy values • Your taxonomy values • Your disclosure of ownership information with antestation • Your disclosure of ownership information with antestation Then we will ask you to review the Coulsiana Medicaid Provider Participation Agreement and confirm your agreement.		ĺ	Name:	Provider Provider	D:	Provider Type: 20 - PHYSICIAN (IND & GP) Provider Specialty: 16 - OB/GYN	Sub-S None Provic	pecialties: nt Status: ler Loaded to web, not logge	ed in	
Then we will ask you to review the coursiana Medicaid Provider Participation Agreement and confirm your agreement.	We recognize that you are an MCO provider (enrolled with one of the Healthy Louisiana plans, Dental Benefits Program Manager plans, and/or the Coordinated System of Care plan). Documentation for the Provider Enrollment web applications can be found by clicking here. Using this web app, we will ask you to perform and verify these items: • Your taxonomy values • Your main practice address and other practice sites (if appropriate) • Your SSN and mail-to • Your disclosure of ownership information with attentation									
			Then we will ask	you to review the to	ouisiana Medicaid Pro	ovider Participation Agreemen	nt and confirm you	ır agreement.	Cause Decograms	

A link to the user manuals associated with the Provider Enrollment System is available on the Start page.

The Navigation Tabs, the **Previous** button, the **Next** button, and the **Save Progress** button are available on every page within the application.

3.1 What If Any of the Pre-populated Data is Wrong?

The Provider's name, Provider ID, and Provider NPI cannot be changed within the application. You must contact the Louisiana Provider Enrollment Portal Call Center (Monday – Friday 8 a.m. – 5 p.m. CST) at 833-641-2140 or <u>louisianaprovenroll@gainwelltechnologies.com</u> to update this information. All other fields, such as addresses, can be changed by simply typing into the specified text box in the application.

3.1.1 Name Change

The Provider name is pre-populated and cannot be changed prior to completion of the application. After the portal application is completed, the Provider can contact the Louisiana Medicaid Provider Enrollment Portal Help Desk (Monday – Friday 8 a.m. to 5 p.m. CST) at 833-641-2140 or <u>louisianaprovenroll@gainwelltechnologies.com</u> to have it changed.

In the case of a name change, the call center staff will check the license website to see if the name has changed with the Provider's governing license board.

3.2 Navigation Tabs

Along the top of the home screen, the navigation tabs consist of links to the steps required to complete the enrollment application. The steps are listed below:

- Start
- Taxonomy
- Practice Address
- Other Addresses
- Mailing Address
- Ownership Disclosure
- Ownership Attestation
- Other Programs
- Participation Agreement
- Review & Submit

As you progress through the steps of enrollment, check marks are added next to each tab for which progress has been saved, similar to that shown below:

\land										
Start 🗸	Taxonomy 🗸	Practice Address	Other Addresses	Mailing Address	Ownership Disclosure	Ownership Attestation	Other Programs	Participation Agreement	Review & Submit	

If you click the **Save Progress** button on a page on which required data has not been entered, a red ribbon is displayed explaining the requirement, similar to that shown below:

				1	Zip is required. Contact name is required. Phone number is required. Fax number is required.				
Start 🗸	Taxonomy 🗸	Practice Address 🛕	Other Addresses	Mailing Address	Ownership Disclosure	Ownership Attestation	Other Programs	Participation Agreement	Review & Submit
	Nam	ie:	Provider ID: Provider NPI:	•	Provider Type: 20 - PHYSICIAN (IND & GP) Provider Specialty: 16 - OB/GYN	Sub-Specialties None Current Status: Information Gat	: hering Started and saved	for later	
		Please verify the for Main Practice Addr	ollowing information	and make chan	ges if necessary:				
		Street Address 1: *		7600 Bee	chnut				
		Street Address 2:							
		City: *		Houston					
		State: *		FL 🗸					
		Zip: *		##### or	*****				
		Contact Name: *							
		Contact Phone: *		###_###	####				
		Contact Fax: *		###_###	.####				
		Previous No	ext \varTheta				¥	Save Progress	

Once the required data has been entered, you can click the **Save Progress** button and a green ribbon at the top of the page will indicate that you have successfully entered all of the required data, similar to the one shown below.



3.3 Control Buttons

The Control Buttons near the bottom of the screen are the only methods of navigation and saving your progress.

3.3.1 Previous



The **Previous** button (when enabled) allows the user to go back one step from the current page within the application.

3.3.2 Next



The **Next** button (when enabled) allows the user to move forward one step from the current page within the application.

3.3.3 Save Progress



The **Save Progress** button saves the data entered so far into the application where progress was last saved. In this way, for instance, the user can log off and come back later to resume work on the enrollment application. The **Save Progress** function is also used to finalize the submission for the current section of the enrollment process. As each section is completed, be sure to click on the **Save Progress** button. When all the sections are complete and the enrollment request has been successfully submitted, a check mark is displayed to the right of each section on the Navigation Tabs, as shown below:

Start 🗸	Taxonomy 🗸	Practice Address ✔	Other Addresses✔	Mailing Address √	Ownership Disclosure✔	Ownership Attestation✔	Other Programs✔	Participation Agreement✔	Review & Submit✔	

4.0 Taxonomy

The **Taxonomy** page enables the user to provide the necessary taxonomy information. Only Primary Taxonomy is required (and is usually pre-populated). Taxonomy options are limited by Provider Type and Provider Specialty. If the Provider has more than one taxonomy number, up to nine taxonomies may be entered. Since this data is important, it should be entered if the Provider has more than one taxonomy. CMS requires this information for reporting purposes. All relevant taxonomies must be entered.

Start 🗸	Taxonomy	Practice Address	Other Addresses	Mailing Address	Ownership Disclosure	Ownershi Attestatio	ip Other on Programs	Participation Agreement	Review & Submit
	Na	me:	Provider ID Provider N	: Pt:	Provider Type: AK - LICENSED PROFES Provider Specialty: 8E - CSoC/Behavioral H	SION COUNSEL	Sub-Specialties: None Current Status: Information Gathering Started	and saved for later	
		Please verify If you disagre link below:	your taxonomy inform e with the given provid	ation and make ch er type and/or prim	n <mark>anges if necessary.</mark> (Prima nary specialty, or cannot f	iny taxonomy is requ ind your taxono	uired) omy in the dropdown list	, please click this	
		Change requ	est form						
		Primary Taxon	omy:	101YM0800X - Counse	elor - Mental Health		٩		
		Other Taxonor	ny 1:	use the lookup to selec	t		٩		
		Other Taxonor	ny 2:	use the lookup to selec	t		٩		
		Other Taxonor	ny 3:	use the lookup to selec	t		٩		
		Other Taxonor	ny 4:	use the lookup to selec	ŧ		٩		
		Other Taxonor	ny 5:	use the lookup to selec	t		٩		
		Other Taxonor	ny 6:	use the lookup to selec	t		۹		
		Other Taxonor	ny 7:	use the lookup to selec	t		۹		
		Other Taxonor	ny 8:	use the lookup to selec	ŧ		۹		
		Other Taxonor	ny 9:	use the lookup to selec			٩		
	1	← Previous	Next 🥱					🛓 Save Progress	

Click the lookup icon () next to each Taxonomy Code field where you need to add information. A dialogue box similar to the one shown below is displayed:

Select Taxon	omy	×
Choose a taxono	my from the list below	:
Taxonomy:	no selection	~
		Close Accept

Click the down arrow in the dialogue box to display the Taxonomy dropdown list:

no selection 208U00000X - Clinical Pharmacology 204R00000X - Electrodiagnostic Medicine 207P00000X - Emergency Medicine 207PE0004X - Emergency Medicine - Emergency Medical Services 207PH0002X - Emergency Medicine - Hospice and Palliative Medicine 207PT0002X - Emergency Medicine - Medical Toxicology 207PS0010X - Emergency Medicine - Sports Medicine	Use the navigation tool to scroll through the Taxonomy options. When you find the one you want, select it, and then click on the Accept button in the dialogue box.
207PE0005X - Emergency Medicine - Undersea and Hyperbaric Medicine 209800000X - Legal Medicine 207SC0202X - Medical Genetics - Clinical Biochemical Genetics 207SC0300X - Medical Genetics - Clinical Cytogenetics 207SG0201X - Medical Genetics - Clinical Genetics (M.D.) 207SG0203X - Medical Genetics - Clinical Molecular Genetics 207SM0001X - Medical Genetics - Molecular Genetic Pathology 207SG0205X - Medical Genetics - Nolecular Genetics 208VP0014X - Pain Medicine - Interventional Pain Medicine 208VP00000X - Pain Medicine - Pain Medicine 202K00000X - Philebology 2083A0300X - Preventive Medicine - Addiction Medicine	Select Taxonomy × Choose a taxonomy from the list below: Taxonomy:no selection Close Accept

Click the **Close** button to close the lookup taxonomy dialogue box at any time.

Continue entering Taxonomies as needed. Then click on the **Save Progress** button at the bottom of the screen.

	X
Previous Next ●	🛓 Save Progress

4.1 Change Request Form

If you disagree with the given Provider Type and/or primary specialty, or cannot find your taxonomy in the dropdown list, click on the **Change request form** link:

Please verify your taxonomy i	nformation and make changes if necessary. (Primary taxonomy is required)
If you disagree with the given p link below:	provider type and/or primary specialty, or cannot find your taxonomy in the dropdown list, please click this
Change request form	
Primary Taxonomy:	101YM0800X - Counselor - Mental Health

The system responds with the following prompt:



Click the **No** button to return to the Taxonomy page. Click the **Yes** button to open the Specialty – Sub-Specialty – Provider Type – Taxonomy Change Form, as shown below:

Specialty - Sub-Specialty - Provider Type	- Taxonomy Change Form	×
This form will gather the necessary information f Taxonomies. Fill out the form and click the Subm Taxonomy screen.	or you to request changes be made to your Provider Type, Primary Specialty, Sub-Specialties, or It button to make a request. Click the Cancel button to not make any changes and return to the	
Provider Name:		
Provider ID:		
Provider NPI:		
Provider Type:	LICENSED PROFESSION COUNSELOR	
Entity Type:	MCO Individual	
Click this link to see Change Provider Specialty To: * Change Provider Type To: * Change Provider Sub-Specialty To: * Desired Taxonomy: * If the desired taxonomy is not listed, check this Requestor's Signature:	e information about relationships and choices regarding existing options Select Select Select Select box and enter your taxonomy in the field provided. Test Test	
	Cancel	nit

4.1.1 Information About Relationships and Choices Regarding Existing Options

Optionally, you are enabled to view the Provider Change Form Instruction page (<u>www.lamedicaid.com/provweb1/forms/ProviderChangeFormInstructions.pdf</u>), which provides details regarding Provider Types and Specialties/Sub-specialties.

4.1.2 Change Provider Specialty To

Click within the Change Provider Specialty To:	Change Provider Specialty To: *	Select		Use the scroll tool to browse the available
selection box to display the drop	Change Provider Sub-Specialty To: *	7P - ABA THERAPY PSYCHOLOGIST 4N - Acupuncturist-MCO Only		options and click on the specialty.
available options.	Desired Taxonomy: *	2W - Addiction Specialist 8K - ADHC HCBS 76 - Adult Day Care	-	

You can also enter the first few letters of the specialty into the box to quickly locate the one required. For instance, you can enter "adu" in the box, and any specialty that begins with the letters "adu" is displayed:

Select	*
adu	
76 - Adult Day Care	

4.1.3 Change Provider Type To

Once the specialty has been selected the Change Provider Type To: selection box is enabled. Click within the selection box to display the Provider Type associated with the previously selected specialty:

Select	٠
Select	
31 - PSYCHOLOGIST (LIC/MED) (IN-ST)	

Click on the Provider Type to continue.

You can also enter the first few letters of the Provider Type into the box to quickly locate the one required.

4.1.4 Change Provider Sub-Specialty To

Once the Provider Type has been selected, the Change Provider Sub-Specialty To: selection box is enabled. Click within the box to see the drop down list of available options:



You can also enter the first few letters of the sub-specialty into the box to quickly locate the one required.

You are enabled to enter up to nine sub-specialties; in the instance below, four have been chosen.

Change Provider Sub-Specialty To: *	×4W - Waiver Services
	$\times62$ - Psychologist Crossovers only
	× 6A - Psychologist -Clinical
	× 6B - Psychologist-Counseling

Note: You can also elect to change the sub-specialty none.

4.1.5 Desired Taxonomy

Once a sub-specialty has been selected, the Desired Taxonomy drop down box is enabled. Click within the box to see the drop down list of available options:

Select	
103T00000X - Psychologist	
103TA0400X - Psychologist - Addiction (Substance Use Disorder)	
103TA0700X - Psychologist - Adult Development & Aging	
103TB0200X - Psychologist - Cognitive &	•

Use the scroll tool to browse the available options and click on the sub-specialty.

If the desired taxonomy is not listed, click on the check box below the Desired Taxonomy drop down box to enable a text box into which you can type the desired taxonomy:

If the desired taxonomy is not listed, check this bo	ix and enter your taxonomy in the field provided.
Requested Taxonomy: *	

You are enabled to select up to nine taxonomies.

4.1.6 Requestor's Signature

The user's name is pre-populated in the Requestor's Signature text box:



When you have completed the change request form, click on the **Submit** button in the lower right hand corner to proceed.



Confirm Submission	ĸ
By confirming this option, this form will be sent for review for your requested changes. This application will become locked and will not be unlocked until the review is complete. You will be notified via e-mail of the next steps.	
bo you suit wish to submit this change request:	
NoYes	

Click on the **Yes** button to proceed with the request. Otherwise, click on the **No** button to return to the change request form.

Alternatively, you can click on the **Cancel** button to cancel the request.



Click on the **Yes** button to continue with the cancellation. Other wise click on the **No** button to return to the Form screen.

If you elected to proceed with your change request, look for the yellow banner at the top of the Taxonomy page when you return:



4.1.7 Check Your Email

Check your email for confirmation of the requested changes. The email is similar to that shown below:

Subject: Received – Request of Change made on Louisiana Medicaid Provider Enrollment Portal for Provider ID xxxxxxx

You have submitted a request to change your Provider type, primary specialty, or to add a taxonomy on the Provider Enrollment Web Portal. This request will be reviewed. While it is under review, your application on the portal is locked, meaning that you cannot continue to work on it. Another email will be sent to this email address when the review is completed. At that time, your application will be unlocked allowing you to finish and submit your enrollment application.

Should you have any questions or concerns, please email <u>LouisianaProvEnroll@gainwelltechnologies.com</u>.

Sincerely,

Gainwell Technologies

Emails will also be sent upon denial or approval of your requested Provider Type, primary specialty, sub-specialty, or taxonomy changes. The emails are similar to those shown below:

Subject: Decision on your Provider Data Change Request for the Louisiana Medicaid Provider Enrollment Portal for Provider ID xxxxxx

This email is to inform you that your Louisiana Medicaid enrollment application change for Provider type, Provider specialty or taxonomy that you requested via the Louisiana Medicaid Provider Enrollment Portal has been approved. Your information has been updated to:

Requested Type:31 - PSYCHOLOGIST (LIC/MED) (IN-ST)Requested Primary Specialty:7P - ABA THERAPY PSYCHOLOGISTRequested Sub-Specialty:4W - Waiver ServicesRequested Primary Taxonomy:103T00000X

Please log back into website <u>here</u> and complete your application for enrollment before September 30, 2022.

Subject: Decision on your Provider Data Change Request for the Louisiana Medicaid Provider Enrollment Portal for Provider ID xxxxxxx

This email is to inform you that your request for a change in Provider type, primary specialty, or taxonomy has been denied. This was done in accordance with existing LDH processes and procedures for enrolling with Louisiana Medicaid. Please contact Gainwell Provider Enrollment at 833-641-2140 or LouisianaProvEnroll@gainwelltechnologies.com for additional information.

Your online application at website here has been unlocked and you may now complete your application for submission. The last day to submit your application is September 30, 2022.

An email is also generated and sent if you requested a desired taxonomy that was not listed (see 4.1.5).

When the change request form is approved or denied, the application is unlocked/editable and you can continue with the application submission.

5.0 Practice Address

The **Practice Address** is the physical facility location of the practice that is enrolling in Louisiana Medicaid. The **Practice Address** page is also used to capture Contact Name, Contact Phone, and Contact Fax, as shown below.

Please verify the following information and	I make changes if necessary:	
Main Practice Address Information		
Street Address 1: *	4200 WHITEHALL DR SUITE 150]
Street Address 2:]
City: *	Ann Arbor]
State: *	MI 🗸	
Zip: *	481059694]
Contact Name: *]
Contact Phone: *	###-###-####]
Contact Fax: *	###-###-####]
G Previous Next O		🛓 Save Progress

Some fields may be pre-populated, but if it is incorrect you are enabled to correct it. Fields with an asterisk are required. Enter the information into the text boxes (except for State, for which a drop-down box similar to the one shown below is available).

LA	~	
		L
AL	-	
AK		
AZ		
AR		
CA		l
co		l
СТ		l
DC		l
DE		l
FL		l
GA		l
HI		l
ID		
IL		
IN		
IA		
KS		
KY		
LA	•	

Click on the **Save Progress** button at the bottom of the screen.

Previous	Next 🔿		🚣 Save Progress

6.0 Other Addresses

If the practice has multiple physical addresses in addition to the primary location (satellite, branch, or regional locations), enter them here. If you have only one physical address for this Provider Number, nothing needs to be entered here.

Please verify the fo	llowing information a	nd make changes if necess	ary:	
f the practice has m	ultiple physical addresse	es in addition to the primary	location (satellite, branch, or region	al locations), enter them here.
f you on <mark>ly h</mark> ave one	practice site, you may s	kip this page.		
Click Add New Row,	or use the edit and delet	e buttons to correct an existir	ng entry.	
# Addre	55	Contact Name	Phone	Fax
# Addre	55	Contact Name	Phone	Fax
# Addre	55	Contact Name	Phone	Fax

Click the **+Add New Row** button to open the Edit Site window and add another address and the contact information (note required fields marked with an asterisk).

Edit Site		×Y
Street Address 1: *		
Street Address 2:		ri
City: *		
State: *		
Zip: *	##### OF ##########	
Contact Name: *		
Contact Phone: *	###.4##.####	
Contact Fax: *	***.***	
		Cancel Save

You can cancel this operation with the **x** function in the upper right corner of the Edit Site window or the **Cancel** button in the lower right.

When you are finished entering the required data, click on the **Save** button.

The additional address or addresses will now be displayed on the Other Addresses screen, similar to that shown below:

	practice has multiple physical addresses in addition to the primary location (satellite, branch, or regional locations), enter them here.								
ou only have one practice site, you may skip this page.									
			·						
:k.	Add New Kow, or use the edit and delete b	outtons to correct an exist	ing entry.						
# Address Contact Name Phone Fax									
	1st Street Miami, FL 12345	John Smith	123-123-1223	234-234-2345	🖉 Edit 🔋 Delete				
					7				
	2nd Street Chicago, IL 654321234	James Johnson	654-654-6543	234-234-2346	🖋 Edit 🛛 👕 Delete				

You are enabled to edit or delete the entry or entries with the control functions provided to the right of each row.

6.1 Edit Site

The **Edit** function opens the Edit Site window, shown with the existing data, which can be corrected as needed.

Edit Site	×
Street Address 1: *	
Street Address 2:	
City: *	
State: *	🗸
Zip: *	##### OF #########
Contact Name: *	
Contact Phone: *	###_###.####
Contact Fax: *	###_#########
	Cancel

Make changes and click the **Save** button. The changes are immediately displayed.

6.2 Delete Site

The **Delete** function opens the Confirm Site Delete window.



Click on the **Confirm** button to delete the data in the row. The row will be immediately removed from the Other Addresses screen.

Click on the Save Progress button at the bottom of the screen.



7.0 Mailing Address

The **Mailing Address** screen enables the capture of the primary mailing address for the practice. The **Mailing Address** screen is also used to capture Provider SSN, Date of Birth, Address information, Contact Name, Contact Phone, and Contact Fax, as shown below. If the email address is incorrect, use the account management tool to correct it (see https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid Provider Login Admin Manage Users.pdf).

Only the primary practice mailing address should be entered here. Satellite, branch, or regional location addresses should be entered in the Other Addresses tab.

ng information and ma	les channes if announce	
	ike changes if necessary:	
ormation		
[33333333	
[3/3/2003	
[PO Box 591159	
[
[SAN ANTONIO	
[ТХ 🗸	
[78259	
[Testa Napp	
[225-216-6081	
[225-216-6082	
t	testing@test.com	
		333333333 3/3/2003 PO Box 591159 SAN ANTONIO TX 78259 Testa Napp 225-216-6081 225-216-6082 testing@test.com

Some fields may be pre-populated, but if it is incorrect you are able to correct it by simply typing into the field. Fields with an asterisk are required. Enter the information into the text boxes (except for State, for which a drop-down box is available).

Click on the Save Progress button at the bottom of the screen.

Previous Next	Save Progress
-------------------	---------------

8.0 Ownership Disclosure – "Yes" Answers



In the **Ownership Disclosure** section of the application, use the radio button to answer "Yes" or "No" to the questions. If "**Yes**", you must be prepared to respond with information including the DBA Name(s) and address(es), the Tax ID(s), the Social Security Number(s), % ownership, the location (state) and the Plan Number(s).

Depending on your responses, the application will expand to display further questions.

8.1 Yes (5% or More Ownership Interest)

Click the **Yes** radio button if the enrolling individual has any direct, indirect, or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in Federal/State funded healthcare program(s). The enrollment application responds by displaying a screen similar to the one shown below.

pes the enrolling	individual have any direct, indirect, or (controlling ownership int	terest of 5% of	or more in any oth	er healthcare	entities/businesse
rrently enrolled i	in Federal/State funded healthcare prog	gram(s)?				
Yes O No						
Please complete	the following for each entity/business:	(click Add New Row, or u	ise the edit a	nd delete buttons to	o correct an e	xisting entry)
Please complete Plan Name	the following for each entity/business: Doing Business As/Address	(click Add New Row, or u % Ownership	use the edit au State	nd delete buttons to ID Number	o correct an e	xisting entry)

Click on the **+Add New Row** button to enter ownership data for the first other business interest. The system responds by opening the Other Business window, as shown below:

Other Business	×
Plan Name *	
DBA Name	
State *	•
Percent Ownership *	0
ID Number *	
	Cancel

Enter the Plan Name (usually Medicaid or Medicare). Enter the Doing Business As (DBA) Name. If the DBA Name is different from the IRS business name, use the business "sign" name, i.e., the name on the business letterhead and/or the physical facility signage. Enter the Tax ID of the business. Select the State abbreviation in which the business is conducting operations. Enter the Percent Ownership in the business of the enrolling individual, and the seven digit Louisiana Medicaid ID Number (or 10 digit NPI) of the enrolling individual.

Type your responses into the text boxes. Use the down arrow to open the State drop down box to select a state.

		•
LA	~	
AL	_	
AK		
AZ		
AR		
CA		1
co		
СТ		
DC		
DE		
FL		
GA		
HI		
ID		
IL -		
IN		
IA		
KS		
KY		
LA	•	

The Percent Ownership text box will accept a typed entry, but up and down arrows are provided as an optional way to select a value for the field:



	Other Business		:	× 01	nce the fiel	ds have been populated with
	Plan Name *			co	rrect data,	click the Save button.
	State *	- 🗸				
	ID Number *					
		Car	icel Save			
L						
Disclosure of Ownership for In	idividuals ve any direct, indirect, or con	trolling ownership intere:	t of 5% or more	e in any other healthcare	entities/businesses	Your information will be displayed on the Disclosure of
currently enrolled in Federal/Sta ⊛ Yes ○ No	te funded healthcare prograr	n(s)?			/	and Delete functions, similar
Please complete the following Plan Name Doing Bu	for each entity/business: (cli usiness As/Address	ck Add New Row, or use t % Ownership	State ID N	te buttons to correct an e Number	xisting entry)	
test plan		99	LA 878	9987 🖋 Edit	Telete	
+ Add New Row						

8.1.1 Edit

The **Edit** function re-opens the Other Business window, shown with the existing data (previously entered).

Plan Name *	×	Other Business
DBA Name State * Percent Ownership ID Number *		Plan Name *
State * ··· · · · · · · · · · · · · · · · ·		DBA Name
Percent Ownership		State *
ID Number*		Percent Ownership
		ID Number *
Cancel Save	ve	Cancel Save

Make any changes and then click on the **Save** button.

8.1.2 Delete

...

The **Delete** function opens the Confirm Other Business Delete window.

Confirm Other Business Delete ×				
Are you sure you want to delete this business? (this action cannot be undone)				
Cancel				

Click on the **Confirm** button to delete the data in the row. The row is immediately removed.

Continue Adding, Editing, and Deleting other businesses as needed.

8.2 Yes (Relative With Ownership Interest of 5% or Greater)

Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed above?

Click on the **Yes** radio button if the enrolling individual is related to a person with an ownership or controlling interest of 5% or greater in any of the entities/businesses entered on the Disclosure of Ownership page. The application responds with a screen similar to the one shown below:

Is the enrolling indi above?	Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses lister above?								
● Yes ○ No									
Please complete the following for each related individual: (click Add New Row, or use the edit and delete buttons to correct an existing entry)									
Full Name Maiden Name Relationship % Ownership Date of Birth Social Security Numb									
+ Add New Row									

Click on the **+Add New Row** button to enter ownership data for the first relative. The system responds by opening the **Edit Relative** window, as shown below:

0

All fields are required. Enter the relative's Full Name, Maiden/Other Name, Relationship (for instance, son, mother, father, daughter), Percent Ownership, relative's Date of Birth, and relative's SSN. Then click on the **Save** button.

The Percent Ownership text box will accept a typed entry, but up and down arrows are provided as an optional way to select a value for the field:

	Percent Ownersh	
Edit Relative	×	Once the fields have been populated with
Full Name: *		
Maiden/Other Name:		
Relationship: *		
Percent Ownership: *	0	
Date of Birth: *		
SSN *		
	Cancel Save	

Your information will be displayed with the **Edit** and **Delete** functions, similar to those shown below:

Please complete the following for each related individual: (click Add New Row, or use the edit and delete buttons to correct an existing entry)						
Full Name	Maiden Name	Relationship	% Ownership	Date of Birth	Social Security Number	
Ralph Lauren		son	0	6/6/2006	33333333	🖋 Edit 🔋 Delete
+ Add New Row]					

8.2.1 Edit

The Edit function re-opens the Edit Relative window	, shown wi	rith the e	xisting data	, which ca	n
be corrected as needed.			-		

×
0
Cancel

Make any changes and then click on the Save button.

8.2.2 Delete

The Delete function opens the Confirm Other Relative Delete window.

Confirm Other Relative Delete	×
Are you sure you want to delete this business? (this action can be undone)	not
Cancel	m

Click on the **Confirm** button to delete the data in the row. The row will be immediately removed.

Continue Adding, Editing, and Deleting relatives as needed.

8.3 Enrolling Individual Questionnaire

Carefully read the instructions at the beginning of the questionnaire section. For each **"Yes"** answer, you must submit a written statement providing the details and you must attach all official legal documents regarding the occurrence.

dual Questionnaire
Ever been convicted of a criminal offense in any program under medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program?
Ever had any disciplinary action taken against any license or certification held in any State or US Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license of certification?
Ever been denied enrollment, suspended, or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid, or other healthcare program(s) in any State or US Territory?
Currently have a negative balance or currently owes money to any State or Federal Funded program including Medicaid and Medicare?
Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency?
Currently have any open or pending healthcare court cases?
Ever been denied malpractice insurance?
Currently has or ever had any type of felony conviction(s)?
ails <u>MUST</u> be provided in the box below for questions answered "YES" and supporting documentation <u>MUST</u> be attached. (Failul and an attachment will result in a suspended application)

All questions are required. Use the text box to submit details regarding each "**Yes**" answer. If necessary, use box re-size function to expand or reduce the size of the text box to fit your requirement.

8.3.1 Attach Documentation

Allowed file extensions for uploads are pdf, jpg, gif, png, doc, docx, tif and tiff.

- No limit to the number of uploads
- 10mb max per file



Click on the **Attach Documentation** button to open the **Upload Documentation** window. Attach all official legal documents regarding the occurrence of a Yes answer, including any reinstatements.

opioad Documentation	×
Choose File No file chosen	
Close Upload	

Click on the **Choose File** button to begin the upload. Your computer's file exploration tool will open.

🜍 Open				×
\leftarrow \rightarrow \cdot \uparrow] \blacktriangleright This	s PC > Desktop > PES	∨ ७	Search PES	
Organize • New folde	r		83	• 🔳 🕐
SThis PC	Name		Status	Date mo '
3D Objects	Enrollment_Entities		\odot	5/5/202
Desktop	Enrollment_Entities		\odot	5/5/202'
Documents	PES_Fac_FFS		\odot	4/21/202
Downloads	PES_Fac_FFS		\odot	4/21/202
Music	PES_Fac_MCO		\odot	4/21/202
a) Music	PES_Fac_MCO		\odot	4/21/202
Pictures	PES_Ind_FFS		\odot	4/21/202
💥 Videos	PES_Ind_FFS		\odot	4/21/202
🤩 OSDisk (C:)	PES_Ind_MCO		2	5/10/202
👡 SheehanR (\\labr	PES_Ind_MCO		\odot	5/3/2021
🥁 Genpublic\$ (\\lat	PES_Ind_MCO-tb edits		\odot	5/10/202
🛶 Shared A\lahrfsr 🗡	<			>
File nar	me: PES_Ind_MCO	~ Cust	om Files	~
			Open	Cancel

Find the file you want and select it, then click on the **Open** button. The file name you selected is now displayed in the Upload Documentation window.

Upload Documentation X	
Choose File PES_Fac_MCO.pdf	Type a description of the document into the text box.
	Use box re-size function to expand or reduce the size of the text box to fit your requirement.
Close	Then click on the Upload button.

8.3.2 Uploaded Files

After you have uploaded files, they are displayed in a manner similar to that shown below:

Uploaded files:				Use the Delete
File Name	Description	Added		 function to remove
test 2.docx	N/A	07/07/2021	Telete	any uploaded life.

If you misplace the file, you are enabled to click on the file name to download it to your computer.

Delete File? ×	
Are you sure you want to delete this file? (this action cannot be undone)	
Cancel	

Click on the **Confirm** button to delete the file. The file will be immediately removed, and the following message displayed:



8.4 Yes (Form Completed by Individual Other Than Enrolling Provider?)



Click on the **Yes** radio button if a person other than the enrolling individual Provider is the one filling out the online Provider Enrollment form. The page expands to reveal the following questions:

Complete the section below for the individual co	mpleting this form:
Full Name: *	
Maiden/Other Name:	
SSN: *	
Date of Birth: *	
Person completing this form is: *	$^{\circ}$ Staff $^{\circ}$ Third Party/Independent Agent $^{\circ}$ Other (Specify)
Phone Number: *	###_###_###
Email Address: *	

Enter Full Name, Maiden/Other Name, SSN, and Date of Birth. Click on a radio button to specify whether the person entering the form is Staff, Third Party/Independent Agent, or Other (Specify). If Other (Specify) is selected, then the text box is activated, and you can type in the specific function of the person entering the data. Enter the Phone Number and the Email address of the person filling out the online form.

This completes the **Ownership Disclosure** section pertaining to "Yes" answers.

This section is now complete. Click the "Next" button to proceed to the next section.	
G Previous Next €	J

Click on the Save Progress button.

9.0 Ownership Disclosure – "No" Answers

Start 🗸	Taxonomy 🗸	Practice Address 🗸	Other Addresses 🗸	Mailing Address 🗸	Ownership Disclosure	Ownership Attestation	Other Programs	Participation Agreement	Review & Submit
	Nan	ne:	Provider ID: Provider NPI:		Provider Type: 20 - PHYSICIAN (IND & GP) Provider Specialty: 16 - OB/GYN	Sub-Speci None Current St Information	alties: atus: n Gathering Started and sa	aved for later	
		Disclosure of Own Does the enrolling i currently enrolled in O Yes O No	ership for Individuals individual have any direc n Federal/State funded h	t, indirect, or contr ealthcare program	rolling ownership interest of (s)?	5% or more in any o	ther healthcare entiti	es/businesses	

In the **Ownership Disclosure** section of the application, use the radio buttons to answer Yes or No to the questions. Depending on your responses, the application will expand to display further questions.

9.1 No (5% or More Ownership Interest)

Click the **No** radio button if the enrolling individual has no direct, indirect, or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in Federal/State funded healthcare program(s). The enrollment application responds by expanding to display more of the Ownership Disclosure form, starting with the relatives with an ownership interest question, as shown below:

```
Disclosure of Ownership for Individuals
Does the enrolling individual have any direct, indirect, or controlling ownership interest of 5% or more in any other healthcare entities/businesses
currently enrolled in Federal/State funded healthcare program(s)?
○ Yes ● No
Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed
above?
○ Yes ● No
```

9.2 No (Relatives with Ownership Interest)

Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed above?

○ Yes ○ No

Click on the **No** radio button if the enrolling individual Provider is not related to a person or persons with significant ownership interest in the entities/businesses. The screen expands to reveal the next ownership question (see below).

9.3 Enrolling Individual Questionnaire

See 8.3, above.

9.4 No (Form Completed by Individual Other Than Enrolling Provider?)



Click on the **No** radio button if a person other than the enrolling individual Provider is the one filling out the online Provider Enrollment form. Click on the **Save Progress** button.



10.0 Ownership Attestation

The Attestation of Ownership page certifies that the information that has been entered is true, correct, and complete.

WITH	IY SIGNATURE BELOW, I ATTEST.
1.	HAT HAVE DISCLOSED ALL NECESSARY INFORMATION;
2.	44T I AM THE INDIVIDUAL IDENTIFIED IN SECTION I AND, AS SUCH, HAVE THE AUTHORITY TO ENTER INTO A PROVIDER
AGRE	ient with the Louisiana Medicaid Program;
3.	HAT I HAVE REVIEWED THE INFORMATION ON THIS INDIVIDUAL DISCLOSURE FORM AND ATTEST THAT IT IS TRUE, ARCURATE
AND	MPLETE;
4.	HAT I UNDERSTAND THAT KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLORE THE INFORMATION
REQU	ted may result in the denial of any request to participate in Louisiana's Medicard Program, or where the
NDIN	ual already participates, a termination of the provider agreement or compact with LDH or the Secretary.

Use the scroll tool to read the entire attestation statement.

Once you have read and understood the attestation statement, click on the **I Agree** check box so that a check mark is inserted:



Then click on the Sign Attestation button.

Click on the Save Progress button at the bottom of the screen.



11.0 License Information and Other Programs

The License Information and Other Programs section gathers License Information and data concerning other Federal/State-Funded Healthcare Programs.

License Information	
A valid license, if applicable, <u>MUST</u> be up The license information entered below <u>M</u>	looded in the "Attach Documentation" box located under "Enrolling Individual Questionnaire" (Ownership Disclosure Tab) <u>UST</u> match exactly as it appears on the issued license
Failure to upload a valid license or enter	ing incorrect license information will cause a suspension, delaying the enrollment process.
Please enter the license information rec	uested below (required):
Name on License: *	
License Number: *	l
License State: *	
Other Federal/State-Funded Healthc	re Programs (e.g. Medicare, other State Medicaid)
Is the Social Security Number(s) listed c	urrently enrolled in any other Federal/State funded healthcare programs?
🔿 Yes 🔹 No	
Click the "Next" button below to procee	d.
Previous Next ()	& Save Progress

Enter the Name on the License and the License Number into the text boxes. Click on the down arrow to open the drop-down box to select the state from which the license was issued (see below).

LA AL AL AK AZ AR CA CO CT DC DE FL GA HI ID IL IN			
AL AK AZ AR CA CC DC DE FL GA HI ID IL IN	LA	~	
AL AK AZ CA CO CT DC FL GA HI ID II II			
AK AZ AR CA CC CC CT DC DE FL GA HI ID II II	AL	-	
AZ . AR CA CO CT DC DE FL GA HI ID IIL IN	AK		
AR CA CO CT DC DC FL GA HI ID IL IN	AZ		
CA CO CT DC DE FL GA HI ID IL IN	AR		
CO CT DC DE FL GA HI ID IL IN	CA		
CT DC DE FL GA HI ID IL IN	co		
DC DE FL GA HI ID IL IN	CT		
DE FL GA HI ID IL IN	DC		
FL GA HI ID IL IN	DE		
GA HI ID IL IN	FL		
HI ID IL IN	GA		L
ID IL IN	HI		L
IL IN	ID		
IN	IL		
	IN		
IA	IA		
KS	KS		
KY	KY		
LA	LA	▼	

11.1 Enrolled in Other Programs

Other Fed	eral/State-Funded Healtho	care Programs (e.g. N	Aedicare, other State	Medicaid)	
Is the Socia	I Security Number and/or T	「ax ID number(s) listed	currently enrolled in a	any other Federal/State	funded healthcare programs?
○ Yes _○	No				

Click on the **Yes** radio button if the enrolling Provider is currently enrolled in Federal or State programs other than Louisiana Medicaid.

The screen expands to reveal the Add Plan tool, as shown below:

Please complete the following: (click Add New Row, or use the edit and dele		nd delete buttons	to correct a		
Plan Name	Doing Business As (DBA) Name	;	SSN	State	ID Number
+ Add New Row					

Click on the +Add New Row button to open the Add Plan window, as shown below:

Enter the Plan	Add Plan ×	Use the State
Name, the DBA Name of the enrolled Provider, the SSN, and the ID Number of the Provider in the other plan.	Plan Name: *	drop-down box to select the state in which the plan being reported is located, then click on the Save button.
	Cancel Save	

Once you have entered and saved the Other Plan data, it is displayed in a manner similar to that shown below:



11.1.1 Edit

If you need to edit this information, click **Edit** function to re-open the Edit Site window, shown with the existing data, which can be corrected and saved as needed.

Edit Plan		×
Plan Name: *	Medicare	
DBA Name:	Satellite	
SSN: *	33333333	
State: *	LA 🗸	
ID Number: *	333333333	
		Cancel

11.1.2 Delete

If you need to delete an item, click the **Delete** function to open the **Confirm Other Program Delete** window.

Confirm Other Program Delete ×
Are you sure you want to delete this program? (this action cannot be undone)
Cancel

Click on the **Confirm** button to delete the data in the row. The row will be immediately removed.

Continue Adding, Editing, and Deleting other programs as needed.

11.2 Not Enrolled in Other Programs



Click on the **No** radio button if the enrolling Provider is not currently enrolled in Federal or State programs other than Louisiana Medicaid.

Then click on the **Save Progress** button.



12.0 Participation Agreement

The Participation Agreement is a legally binding certification of agreement to participate in Louisiana Medicaid and to adhere to requirements specified in the agreement.

Use the scroll bar to view and read the entire agreement.

THE UNDERSIGNED, CERTIFY AND AGREE TO THE FOLLO	VING:		
NROLLMENT IN LOUISIANA MEDICAID			
I have read the contents of this Louisiana Mi	dical Assistance Program Portal Application and the		
IFORMATION SUPPLIED HEREIN IS TRUE, CORRECT AND C	OMPLETE;		
UNDERSTAND THAT IT IS MY RESPONSIBILITY TO EP	SURE THAT ALL INFORMATION IS KEPT UP TO DATE ON THE LOU!	IANA	
edicaid Provider File;			
• I MUST SEND A NOTICE TO THE LDH PROVIDER ENR	ollment section for any changes such as address, etc. Fa		
D DO SO MAY NEGATIVELY AFFECT ATTEMPTS TO REVALID	ATE THE INFORMATION AND RESULT IN ACCOUNT CLOSURE.		
FTER YOUR REVIEW OF THIS INFORMATION, PL	ASE INDICATE YOUR AGREEMENT BELOW.		

Click on the Sign Participation Agreement button. The screen expands to display the Electronic Signature statement and the I Agree check box, as shown below:

ELECTRONIC SIGNATURE BY INDICATING "I AGREE" BELOW, I AM SIGNING THIS AGREEMENT ELECTRONICALLY AND UNDERSTAND THAT THIS ELECTRONIC SIGNATURE IS THE LEGAL EQUIVALENT OF MY MANUAL SIGNATURE ON THIS AGREEMENT. I CONSENT TO BE LEGALLY BOUND BY THIS AGREEMENT'S TERMS AND CONDITIONS. I AGREE THAT NO CERTIFICATION AUTHORITY, OR OTHER THIRD-PARTY VERIFICATION, IS NECESSARY TO VALIDATE THIS ELECTRONIC SIGNATURE AND THAT THE LACK OF SUCH CERTIFICATION OR THIRD-PARTY VERIFICATION WILL NOT IN ANY WAY AFFECT THE ENFORCEABILITY OF THIS ELECTRONIC SIGNATURE, OR ANY RESULTING CONTRACT BETWEEN MYSELF AND THE LOUISIANA DEPARTMENT OF HEALTH. I REPRESENT THAT I AM THE PROVIDER APPLICANT, OR THAT I AM AUTHORIZED TO ENTER INTO THIS AGREEMENT ON BEHALF OF THE PROVIDER APPLICANT. I AGREE THAT THE TERMS OF THE AGREEMENT ARE EQUALLY BINDING WHETHER THE PROVIDER SIGNS THE AGREEMENT OR AN AUTHORIZED SIGNER ENTERS INTO THE	Use the scroll bar to view and read the entire signature statement, then click on the I Agree check box.
■ lAgree	CHECK DOX.

An email similar to the one shown below will be sent to the email address on file:

Test Email 229794 : Louisiana Medicaid Provider Enrollment Electronic Signature for provider nnnnnn Accepted	nail 229794 : Louisiana Medicaid Provider Enrollment Electronic Signature for provider nnnnnn Accepted	
DoNotReply@gainwelltechnologies.com To Foree, Robert (S&L HHS); Chapman, Karen (S&L HHS)	5	R
We have accepted your electronic signature for the Provider Participation Agreement with the Louisiana Medicaid Program for provider nnnnnn.		
Please retain this email message for your records. Please continue the enrollment process and submit your application.		
Please contact the Louisiana Medicaid Provider Enrollment Call Center at 1-833-641-2140 should you have questions or need assistance.		
Please do not reply to this message as it was sent from an unattended mailbox.		
Louisiana Medicaid		

The screen expands to reveal the Verification Code function, as shown below:

Click the "Re address can	equest Verification Cod only be changed by th	e" button below to have a verification code se e Admin user at LAMedicaid.com.	nt to the email address we have on file for	you. If this email address is not correct, the Email
Email:	tom@cat.com	Request Verification Code 💿		
Code:			Submit Code 刘	
If you did no	ot receive the verification	on code, check your email spam folder or if ver	rification code has expired, please request	new code by clicking the Request New Code button :
Reques	st New Code 실			
		/		

Click on the **Request Verification Code** button. The "Verification code sent" window opens, as shown below.

Verification code sent	Х
The verification code has been sent to the email address shown	
Close	e

Click on the **Close** button and check your email for the code.

Code:	Submit Code 封

Type the code sent to the email address on file (sample email shown below) and click on the **Submit Code** button.



If you do not receive your code within five minutes, carefully check the various folders of your email account to see if the code is in one of them. If you can't find the code, verify that your email address is correct and then click on the **Request New Code** button. If the email address is incorrect, use the account management tool to correct it (see

https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid_Provider_Login_Admin_ Manage_Users.pdf).

If you did not receive the verification cede, check your email spam folder or verify the email address shown above. If you need to request a new verification code, click t
Request New Code button:
Request New Code 🤷

After you enter the code sent to you, click on the **Save Progress** button at the bottom of the screen.



13.0 Review & Submit

Review and Submit	
Review the checklist below to ensure you have completed all sections of this application. If corrections are needed please visit the application to revise. Once all items are complete, click the Submit button.	pages
Taxonomy/Taxonomies	
Practice addresses	
SSN and mailing address	
Disclosure of ownership information with attestation	
Participation Agreement	
Note: Once the submit button is clicked, your application will be submitted and no further changes can be made!	
Submit Application 🔶	
G Previous Next O	

Click on the **Submit Application** button. Once you click the Submit Application button, the information is locked for review and can only be viewed.

Note: If you are not able to click the **Submit Application** (i.e., the button is not activated), it means that a portion or portions of the online form are incomplete. Use the navigation tabs to identify the section or sections that need further attention. If any tabs do not have a check mark, they are incomplete. Use the **Previous** and **Next** buttons to navigate to a page that needs work.

After selecting the **Submit Application** button, the system responds with the Confirm Submission window:



13.1 Submission Results

Your submission may result in any of the following:

Your submission has been received
Screening is in process
Your enrollment with the State is complete
Your enrollment with the State is denied and a letter is being mailed

You will receive an email (similar to that shown below) that contains a link to check the status of your submission. Using the link, check back after 24-48 hours to review your submission status.



14.0 Louisiana Medicaid Provider Enrollment Portal Help Desk

The Louisiana Medicaid Provider Enrollment Portal Help Desk is available to assist you Monday – Friday 8 a.m. to 5 p.m. CST. The toll-free number is 833-641-2140.