State of Louisiana
Instructions for Provider Enrollment File Update Form

Preparation

Complete the File Update Form as an **original** document. The form may be photocopied for your records.

You must enter your NPI and the Medicaid Provider Number. Thereafter, complete only the fields that need to be updated.

National Provider Identifier (NPI) – provider types that are required to obtain the NPI number must enter the number in this field. Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do for more information on obtaining an NPI.

Medicaid Provider Number – your seven- (7) digit Medicaid provider number.

Medicaid Submitter Number – submitter number used to submit electronic claims (if same as provider name).

Provider Name – provider name as it appears on the Louisiana Medicaid provider file. If individual, list Last Name, First Name, Middle Initial, Title. If entity, list name under which provider does business.

Address Of Physical Location – your primary physical location address.

Telephone – the telephone number where you may be reached.

Mailing Address, if different – enter your mailing address if mail cannot be received at the Physical Location

Physical Location Parish – the parish in which your physical location is located.

Parish Code – the parish code of your physical location (see list below and enter appropriate code for the parish).

"Pay To" Name – enter the name in which you wish your payments to be issued. This name must match the accompanying IRS documentation EXACTLY.

Other – this space is to identify additional information such as attention to a specific person, department, floor, care of, etc.

Tax ID Number – the Tax ID number assigned to your Provider number. This number is used in reporting payment amounts for this provider number to the IRS.

PAY-TO ADDRESS – the address to which you wish your payments and/or remittance advices to be mailed.

UPIN – your Universal Provider Identification Number, if applicable

Acadia	1	East Carroll	18	Natchitoches	35	St Tammany	52
Allen	2	East Feliciana	19	Orleans	36	Tangipahoa	53
Ascension	3	Evangeline	20	Ouachita	37	Tensas	54
Assumption	4	Franklin	21	Plaquemines	38	Terrebonne	55
Avoyelles	5	Grant	22	Pointe Coupee	39	Union	56
Beauregard	6	Iberia	23	Rapides	40	Vermilion	57
Bienville	7	Iberville	24	Red River	41	Vernon	58
Bossier	8	Jackson	25	Richland	42	Washington	59
Caddo	9	Jefferson	26	Sabine	43	Webster	60
Calcasieu	10	Jefferson Davis	27	St Bernard	44	West Baton Rouge	61
Caldwell	11	Lafayette	28	St Charles	45	West Carroll	62
Cameron	12	Lafourche	29	St Helena	46	West Feliciana	63
Catahoula	13	LaSalle	30	St James	47	Winn	64
Claiborne	14	Lincoln	31	St John	48	Texas	87
Concordia	15	Livingston	32	St Landry	49	Mississippi	88
DeSoto	16	Madison	33	St Martin	50	Arkansas	89
East Baton Rouge	17	Morehouse	34	St Mary	51	Other	99

INDIVIDUALS ONLY - indicate whether or not you will bill under your individual provider number or the group will bill with your number as an attending number.

Direct Deposit Information – indicate whether or not the current direct deposit information on file is changing.

Provider Signature & Date – signature of the person authorized to sign the form and date of signature.

ORIGINAL SIGNATURES ONLY; NO STAMPS OR COPIED SIGNATURES WILL BE ACCEPTED. INDIVIDUAL PROVIDERS MUST SIGN THEIR OWN FORMS.

Revised 01/22

FILE UPDATE FORM

COMPLETE ONLY THE FIELDS THAT NEED TO BE UPDATED

CANNOT FAX THIS FORM, MUST BE MAILED-ORIGINAL SIGNATURE REQUIRED

PROVIDER NPI NUMBER (required)	MEDICAID PROVIDER #	SUBMITTER NO.

PHYSICAL LOCATION ADDRESS

Provider Name:

Physical Location Address(Street, City, State, Zip):

Telephone Number to Physical Location:

Can mail be received at the above Physical Location Address? Yes_______ No ______.
If no, please indicate mailing address below.

Mailing Address: (if mail cannot be received at the above Physical Address)

Physical Location Parish/County:

Parish/County Code:

PAY-TO / CORRESPONDENCE ADDRESS

Pay-To Name:

Attn/Other:

Tax ID Number: **

****IRS: You must submit preprinted IRS verification if Pay-To Name and/or EIN is changing**

Pay-To / Correspondence Full Mailing Address:

UPIN:(if applicable)

COMPLETE SECTION BELOW IF ANY PAY-TO INFORMATION IS CHANGING

INDIVIDUALS ONLY:

- □ I am currently billing under my individual provider number and DO NOT want to change. (Enroll Stat 1)
- □ I DO NOT bill under my individual provider number. My provider number is used as an attending number on group claims ONLY. (Enroll Stat 0)

IS YOUR DIRECT DEPOSIT(ELECTRONIC FUNDS TRANSFER) CHANGING?

☐ NO ☐ YES

(IF YES, ATTACH REQUIRED EFT FORMS)
***Direct deposit is required for ALL individuals billing under their individual provider number and ALL Business/Entities. (Enroll Stat 1)**

MAIL ORIGINAL FORMS TO:
GAINWELL
PROVIDER ENROLLMENT UNIT
P O BOX 80159
BATON ROUGE, LA 70898-0159

ORIGINAL PROVIDER SIGNATURE REQUIRED. MUST BE DATED (NO COPIES, STAMPS OR INITIALS)

SIGNATURE **DATE**