ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

(Louisiana Medicaid Program)

LaHIPP Only Basic Enrollment Packet for Entities/Businesses (With Instructions)

(Common Forms for All Entity Provider Types)

(Enrollment packet is subject to change without notice)

gainwell

To Whom It May Concern:

This is the Basic Enrollment Packet for Entities/Businesses to enroll in the Louisiana Medical Assistance Program (also known as the Louisiana Medicaid program). Review these materials carefully, including all instructions, before completing the necessary forms.

After completing the enrollment packet materials, please return all forms with original signatures to:

Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

UPS, Fed Ex, etc. will not deliver to a P.O. Box. If a package for a mail delivery service other than the United States Postal Service is addressed to a P.O. Box, your mail could be lost or delayed. If you would like to make arrangements to send your documents to a physical street address using a mail service other than the United States Postal Service, please call the Gainwell Provider Enrollment Unit at (225) 216-6370.

Please be sure to include the National Provider Identifiers (NPIs) to be linked to the newly assigned Medicaid provider number. Claims will not automatically cross electronically from Medicare to Medicaid unless these NPI numbers are linked in our system. NOTE: Each NPI can only be added/linked to one Medicaid provider number; however, multiple NPIs can be added to a single Medicaid provider number.

The Gainwell Provider Enrollment Unit in conjunction with the Louisiana Department of Health (LDH) will take necessary steps to certify each enrollment in the Louisiana Medical Assistance Program, once all required documents are received. Upon certification, an enrollment notification letter, containing the Medicaid provider number, will be sent via the U.S. Postal Service, to the mailing address on the application.

Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify provider enrollment in writing of the intent to withdraw from the Medicaid program within ten (10) working days from the date of the enrollment notification letter mentioned above. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL until either party terminates this contract.

The Provider Service Manuals are located on-line at www.lamedicaid.com. Click on Provider Tools on the left side bar of the Home Page and select Provider Manuals. Choose the appropriate manual.

If the manual needed does not appear on the listing, call Gainwell Provider Relations at 800-473-2783 or (225) 924-5040 for assistance.

For questions concerning the completion of this enrollment packet, please contact the Provider Enrollment Unit at the above address or at (225) 216-6370.

Thank you for your interest in becoming a Louisiana Medicaid provider.

Sincerely,

Provider Enrollment Unit

Louisiana Medicaid Program

Statutorily Mandated Revisions to all Provider Agreements

The 1997 Regular Session of the legislature passed, and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437:14. The provider agreement provisions of MAPIL statutorily establishes that the provider agreement is a contract between Louisiana Department of Health (LDH) and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

1) comply with all Federal and state laws and regulations;
2) provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
3) have all necessary and required licenses or certificates;
4) maintain and retain all records for a period of at least five (5) years;
5) allow for inspection of all records by governmental authorities;
6) safeguard against disclosure of information in patient medical records;
7) bill other insurers and third parties prior to billing Medicaid;
8) report and refund any and all overpayments;
9) accept payment in full for Medicaid recipients providing allowances for copay authorized by Medicaid;
10) agree to be subject to claims review;
11) the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
12) notification prior to any change in ownership;
13) inspection of facilities; and
14) posting of bond or letter of credit when required.

MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

The provider agreement provisions of MAPIL also provide the LDH Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997, or became effective on or after August 15, 1997, are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997, to contain the terms and conditions established in MAPIL.

Office for Civil Rights Policy Memorandum

The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), issued a policy memorandum regarding nondiscrimination based on national origin as it relates to individuals who are limited English proficient. Below is the Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Statement which expresses our Agency's commitment to ensuring that there is no discrimination in the delivery of health care services through CMS programs.

We have committed ourselves to full compliance with the requirements contained in this policy statement. As our partner with the administration of the Medicaid program, you likewise are obligated to comply with those statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The HHS Office for Civil Rights has previously advised CMS that detailed implementation regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

Please share this policy statement with your healthcare providers and all others involved in the administration of CMS programs.

Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Policy Statement

The Centers for Medicare and Medicaid Services' vision in the current Strategic Plan guarantees that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all CMS program operations and activities. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all CMS operating components. Promoting attention to and ensuring CMS program compliance with civil rights laws are among the highest priorities for CMS, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of CMS programs.

CMS, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. CMS will, with your help, continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

To achieve its civil rights goals, CMS will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities including: collecting data on access to, and the participation of minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing CMS publications, program regulations, and instructions to assure support for civil rights; and working closely with the HHS, Office for Civil Rights, to initiate orientation and training programs on civil rights. CMS will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

HHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, CMS will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

CMS's mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries, i.e., our customers. We will enhance our communication with constituents, partners and stockholders. We will seek input from health care providers, states, contractors, and HHS Office for Civil Rights, professional organizations, community advocates and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability.

State of Louisiana (Entity/Business)

Instructions for Louisiana Medicaid PE-50 Provider Enrollment Form

PREPARATION

Please read the instructions in their entirety before completing forms. Complete all forms as an **original** document. The completed form may be photocopied for your records. Inaccurate/Incomplete forms will be returned to you for correction or completion.

GENERAL INFORMATION

A Medicaid provider number will be issued to the entity or business whose name appears in Section A of this form. It is the responsibility of the authorized representative for this entity or business to maintain accurate information on the Louisiana Medicaid provider file through submitting updates (as required) to the Provider Enrollment Unit.

A Medicaid provider number can have only one (1) mailing address. Therefore, this address **MUST** be the address that the business/entity wishes to receive correspondence mailed out from LDH and Gainwell under the Medicaid provider number.

All fields on the PE-50 form **MUST** be completed unless they are labeled as optional.

Louisiana Medicaid Provider Number – enter your 7-digit Louisiana Medicaid provider number (if known) in the boxes. If you are filing for a new enrollment, leave this blank.

This enrollment packet is for – check the appropriate box to indicate if this application is for a new enrollment, re-validation of an existing enrollment, to reactivate a provider number, specify some other reason for the enrollment packet, or Change of Ownership (CHOW). A new enrollment is for an entity or business with no prior Louisiana Medicaid provider number. A re-validation of an existing enrollment is for an entity or business that has a current Louisiana Medicaid provider number and needs to re-validate the information currently on file. A reactivation is for a provider who has had a Louisiana Medicaid provider number in the past but whose number is closed. A CHOW occurs whenever your entity/business experiences a change in ownership.

National Provider Identifier (NPI) – enter your 10-digit NPI number in the boxes. The NPI is a unique 10-digit identification number issued to healthcare providers by the Centers for Medicare and Medicaid Services (CMS). Visit https:/nppes.cms.hhs.gov for more information on obtaining an NPI. You are required to have an NPI number prior to enrollment, unless you are classified as an atypical provider. Atypical providers are non-healthcare providers that do not provide direct healthcare services (e.g., non-emergency transportation companies, construction companies, etc.).

NPI Tie-Breaker (Taxonomy or Zip +4) – **NOTE: The current Louisiana Medicaid system will only allow the linkage of one unique NPI to one Medicaid provider number.** Thus, the recommendation is to obtain one NPI for each Medicaid ID number requested. The use of the same NPI to link to multiple Medicaid numbers requires a unique Tiebreaker each time that NPI is used in conjunction with a different provider number. Acceptable Tiebreakers are valid Taxonomy codes from NPPES or a ZIP Code + 4. The same NPI (or NPI with a Tiebreaker) indicated on the file for a given Medicaid provider number is the same NPI (or NPI with a Tiebreaker) that needs to be on claims.

SECTION A – ENTITY/BUSINESS INFORMATION & PRACTICE LOCATION

"Doing Business As" Name of Enrolling Entity – enter the "Doing Business As" (DBA) Name. If a license is required for the practice / business to enroll in Medicaid, enter the DBA name or operating name so that it matches the name on this license.

Business Telephone Number and Extension – enter the telephone number at the practice location of the business named in "*Doing Business As" Name of Enrolling Entity.* This is the phone number that will be used on the Provider Locator Tool.

Business/Practice Street Address – enter the street address of the main location of the enrolling business. If this business requires a license for enrollment in Medicaid, this address must match the address on the license. Occasionally, there will be an instance when mail or a document or a correspondence may be sent to the street address. If mail cannot be received at the Business/Practice Street Address because there is no receptacle and the postal carrier will not bring the mail inside the building, include a brief note that explains the problem and provide an alternative delivery address for the physical location only.

Business/Practice City – enter the city in which your *Business/Practice Street Address* is located.

Business/Practice State – enter the state in which your *Business/Practice Street Address* is located.

Business/Practice Zip Code – enter the zip code in which your *Business/Practice Street Address* is located.

Parish/County – enter the parish/county in which your *Business*/*Practice Street Address* is located. For out-of-state providers see county codes below.

Parish/County Code – for businesses located in Louisiana, enter the parish code of your physical location. See Table 1 below and enter appropriate code for the parish entered in the *Parish/County* field. Out-of-state providers see Table 2 below.

Table 1. Louisiana Parish Codes

Acadia	01	E. Baton Rouge	17	Madison	33	St. Landry	49
Allen	02	E. Carroll	18	Morehouse	34	St. Martin	50
Ascension	03	E. Feliciana	19	Natchitoches	35	St. Mary	51
Assumption	04	Evangeline	20	Orleans	36	St. Tammany	52
Avoyelles	05	Franklin	21	Ouachita	37	Tangipahoa	53
Beauregard	06	Grant	22	Plaquemines	38	Tensas	54
Bienville	07	Iberia	23	Pointe Coupee	39	Terrebonne	55
Bossier	08	Iberville	24	Rapides	40	Union	56
Caddo	09	Jackson	25	Red River	41	Vermillion	57
Calcasieu	10	Jefferson	26	Richland	42	Vernon	58
Caldwell	11	Jefferson Davis	27	Sabine	43	Washington	59
Cameron	12	Lafayette	28	St. Bernard	44	Webster	60
Catahoula	13	Lafourche	29	St. Charles	45	W. Baton Rouge	61
Claiborne	14	LaSalle	30	St. Helena	46	W. Carroll	62
Concordia	15	Lincoln	31	St. James	47	W. Feliciana	63
DeSoto	16	Livingston	32	St. John	48	Winn	64

For businesses located outside of Louisiana, use the chart below to determine the county/state codes.

Bordering states with counties identified as a "trade-area" to Louisiana have specific county codes that must be used. Use the state code unless your practice location is in one of the trade-area counties. If your practice location is in one of the trade-area counties, be sure to use the appropriate county code (NOT the state code).

Table 2. Out of State County Codes

State	State Code	Trade-Area County	County Code
Texas	87	Cass, Harrison, Jefferson, Marion, Newton, Orange, Panola, Sabine, Shelby	90
Mississippi	88	Adams, Amite, Claiborne, Hancock, Issaquena, Jefferson, Marion, Pearl River, Pike, Washington, Warren, Wilkinson	91
Arkansas	89	Ashley, Chicot, Columbia, Lafayette, Miller, Union	92
ALL OTHER STATES	**99**		

State Status – check "In (0)" if your *Business/Practice Street Address* is located within Louisiana or "Out (1)" if it is located outside Louisiana.

Location Type – check "Urban (1)" if your *Business*/*Practice City* is an urban (city) location or "Rural (2)" if it is a rural (away from city centers) location.

License # - if applicable, enter the license number for the business/entity identified in the *"Doing Business As" Name of Enrolling Entity* field.

Medicare Provider Number (Legacy) (optional) – Only in-state enrollments need Legacy Medicare numbers. Enter the Medicare number or the organizational NPI assigned to the enrolling business/entity (if applicable). Be sure this Medicare number or NPI is the exact number related to the business/entity listed in Section A.

Specialty Code – refer to the checklist in the Provider-Type Specific Packet for the possible Specialty Codes associated with your provider type.

Subspecialty Code (if applicable) – refer to the checklist in the Provider-Type Specific Packet for the possible Subspecialty Codes associated with your provider type.

SECTION B – PAY-TO NAME AND MAILING ADDRESS

Provider Pay-To Name – enter the name registered with the Internal Revenue Service (IRS). This is the name the year-end 1099s are issued under. Enter the name EXACTLY as found on the top line of the pre-printed IRS documentation enclosed with the application. Do not abbreviate or add punctuation not found on the IRS documentation. If the Pay-To Name on the PE-50 **DOES NOT** match the IRS documentation exactly, the application may be returned to you for correction.

Attn. or Other (optional) – this information can be used to help get mail delivered to a complex address (i.e., a certain person, department, floor, a particular area or section, etc.)

Provider Mailing Address – enter the address to which correspondences are to be mailed.

Provider Mailing City – enter the city in which your *Provider Mailing Address* is located.

Provider Mailing State – enter the state in which your *Provider Mailing Address* is located.

Provider Mailing Zip Code – enter the zip code in which your *Provider Mailing Address* is located.

IRS Reporting Number – enter the Federal Tax ID number assigned by the IRS. This number is used in reporting payment amounts for this provider number to the IRS. A copy of a pre-printed document from the IRS showing both the Employer Identification Number (EIN) / Tax ID Number (TIN) and the name that's registered to the EIN is required.

Provider Year-End Date –**This is a required field only for providers required to complete an Annual Cost Report.** Enter the Fiscal Year-end month of your business. Must be the month noted on your CMS letter, if Medicare is required.

SECTION C – HOSPITALS AND/OR LTCs

Hospitals Only – Check the appropriate box for the entity or business entered in the *Provider Name* field in Section A. This field is required for hospitals.

Hospital & Long-Term Care Facilities (LTCs) # Certified Beds – Enter the number of certified beds of the entity or business entered in *Provider Name* field in Section A. This field is required for hospitals and LTCs.

Hospitals & LTCs Name of Administrator – Enter the name of the individual who serves as administrator of the entity or business entered in the *Provider Name* field in Section A. This field is required for hospitals and LTCs.

SECTION D – OTHER

Requested Enrollment Effective Date – the date that you want the provider number to be activated. In some instances, this date can be retroactive as long as it fits the requirements for that provider type and meets the timely filing policy. You must submit a valid license that covers the requested effective date.

Provider Type Description – review the following table and enter the provider description. Entries of provider types other than those listed in this table will result in rejection of this application.

Provider Type Code – after reviewing the following table, enter the appropriate provider type code. Entries of provider types other than those listed in this table will result in rejection of this application.

Code	Description	Code	Description
	Groups	88	Intermediate Care Facility/Developmentally Disabled (ICF/DD) (In-State Only)
30	Chiropractor Group	74	Mental Health Clinic (In-State for Crossovers Only)
91	Certified Registered Nurse Anesthetist (CRNA) Group	77	Mental Health Rehabilitation Center (In-State for Crossovers Only)
27	Dental Group	25	Mobile X-Ray/Radiation Therapy Center
29	Early Steps Group (In-State Only)	MI	Monitored In-Home Caregiver (MIHC)
78	Nurse Practitioner (NP) Group	80	Nursing Facility (In-State Only)
28	Optometrist Group	75	Optical Supplier (In-State Only)
37	Occupational Therapist Group	04	Pediatric Day Health Care (PDHC) Facility
78	Nurse Practitioner (NP)Group	24	Personal Care Services (In-State Only) *
20	Physician (MD) Group	26	Pharmacy (Out-of-State enrolls for Crossovers only)
35	Physical Therapist Group	25	Radiation Therapy Center
32	Podiatrist Group	65	Rehabilitation Center (In-State Only)
39	Speech Therapist Group	87	Rural Health Clinic (RHC) (Independent) (In-State Only)
	Non Group	79	Rural Health Clinic (RHC) (Provider Based) (In-State Only)
85	Adult Day Health Care (ADHC) – Home & Community Based Services (In-State Only)	38	School Based Health Center (In-State Only) *
51	Ambulance Transportation	68	Substance Abuse and Alcohol Abuse Clinic
54	Ambulatory Surgical Center (In-State Only)	SP	OAAS Organized Health Care Delivery System (Super Provider)
95	American Indian/Native Alaskan "638" Facilities	14	Waiver – Adult Day Habilitation (In-State Only)
BC	Birthing Center (Freestanding)	17	Waiver – Assistive Devices
45	Case Management/Support Coordination (In-State Only)	03	Waiver – Children's Choice (In-State Only)
08	Case Management - OAAS	15	Waiver – Accessibility Adaptation (In-State Only)
07	Case Management- Infants & Toddlers (In-State Only)	AN	Waiver – Community Choices Waiver – Caregiver Temporary Support
18	Community Mental Health Center (CMHC)/Partial Hospitalization (In-State Only)	AM	Waiver – Home Delivered Meals
40	DME Providers (Out-of-State enrolls for Crossovers Only) *	AW	Waiver – Permanent Supportive Housing Agent
70	EPSDT Health Services Provided by Local Education Agencies (LEAs)	82	Waiver – Personal Care Attendant (In-State Only) *
71	Family Planning Clinic	16	Waiver – Personal Emergency Response System
72	Federally Qualified Health Center (FQHC) (In-State Only)	13	Waiver – Pre-Vocational Habilitation (In-State Only)
76	Hemodialysis Center (In-State Only)	83	Waiver – Respite Care (Center-Based only) (In-State Only)
44	Home Health Agency (In-State Only)	11	Waiver – Shared Living
09	Hospice Services (In-State Only)	84	Waiver – Substitute Family Care (In-State Only)
60	Hospital	89	Waiver – Supervised Independent Living (In-State Only)
69	Hospital – Distinct Part Psychiatric (DPP) (In-State Only)	98	Waiver – Supported Employment (In-State Only)
64	Hospital – Mental Health Hospital (Free-Standing)		
23	Independent Lab		

Refer to the Provider Type Enrollment Packet checklist to determine Specialty Type.

SECTION E – CONTACT INFORMATION

Contact Name – enter the name of the person who may be contacted for additional information regarding this enrollment application.

Contact Phone Number and Extension – enter the phone number and extension *(if applicable)* of the person who may be contacted for additional information regarding this enrollment application.

Contact Fax Number and Extension - enter the fax number and extension *(if applicable)* of the person who may be contacted for additional information regarding this enrollment application.

Contact Email – enter the email address of the person who may be contacted for additional information regarding this enrollment application.

SECTION F – PROVIDER ATTESTATION OF INFORMATION

Printed Name of Authorized Representative – print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.

Signature of Authorized Representative – the authorized representative must sign the form.

Signatures must be original and in blue ink (not BLACK) (stamped signatures and initials are not accepted). Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.

Title of Authorized Representative – indicate the relationship to the entity or business (e.g., owner, administrator, agent, managing employee, billing manager, etc.).

Date of Signature – enter the date this agreement was signed.

ALL PROVIDERS MUST COMPLETE THE PE-50 FORM IN ITS ENTIRETY – INACCURATE/ INCOMPLETE FORMS WILL BE RETURNED TO THE MAILING ADDRESS FOR CORRECTION

BHSF Form

PE-50 Entity or Business
Louisiana Medicaid Provider Enrollment Form

Rev. 11/2024

Louisiana Medicaid Provider Number (if known)	
National Provider Identifier (NPI)	
NPI Tie Breaker (Taxonomy or Zip, +4)	

This enrollment packet is for a:

- ☐ New Enrollment
- ☐ Re-validation of existing enrollment
- ☐ Reactivation
- ☐ Change of Ownership (CHOW)
- ☐ Other (*Please specify below*):

A
Entity/Business Information & Practice Location

"Doing Business As" Name of Enrolling Entity	Business Telephone Number	Extension
	( ) -	

Business/Practice Street Address		
Business/Practice City	Business/Practice State	Business/Practice Zip Code, +4 *(if known)*

Parish/County	Parish County/Code	State Status	Location Type	License Number
		☐ In (0) ☐ Out (1)	☐ Urban (1) ☐ Rural (2)	

See Provider-Type Specific Packet

Medicare Provider Number (Legacy) *(optional)*	Specialty Code (*required*)	Subspecialty Code (*if applicable*)

B
Pay-To-Name and Mailing Address

Provider Pay-To-Name (**MUST match the first line on the IRS document EXACTLY)**	Attn. or Other *(optional)*

Provider Mailing Address	Provider Mailing City	Provider Mailing State	Provider Mailing Zip Code, +4 *(if known)*

IRS Reporting Number	Provider Year-End Date (*optional*) MM/DD/YYYY

C
Hospitals and/or LTCs

Hospitals Only

☐ Profit (2) ☐ Nonprofit (3) ☐ Public (4) (In-State Only) ☐ LSU Hospitals (7) ☐ State-owned excluding LSU (9) (In-State Only)

Hospital & LTCs	**Hospitals & LTCs**
Number of Certified Beds: _____	Printed Name of Administrator: _____

D
Other

See PE-50 Instructions to get your Provider Type Description and Provider Type Code

Requested Enrollment Effective Date	Provider Type Description	Provider Type Code

E
Contact Information

The following person may be contacted for additional information regarding this enrollment application:

Contact Name:

Contact Phone: ( ) -	Extension *(if applicable)*:
Contact Fax: ( ) -	Extension *(if applicable)*:

Contact Email:

F
Provider Attestation of Information

I, the undersigned, certify the following:

1. I have read the contents of this enrollment packet including the PE-50 Addendum and the information contained herein is true, correct, and complete;
2. I understand that it is my responsibility to maintain current information on the Louisiana Medicaid files and failure to do so may result in delayed payments or closure of the Medicaid Provider Number;
3. I am an authorized party for the entity/business in Section A and can legally bind in this entity to this agreement through my signature below; and
4. I understand that the Louisiana Medicaid files will be updated with information supplied on these forms.

Printed Name of Authorized Representative

Signature of Authorized Representative
(Sign in blue ink only)

Date of Signature
MM/DD/YYYY

Title of Authorized Representative

LaHIPP ONLY (Entity Provider)
PROVIDER AGREEMENT ADDENDUM

Provider Name		
Main Practice Location		
NPI	SSN/Tax ID	Provider Type

This Provider Agreement is for providers whose only relationship with the Louisiana Medicaid Program is receiving direct payment from the Medicaid Program for reimbursement of out-of-pocket expenses incurred by LaHIPP Medicaid recipients who have private health insurance.

I, the undersigned, certify and agree to the following:

Enrollment in Louisiana Medicaid

1. The provider has read the contents of this Louisiana Medical Assistance Program Enrollment Packet and the information supplied herein is true, correct and complete;
2. The provider understands that it is their responsibility to ensure that all information is kept up to date on the Louisiana Medicaid Provider File;
   - the provider must send notice to the LDH Provider Enrollment section for any changes such as the provider's address and change of ownership/management. Failure to do so may negatively affect attempts to revalidate the provider's information and result in account closure.
   - The provider understands that failure to maintain current information may result in payments being delayed or closure of their Medicaid provider number;
3. The provider understands that if the provider number is closed due to inaccurate information or for inactivity, the provider will have to complete a new enrollment packet in its entirety to reactivate the provider number. A new application fee may be required for certain provider types.
4. The provider understands that it is their responsibility to ensure that all employees and/or authorized representatives are U.S. citizens or have legal status and work privilege in the U.S.
5. The provider understands that it is a violation if they fail to comply with any or all federal or state laws, regulations, policies, rules, criteria, or procedures, applicable to the Medical Assistance Program or a program of the Medical Assistance Program in which the provider, provider-in-fact, agent of the provider, billing agent, affiliate or other person is participating (Louisiana Administrative Code Title 50, Subpart 5, Chapter 41, Subchapter A, §4147.
6. The provider understands that individuals who meet one or more of the following conditions may not be eligible to participate in the Medicaid program and that it is the provider's responsibility to immediately report to the Program Integrity Unit at LDH if I, or any owners, managing employees or agents meet one or more of the noted conditions upon discovery of such information.
   - denied enrollment;
   - suspended, or excluded from Medicare, Medicaid or other Health Care Programs in any state;
   - employed by a corporation, business, or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or other Health Care Programs in any state;
   - convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs or any offense delineated in the Louisiana Medical Assistance Programs Integrity Law; 42 CFR 455.106.
   - terminated/revoked by Medicare or another state's Medicaid program
   - negative balances must be paid in full before enrollment, or reenrollment.
7. The provider understands that, as a part of the Louisiana Medicaid enrollment/re-enrollment process, the Social Security Numbers of any person with an ownership or control interest of 5% in the disclosing entity, any managing employees and any agents must be disclosed.
   - The provider understands that failure to provide the Social Security Numbers will result in the rejection and/or denial of enrollment or re-enrollment request.
8. The provider acknowledges that they have read and are familiar with LA R.S. 46:437.10. A&B, continuing liability; assumption of liability by the seller and buyer. Both parties are responsible for recoverable obligations.
9. The provider understands that On-Site Visits, per 42 CFR 455:432, may be conducted by LDH Staff, LDH Representative, CMS, CMS Agents and CMS Designated Contractors:
   - Either announced or unannounced,
   - For both pre-enrollment and/or post-enrollment
   - Failure to cooperate with these On-Site Visits shall result in denial or termination of participation.
10. The provider understands that all providers assessed as high risk are required to submit to fingerprint and background checks for all owners with 5% or more ownership interest.

Providing Services to Louisiana Medicaid Recipients

11. The provider agrees to conduct activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL Louisiana R.S. Title 46, Chapter 3, Part VI-A) as required to protect the fiscal and programmatic integrity of the medical assistance programs;
12. The provider understands that the Medicaid Provider Agreement is voluntary between the LDH and the health care provider and shall be effective for a stipulated period of time;
    - This agreement may be terminated by the LDH for cause without notice;
    - Either party shall terminate the agreement for no cause 30-days after written notice; and
    - The agreement shall be renewable upon mutual agreement.
13. The provider understands that services and/or supplies provided must be medically necessary and medically appropriate for each individual recipient based on needs presented on the date the service is provided and/or delivered;
14. The provider agrees to charge no more for services to eligible recipients than is charged on the average for similar services to others;
15. The provider understands that the provider is held responsible for any and all claims submitted under any Louisiana Medicaid provider number issued;
16. The provider agrees to maintain all records necessary for full disclosure of services provided to individuals under the program and to furnish, at no cost and within the time requested, information regarding those records as well as payments claimed/received for providing such services that the State Agency, the LDH Secretary, the Louisiana Attorney General, or the Medicaid Fraud Control Unit may request for five years from the date of service;
17. The provider agrees to submit all requested medical records within the time frames allowed to the CMS Payment Error Rate Measurement (PERM) contractor if/when claims are selected in a random sample. Failure to do so may result in sanctions.
18. The provider agrees to report and refund any discovered overpayments within sixty (60) days of discovery;
19. The provider agrees to participate as a provider of medical services and shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted as a Medicaid patient;
20. The provider agrees to accept Medicaid payment for covered services as payment in full and not seek additional payment from any recipient;
21. The provider agrees to adhere to the published regulations of the LDH Secretary and the Bureau of Health Services Financing, including, but not limited to, those rules regarding recoupment and disclosure requirements as specified in 42 CFR 455, Subpart B;
22. The provider agrees to adhere to the Federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the Federal HHS, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information, and any additional regulatory requirements imposed under HIPAA;
23. The provider understands the Louisiana Medicaid Program must comply with HHS regulations promulgated under Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; and the American Disabilities Act of 1990 which require that:
    - No person in the United States shall be excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of age, color, handicap, national origin, race or sex under any program or activity receiving Federal financial assistance.

    Under these requirements, LDH, Bureau of Health Services Financing (BHSF) cannot pay for medical care or services unless such care and services are provided without discrimination based on age, color, handicap, national origin, race or sex. Written complaints of non-compliance should be directed to Secretary, LDH, PO Box 91030, Baton Rouge, LA 70821-9030 or DHHS Secretary, Washington, DC or both.
24. The Deficit Reduction Act of 2005, Section 6032 Implementation: As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a)(68) of the Social Security Act, set forth in that subsection and as the Secretary of the United States DHHS may specify. As an enrolled provider/entity, the provider understands that it is their obligation to inform all of their employees and affiliates of the provisions of the Federal False Claims Act, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. When monitored or audited, the provider will be required to show evidence of compliance with this requirement.
25. The Anti-Trust Assignment: The provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed by the State and/or its offices, agencies, departments or political subdivisions through any programs or payment mechanisms. For purposes of this assignment clause, the “provider” shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

Medicaid Direct Deposit Electronic Funds Transfer (EFT) Authorization Agreement

26. The provider has reviewed the Medicaid Direct Deposit (EFT) Authorization Agreement and the Medicaid Provider Requirements and Conditions as listed below and agrees to the following:
    - The provider understands that payment and satisfaction of any claims will be from Federal and State Funds; and any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.
    - The provider understands that LDH may revoke this authorization at any time.
    - The provider hereby authorizes the Louisiana LDH to apply credit entries into the account and the depository name referenced on the EFT Authorization Agreement form. These credits will pertain only to direct deposit transfer payments that the payee has rendered for Medicaid services.
    - The provider certifies that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature below is authorized by the stated Board of Directors to enter into or to change this agreement.
    - The provider agrees to notify the Provider Enrollment Unit if changing financial institutions or accounts. The provider further understands that the maintenance of account information on the Louisiana Medicaid file is the provider's responsibility and failure to notify the Provider Enrollment Unit as noted may result in Medicaid payments being electronically transmitted to incorrect accounts. The provider understands that such changes may not be able to be accommodated if less than 15 business days' notice is given.

Certification of Claims (Paper & Electronic)

27. The provider agrees that all claims submitted to LDH, or its fiscal agent will be for medically necessary and needed services or supplies and that these services and/or supplies will be rendered by an individual or business who is enrolled as a LDH Medicaid provider;
28. The provider understands that all claims submitted to Louisiana Medicaid will be paid and satisfied from Federal and State funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws;
29. The provider attests that all claims submitted under the conditions of this Agreement are certified to be true, accurate, and complete.

The provider understands and agrees that this enrollment in the Louisiana Medicaid Program is for the limited purpose of providing services for LaHIPP enrolled Medicaid clients. The provider understands that only the Medicaid secondary patient responsibility and/or the services rendered as Medicaid primary, not covered by the primary insurance, will be billed to Medicaid.

*** The provider understands only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.

Printed Name of the Authorized Representative	Signature of the Authorized Representative
Title of the Authorized Representative	Date of Signature MM/DD/YYYY

LOUISIANA DEPARTMENT OF HEALTH (LDH)
LOUISIANA MEDICAID DIRECT DEPOSIT ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

GENERAL INFORMATION

Instructions for Completion:

- Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or managing employee. Any other signature will be grounds for rejecting this form.
- Original signatures only; no stamps or copied signatures will be accepted. (Blue ink preferred – not black ink).
- The provider name on this form must match the provider name associated with the Louisiana Medicaid number, the NPI, or both.
- If the entity/business is doing group billing, then an EFT form is required for the group only, and not the individual providers.
- Call Gainwell Provider Enrollment at (225) 216-6370 if you have questions regarding the completion of this form or the status of your request.

Late or Missing EFT Payments:

- Once you are enrolled for EFT and your electronic payments are missing or late, first contact the Automated Clearinghouse (ACH) representative at your bank, not a bank teller.
- If the bank is unable to locate the deposit, check to ensure that the account has not been closed or changed.
- If still unable to locate a deposit, call Gainwell Provider Enrollment and report the late and/or missing EFT transaction.

Remittance Advice Data

- If you sign up for EFT and also receive your remittance advice data in the v501x12 835 transaction (ERA), you must contact your financial institution if you wish to arrange for delivery of the CORE-required Minimum CCD+ data elements needed for re-association of the payment and the ERA.

Send your completed EFT Form to:

Gainwell Provider Enrollment Unit
P.O. Box 80159
Baton Rouge, LA 70898-0159

LOUISIANA DEPARTMENT OF HEALTH (LDH)
LOUISIANA MEDICAID DIRECT DEPOSIT ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

INSTRUCTIONS

1. Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
2. Doing Business As (DBA) Name	The name by which provider is conducting business.
3. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number (TIN), also known as an Employer Identification Number (EIN), used to identify a business entity (9- digits).
4. National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) identification number Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
5. Louisiana Medicaid Provider Number (7- digits)	The provider's 7- digit Louisiana Medicaid Identification number.
6. Provider Contact Name	Name of a contact in the provider office for handling EFT issues.
7. Provider Contact Telephone Number and Extension	This telephone number and extension *(if applicable)* associated with the Provider Contact Name.
8. Provider Contact Email Address	An electronic mail address at which the health plan might contact the provider.
9. Financial Institution Name	The official name of the provider's financial institution.
10. Financial Institution Routing Number	A 9- digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
11. Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Savings (check the appropriate box).
12. Provider Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited (up to 10- digits).
13. Is the bank account you specified located in the United States?	Check yes or no. If no, please provide the country of location of the account.
14. Account Number Linkage to Provider Identifier	Check one: Provider Tax Identification Number (TIN), or National Provider Identifier (NPI)
15. Reason for submitting this form	Indicate the reason for submission of the form: New Enrollment, Change of Ownership (CHOW), Re-validation of Existing Enrollment, Re-enrollment, or Other

NOTE: If a change of ownership (CHOW) occurs, an entire enrollment packet is required, and direct deposit information cannot be changed for the current provider account.

16. Voided check	Attach a voided check or letter from the bank on bank letterhead for identification and/or verification of financial institution account and routing numbers. **Deposit slips are not accepted.**
17. Signature of Authorized Representative	Signature of authorized representative in a blue ink.
18. Printed Name of Authorized Representative	The printed name of the authorized representative.
19. Printed Title of Authorized Representative	The printed title of the authorized representative.
20. Date of Signature	The date the form is completed; Desired format: MMDDYYYY

LOUISIANA DEPARTMENT OF HEALTH (LDH)
LOUISIANA MEDICAID DIRECT DEPOSIT(EFT) AUTHORIZATION AGREEMENT

1. Provider Name: _____

2. Doing Business As (DBA) Name: _____

3. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) (9- digits) | | | | | | | | | |

4. National Provider Identifier (NPI) (10- digits) | | | | | | | | | | |

5. Louisiana Medicaid Provider Number (7- digits) | | | | | | | |

6. Provider Contact Name: _____

7. Provider Contact Telephone Number: _____ Extension: _____

8. Provider Contact Email Address: _____

9. Financial Institution Name: _____

10. Financial Institution Routing Number (9- digits) | | | | | | | | | |

11. Type of Account at Financial Institution (check one): ☐ CHECKING ☐ SAVINGS

12. Provider Account Number with Financial Institution | | | | | | | | | | |

13. Is the bank account you specified located in the United States? ☐ YES ☐ NO

If no, identify the country of location: _____

14. Account Number Linkage to Provider Identifier (check one)

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

15. Reason for Submitting this form: ☐ New Enrollment ☐ CHOW ☐ Re-validation of Existing Enrollment

☐ Re-Enrollment ☐ Other

16. Attach a voided check or letter from the bank on bank letterhead with this document for identification and/or verification of financial institution account and routing numbers. **Deposit slips are not accepted.**

- The provider understands that payment and satisfaction of this claim will be from Federal and State Funds and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.
- **The provider understands that LDH may revoke this authorization at any time.**
- The provider hereby authorizes the Louisiana Department of Health to present credit entries into the account and depository named above. These credits will pertain **only to direct deposit transfer payments** that the payee receives from Medicaid.
- The provider certifies that if a Board of Directors' approval is necessary to enter into this agreement, that approval has been obtained and the signature below has been authorized by the stated Board of Directors to enter into this agreement.
- The provider agrees to notify the Provider Enrollment Unit if changing financial institutions or accounts and understands that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility. Failure to notify the Provider Enrollment Unit may result in Medicaid payments being electronically transmitted to incorrect accounts. The provider understands that such changes may not be accommodated if less than a 15-business day notice is given.
- Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid on behalf of the provider.

17. Signature of Authorized Representative _____

18. Print Name of Authorized Representative _____

19. Print Title of Authorized Representative _____

20. Date of Signature (MM/DD/YYYY) _____

PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT FOR BUSINESS/ENTITY)

INSTRUCTIONS

Prior to submitting electronic claims to Louisiana Medicaid, a seven-digit Submitter number (450XXXX) must be obtained from the Gainwell Provider Enrollment Unit. The Submitter number must be linked to all provider numbers for whom claims will be submitted.

The following form(s) is (are) to be completed if the Entity/Business enrolling at this time plans to submit claims electronically to Louisiana Medicaid.

Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract for Business/Entity)

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Gainwell. (Leave blank if applying for new Provider Number.)

National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.

DBA Name of Enrolling Business/Entity – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.

Billing Agent/Submitter Name/Business Name – enter the business name of the billing / submitting agent.

Name of Contact Person – enter the name of the person designated as the point of contact for questions regarding this request.

Contact Phone Number and Extension – enter the phone number and extension *(if applicable)* of Contact Person.

Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)

Printed Name of Authorized Representative – print the name of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Title/Position – enter the title/position of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Signature of Authorized Representative – enter the signature of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Date of Signature – enter the date the authorized representative signed the form.

Entity/Business Medicaid Electronic Media Limited Power of Attorney (EDI Power of Attorney)

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Gainwell. (Leave blank if applying for a new Provider Number.)

National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.

DBA Name of Enrolling Business/Entity – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.

Service Address of Business/Entity – enter the service address of the provider name entered.

Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)

Billing Agent/Submitter Business Name – enter the business name of the Billing Agent/Submitter.

Billing Agent/Submitter Contact Person – enter the name of the person designated as the point of contact for the Billing Agent/Submitter business.

Billing Agent/Submitter Phone Number and Extension – enter the phone number of the Billing Agent/Submitter contact person.

Enter the Parish (or County) Name where the Notary Public is located

Enter City, State and Date of Notarization

Signature of Authorized Representative – enter the signature of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Printed Name of Authorized Representative – print the name of the person authorized to enter into a binding agreement with Louisiana Medicaid.

Notary Public Signature – the Notary Public should sign the form and affix his/her seal.

If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized. Please complete the enclosed Limited Power of Attorney in its entirety to be mailed with your completed EDI Contract.

PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT FOR BUSINESS/ENTITY)

Louisiana Medicaid Provider Number (7- digits)

4	5	0				

Submitter Number (7- digits)

(leave blank if applying for new number)

National Provider Identifier (NPI) (10- digits)

DBA Name of Enrolling Business/Entity: _____

Billing Agent/Submitter Name/Name of Business that will be submitting claims (provider name or third-party biller's name): _____

Name of Contact Person: _____

Contact Phone Number: _____ Extension: _____

The Medicaid File can hold a maximum of three Submitter Numbers per Medicaid Provider Number at any one time. Current policy is to close old Submitter Numbers as new ones are opened unless otherwise requested by the provider. It is also vital to identify which Submitter Number will be designated to download the Electronic Remittance Advices (ERA).

In order for Louisiana Medicaid to gather this information, complete the following, if applicable:

When a new Submitter Number is issued, it will be set up to retrieve ERAs. If a previously assigned Submitter Number is to be used to retrieve ERAs as well, then place it in the spaces provided below.

4	5	0				

☐ By checking this box, you are giving authorization to have 835s produced and made available for download by either this new submitter number or the previously assigned submitter number.

List other Submitter Number(s) that are currently on file which will NOT be used for 835 ERA, but which need to remain open in the spaces below:

4	5	0				
4	5	0				

☐ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to submit my own claims electronically to Louisiana Medicaid.

☐ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to use a Third Party (Clearinghouse, Billing Agent, Submitter, etc.) to submit my claims electronically to Louisiana Medicaid. **(Power of Attorney form is required.)**

Provider Name _____

PROVIDER ACKNOWLEDGEMENT

1. The providers attest that all information supplied with this Agreement is true, accurate and complete.
2. On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 4 through 17 below. This is done in consideration for the Louisiana Department of Health (LDH), Bureau of Health Services Financing's (BHSF) processing of provider claims, as well as other valuable considerations.
3. All published specifications set forth shall be met as to every entry sought to be processed. The effective date for EDI submission will be set by Provider Enrollment once the contract has processed.
4. The Provider, or his agent, shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers. The Provider's data processing agent for submission of medical assistance claims is stated above and any changes in the Provider's data processing agent shall be preceded by 30 days' written notice to LDH.
5. The Provider shall provide upon request of LDH or any authorized agent of LDH any supportive documentation to ensure that all technical requirements are being met, i.e. program listings, data submissions, flow charts, file descriptions, accounting procedures, etc.
6. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to submit electronic claims and the Annual Certification form. A copy of the certification statement is attached and is hereby incorporated by reference into this paragraph.
7. It is expressly understood that LDH or its Fiscal Intermediary (Gainwell) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
8. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to their provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
9. LDH and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
10. The Provider agrees to submit to LDH, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
11. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
12. The Provider and LDH agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.
13. Further, for a period of five years, during the course of a Federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested and produce such for examination and copying at no cost.
14. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify LDH's limited obligations as set in a certain Provider Agreement between LDH and the Provider.
15. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
16. I understand that all claims submitted under the conditions of this Agreement will be paid and satisfied from Federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.
17. **Applicable to those receiving 835s:** I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information; payment information; and bank account information, provided by me and currently on file if enrolled in **E**lectronic **F**unds **T**ransfer, to the submitter identified above. This authorization will remain in effect until discontinued by written request or changed by a future request.

Printed Name of Authorized Representative	Title/Position
Signature of Authorized Representative	Date of Signature

ENTITY / BUSINESS
MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY
(EDI POWER OF ATTORNEY)

This form is required by all providers who will have electronic claims submitted by a third party.

Louisiana Medicaid Provider Number (7- digits)

4	**5**	**0**				

Submitter Number (7- digits)
(leave blank if applying for new number)

National Provider Identifier (NPI) (10- digits)

DBA Name of Enrolling Business/Entity (Provider Name): _____

Service Address of Business/Entity: _____

Billing Agent /Submitter Business Name: _____

Billing Agent /Submitter Contact Person: _____

Billing Agent /Submitter Phone Number: _____ Extension: _____

BE IT KNOWN that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the

Parish of_____, State of Louisiana, therein residing:

PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing / Submitter Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program's applicable claims, by provider type, for electronic submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____, State of _____on the _____ day of _____, 20___.

_____
Signature of Authorized Representative

_____
Notary Public Signature

_____
Printed Name of Authorized Representative

Notary Seal or Notary Identification Number *(required)*

Instructions for Louisiana Medicaid Ownership Disclosure Information Entity/Business

This is a multi-page form. Please review the instructions in their entirety before completing the form. *Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.*

Refer to the web sites listed on the previous pages for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Enter your Provider Name at the top of each page in the space provided.

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number, if known. If this application is for a new Medicaid provider number, leave this field blank.

Taxpayer ID Number – Enter the nine (9) digit Tax ID number for this provider.

National Provider Identifier (NPI) – Enter your ten (10) digit National Provider Identifier (NPI). This number can be obtained by going to: https://nppes.cms.hhs.gov

This enrollment packet is for a – Check the appropriate box from among New Enrollment, Update to Current Enrollment, Re-Validation, Re-Enrollment or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.

Provider Type – Enter the Louisiana Medicaid Provider Type for this Entity/Business.

Primary Telephone Number(s) of Disclosing Entity/Business - Enter the area code and telephone number(s) at the street address of this Entity/Business.

Doing Business As (DBA) Name – Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the Entity/Business license.

Legal Name of Disclosing Entity/Business – Enter the legal name of the Entity/Business in the space labeled "Legal Name of Entity/Business."

Primary Disclosing Entity/Business Street Address, City, State, Zip - Enter the physical business street address of the Entity/Business requesting enrollment. Enter the city, state and zip code of the physical business street address.

Primary Disclosing Entity/Business Mailing Address/PO Box, City, State, Zip – Enter the mailing address or PO Box of the Entity/Business requesting enrollment. Enter the city, state and zip code of the mailing address.

Additional Post Office Boxes Not Identified Above – Enter any additional Post Office Boxes for the Entity/Business that are stand-alone or not associated with any business location.

Disclosing Entity/Business Telephone Number to Request Medical Records – Enter the area code and telephone number(s) that the Entity/Business uses to answer requests for medical records.

Disclosing Entity/Business Primary Fax Number – Enter the area code and fax number(s) of this Entity/Business.

Email Address of Entity/Business contact person - Enter the email address of the contact person who should receive official LDH notices.

Entity/Business Website – Enter the web address of the Entity/Business website if applicable.

A. Is there a Corporate Office location for the disclosing Entity/Business? Check the appropriate box.
DBA Name of Corporate Office – If the Entity/Business does have a corporate office location, enter the DBA Name of that office.
Corporate Office contact information – Enter the street address, mailing address/PO Box, additional PO boxes, phone number, fax number and email address for the corporate office.

B. Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e. satellite, branch or regional locations) related to Louisiana healthcare services? Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below. Lists are not acceptable.
DBA Name of Additional Location – Enter the DBA name of the additional practice location.
Medicaid Provider Number - Enter the Medicaid Provider number of the additional practice, if applicable.
Additional Location contact information – Enter the mailing address/PO Box, street address, additional PO boxes, phone number, fax number and email address for the additional location office. Continue identifying additional locations and the contact information in the spaces provided. If needed, please attach additional sheets if there are more than three additional locations.

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service – Select only 1 of the categories. Multiple selections may result in a rejection for clarification.
Privately owned or Non-profit Providers Only – Identify the type of Entity/Business as it is registered with the Internal Revenue Service (IRS). Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of Entity/Business in the space(s) provided. Optional: May add comments in the space provided. Continue to Section II.
OR

Louisiana Government Providers Only – Identify the type of Entity/Business if Louisiana government owned. Select only one from among City and/or Parish, Department of Children and Family Services (DCFS), Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Villa, Other LDH agency, Local Education Agency (LEA), Louisiana State University (LSU), or Other State-owned entity. Check the appropriate box and complete the applicable fields.

D. Is this disclosing Entity/Business publicly traded? A publicly traded company is one which is traded on the open market, also called publicly held or public company. Check the appropriate box.

E. Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application? Check the appropriate box. If yes, list all names and Tax IDs in the spaces provided. Attach additional pages if needed.

SECTION II – ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

A. Has this Entity/Business (since its existence) AND any entity/business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs) as follows: Check the appropriate yes or no box for each statement. Every item needs to have either or no check. Do not leave any blanks. If yes for any question, 1) provide a written statement including the details on all occurrences and 2) attach all official legal documents, including any reinstatements.

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program? Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name (including maiden name and hyphenated last name if applicable), social security number, date of birth, and job title. Check one box to identify whether the person completing the form is staff, owner, third party/independent agent, or other. If you check other, please specify by writing the relationship in the space provided. List the Entity/Business address, Entity/Business telephone number, and the Entity/Business email address of the person completing this form. Finally, enter any additional Entity/Business telephone number(s) and Entity/Business email address(es).

SECTION V – OWNERSHIP INFORMATION

Medicaid requires that an Entity/Business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this Entity/Business. A separate form, Section V(b), is required for each owner, therefore, please make the necessary copies as a list of owners will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or *Jenny Rae Jones-Smith*, not *J.R. Jones-Smith* or *Jenny Jones-Smith.*

Owners are individuals and/or organizations having direct, indirect, or controlling ownership interest in the disclosing Entity/Business.

- Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing Entity/Business.
- Indirect ownership is defined as an ownership interest in an Entity/Business that has direct or indirect ownership in this disclosing Entity/Business.
- Controlling interest is defined as having operational direction or management or the ability and authorization:
    - To amend or change the corporate identity.
    - To nominate or name members of the board, directors, or trustees
    - To amend or change the bylaws, constitution, or other operating or management direction
    - To control the sale of any or all of the assets or property upon dissolution of the Entity/Business.
    - To dissolve or transfer this disclosing Entity/Business to new ownership or control.
    - Et cetera.

Owners may also be individuals associated with the Entity/Business:

- Whose personal assets are used to satisfy the Entity/Business creditors.

- Who join together to carry on an Entity/Business and expect to share in the profits and losses of the Entity/Business.
- Who report their share of profits and losses of the Entity/Business on their own personal tax returns.
- Who own corporate stock.
- Who are policy makers.
- Who have veto powers.
- Who have voting power.
- Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION V(a) – INFORMATION ON ALL OWNERS

NEW FORMAT! Please read these directions in detail.

A. Individuals & Entities/Businesses with Direct Ownership –List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/ or controlling interest of 5% or greater in the disclosing Entity/Business. Add additional pages if needed.

NOTE: Section V(b) must be completed for each individual listed. Item B and Section V(c) must be completed for each entity/business listed.

B. Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business –
First column: List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business in the first column. The disclosing Entity/Business cannot list itself as an owner.
Second column: Name all owners of the entity/business listed in the first column.
Third column: Indicate the percent of ownership each owner has in the entity/business in the first column.
Fourth column: Indicate the percent ownership each owner has in the disclosing Entity/Business. This percent of indirect ownership in the disclosing Entity/Business is determined by multiplying the percentages of ownership in each entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported. Add additional pages if needed.

NOTE: Section V(c) must be completed for each Entity/Business listed and Section V(b) must be completed for each individual listed.

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

An entire Section V(b) (consisting of two pages) must be completed for **each, and every individual owner named in Section V(a)**, whether the individual owns a direct or indirect stake in the disclosing Entity/Business. A list of all owners will not be accepted. **Make a copy of the blank form for each owner you report before you fill it out the first time. For example, if you have five owners, you need to submit five completed Section V(b) forms.**

A. Individual Owner Information – Enter the First Name, Middle Name, Maiden Name, Last Name and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Title/Job Position within this Entity/Business, the percentage of ownership of the Entity/Business, the Social Security Number (required), date of birth, current mailing address and physical address, telephone number and email address of the owner in the spaces provided.

B. Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias? – Read the question carefully and check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. Is this owner a U.S. citizen? Check the appropriate box. If no, provide the Alien Verification number.

D. Does this owner reside outside the State of Louisiana? – Check the appropriate box. If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the appropriate box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided. Attach additional pages if needed.

E. **Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?** Check the appropriate box. If yes, list all individuals and how they are related (e.g. spouse, parent, child, sibling) in the spaces provided. Attach additional pages if needed.

F. **Does the individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?**
Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

G. **Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business participating in a Federal/State funded healthcare program?** Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

H. **Has the individual owner named above (ever) –** Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. **Entity/Business Owner Information** – Enter the Entity/Business Name, the DBA Name, the Tax ID Number, the current street address of the primary location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided.

B. **Are there any business locations in addition to the location listed above?** Check the appropriate box. If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location. Enter the DBA Name of the additional location, the Tax ID Number, the current street address of the additional location, the mailing address, any additional Post Office Boxes not previously identified, telephone number, fax number, email address of the contact person and website of the Entity/Business in the spaces provided. Attach additional pages if needed.

C. **Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?** Check the appropriate box. If yes, list all names and Tax IDs below. Attach additional pages if needed.

D. **Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more?** Check the appropriate box. If yes, provide the Subcontractor Business Name, Owner, Address and Phone Number for each subcontractor.

E. **Is this Entity/Business and Tax ID listed in the Section I currently enrolled in a Federal/State funded healthcare program?** If yes, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments.

F. **Has this Entity/Business (since its existence) AND any Entity/Business affiliated with the same Tax ID number AND any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with, since the inception of those programs, as follows:** Check the appropriate yes or no box for each statement. Every item needs to have either a yes or no check. Do not leave any blanks. If yes for any question, provide a written statement including the details on all occurrences. Attach all official legal documents, including any reinstatements.

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B/section-455.106

A separate VI(b) form is required for each agent or managing employee, therefore, please make the necessary copies as a list of all managing employees and/or agent names will not be accepted. Incomplete applications will be rejected.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or *Jenny Rae Jones-Smith,* not *J.R. Jones-Smith* or *Jenny Jones-Smith*.

Managing employee is defined as a general manger, business manager, administrator, director, or other individual who exercises operational or manager control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.

Agent is defined as any person who has been delegated the authority to obligate or act on behalf of a provider.

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors
- Board of trustees
- Chairman or chairperson
- Chief Business Officer (CBO)
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Chief Operating Officer (COO)
- Director
- Managing employee/agent
- Officer
- Trustee

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise

These lists are not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

In the first table, enter the names of each agent, member or officer who is a part of management for the disclosing Entity/Business. In the second table, enter the names of each managing employee for the disclosing Entity/Business. Select the appropriate box to indicate if the individual is also an owner. If so, list their percentage of ownership. Add additional pages if needed.

NOTE: Section VI(b) must be completed for each individual listed unless individual has already been reported in Section V.

SECTION VI(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Make a photocopy of Section VI(b) for each managing employee/agent you report.

A. AGENT – or – MANAGING EMPLOYEE – Check a box to specify whether the person is a Managing employee or an Agent. Enter the managing employee/agent's First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable), Title/ Job Position, Social Security Number, Date of Birth, current mailing address, current physical address, telephone number and email address in the spaces provided.

B. Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? – Check the appropriate box. If yes, enter the name(s) in the spaces provided. Attach additional pages if needed.

C. Is this agent or managing employee a U.S. citizen? Check the appropriate box. If no, provide Alien Verification number.

D. Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business? Check the appropriate box. If yes, list all individuals and how they are related in the spaces provided. Attach additional pages if needed.

E. Has the agent or managing employee named above (ever) – Read the questions carefully and check the appropriate yes or no boxes. Every item needs to have either a yes or no check. Do not leave any blanks. If yes to any question, 1) provide a written statement providing the details on all occurrences and 2) attach all official legal documents regarding the occurrence, including any reinstatements.

F. Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program? Check the appropriate box. If yes, identify the applicable plan(s) [Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program]. In each instance, provide the Doing Business As (DBA) Name, the Tax ID number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

SECTION VII – AUTHORIZED REPRESENTATIVES

List the individuals who are authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms. Every person listed here must be either an owner or a managing employee as disclosed in the Disclosure of Ownership forms. Check one box for each person to indicate whether the individual is an owner, a managing employee, or other (specify the title in the space provided).

Printed Name of Authorized Representative – print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.

Title/Position of Authorized Representative – indicate the Authorized Representative's relationship to the entity or business (e.g., owner, administrator, agent, managing employee, billing manager, etc.).

Signature of Authorized Representative – the authorized representative must sign the form. Signatures must be original and in blue ink (stamped signatures and initials are not accepted). Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.

Date of Signature – enter the date this agreement was signed.

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date. Please sign in colored ink (not black).

Reference Material for
Louisiana Medicaid Ownership Disclosure Information
for an Entity/Business

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana **Medicaid Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455#sp42.4.455.b

MAPIL Louisiana R.S., Title 46:437.1-14. https://www.legis.la.gov/legis/Law.aspx?d=100852

Louisiana Register, Vol. 29, No. 4, April 20, 2003: https://www.doa.la.gov/media/m23b1mhf/0304.pdf

Louisiana Update January/February 2009: https://www.lamedicaid.com/ProviderUpdate/provider_update0109.pdf

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (Louisiana Register, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at www.lamedicaid.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: https://www.law.cornell.edu/uscode/text/42/1320a-3

Social Security Act 1128 a: https://www.ssa.gov/OP_Home/ssact/title11/1128A.htm

Provider Name: _____

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – ENTITY/BUSINESS

Must be completed in its entirety. Refer to instructions found at www.lamedicaid.com

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number (Leave blank if applying for a new number)								

Taxpayer ID Number										

National Provider Identifier (NPI)										

This enrollment packet is for a: ☐ New Enrollment ☐ Update to Current Enrollment ☐ Re-Validation ☐ Re-Enrollment	☐ Change of Ownership (CHOW) _____ Date of Chow (MM/DD/YYYY) _____ Current Medicaid Provider Number
Provider Type:	Primary Telephone Number of Disclosing Entity/Business ( ) - Extension:

Doing Business As (DBA) Name	Legal Name of Disclosing Entity/Business

Primary Disclosing Entity/Business Street Address	City	State	Zip Code, +4 *(if known)*
Primary Disclosing Entity/Business Address /PO Box	City	State	Zip Code, +4 *(if known)*
Additional PO Boxes Not Identified Above	City	State	Zip Code, +4 *(if known)*

Disclosing Entity/Business Telephone Number to request Medical Records ( ) - Extension:	Disclosing Entity/Business Primary Fax Number Extension ( ) -
Email Address of Entity/Business Contact Person	Entity/Business Website *(if applicable)*

A. Is there a Corporate Office location separate from the primary location of the disclosing Entity/Business ☐ **Yes** ☐ **No**

If yes, complete the section below for each location.

DBA Name of Corporate Office			
Corporate Office Street Address	City	State	Zip Code, +4 *if known)*
Corporate Office Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Additional PO Boxes Not Identified Above	City	State	Zip Code, +4 *(if known)*

Corporate Office Phone Number ( ) -	Extension	Corporate Office Fax Number ( ) -	Extension
Corporate Office Email Address			

Provider Name: ______________________________________

Make a photocopy of this page if more space is needed to list additional locations

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION (continued)

B. Does the disclosing Entity/Business have any business locations in addition to the primary location listed above (i.e., satellite, branch or regional locations) related to Louisiana healthcare services? Lists are not acceptable. ☐ **Yes** ☐ **No**

If yes, provide the number of locations in the field to the right and complete the section(s) below for each additional location. ________

DBA Name of Additional Location		Medicaid Provider Number *(if applicable)*	
Additional Location Street Address	City	State	Zip Code, +4 *(if known)*
Additional Location Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Additional PO Boxes Not Identified Above	City	State	Zip Code, +4 *(if known)*
Additional Location Phone Number ( ) -	Extension	Additional Location Fax Number ( ) -	Extension
Additional Location Email Address			

DBA Name of Additional Location		Medicaid Provider Number *(if applicable)*	
Additional Location Street Address	City	State	Zip Code, +4 *(if known)*
Additional Location Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Additional PO Boxes Not Identified Above	City	State	Zip Code, +4 *(if known)*
Additional Location Phone Number ( ) -	Extension	Additional Location Fax Number ( ) -	Extension
Additional Location Email Address			

DBA Name of Additional Location		Medicaid Provider Number *(if applicable)*	
Additional Location Street Address	City	State	Zip Code, +4 *(if known)*
Additional Location Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Additional PO Boxes Not Identified Above	City	State	Zip Code, +4 *(if known)*
Additional Location Phone Number ( ) -	Extension	Additional Location Fax Number ( ) -	Extension
Additional Location Email Address			

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item E below

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service
Select only one (1) – multiple selections may result in a rejection for clarification.

Privately Owned or Non-Profit Providers Only

☐ **Sole Proprietorship**

☐ **Partnership/Limited Liability Partnership:** How many members are identified with this partnership? _____

☐ **Corporation:** Revenue greater than or equal to $5M annually _____ Revenue less than $5M annually _____

In the (current) Articles of Incorporation:

How many stakeholders/individual owners are identified? _____

How many Board of Director members are identified? _____

How many officers are identified? _____

☐ **Limited Liability Corporation (LLC)**
In the (current) Articles of Organization

How many members are identified? _____

How many managing employees are identified? _____

☐ **Non-profit:** How many members are appointed to the governing board? _____
(Must attach IRS verification showing the non-profit status)

Comments: _____

Louisiana Government Providers Only

☐ **CITY and/or PARISH**	☐ **DCFS**
☐ **LEA (Local Education Agency)**	☐ **LSU** **Hospital:** _____
☐ **LDH** ☐ OBH ☐ Villa ☐ OCDD ☐ OAAS ☐ OPH ☐ Other: _____	☐ **Other State-Owned Entity:** _____

D. Is this disclosing Entity/Business publicly traded? ☐ **Yes** ☐ **No**
See instructions.

E. Has this disclosing Entity/Business used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name documented in this application? ☐ **Yes** ☐ **No**

If yes, list all names and Tax ID below. Attach additional pages, if needed.

Name	Tax ID
Name	Tax ID
Name	Tax ID
Name	Tax ID

Provider Name: _____

SECTION II – DISCLOSING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Check the appropriate Yes or No box regarding the questions below. Every item needs to have either a Yes or No marked. Do not leave any blanks.		
A. Has this Entity/Business (since its existence) – AND – **Any Entity/Business affiliated with the same Tax ID number – AND –** **Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since of those programs) as follows:**		
Been convicted of a criminal offense in any program under Medicare, Medicaid, and Titled Services in the Louisiana Medical Assistance Program?	☐ **Yes**	☐ **No**
Has any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?	☐ **Yes**	☐ **No**
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 U.S. Territory?	☐ **Yes**	☐ **No**
Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?	☐ **Yes**	☐ **No**
Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency at any time?	☐ **Yes**	☐ **No**
Currently have any open or pending healthcare court cases?	☐ **Yes**	☐ **No**
Been denied malpractice insurance?	☐ **Yes**	☐ **No**
Has or had a felony conviction(s) of any type?	☐ **Yes**	☐ **No**

IF "YES" WAS ANSWERED TO ANY QUESTIONS LISTED ABOVE:

1. ***PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.***
2. ***ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.***

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item A below

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. Is the disclosing Entity/Business and the disclosing Entity/Business Tax ID listed in Section I currently enrolled in a Federal/State Funded healthcare program? ☐ **Yes** ☐ **No**

If yes, provide the details in the fields below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID #

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name

Social Security Number	Date of Birth MM/DD/YYYY	Job Title
- -		

The person completing this form is (please check one):

☐ Staff ☐ Owner ☐ Third Party/Independent Agent ☐ Other (explain) _____

Entity/Business Address	Entity/Business City	Business State	Business Zip Code, +4 *(if known)*

Entity/Business Telephone Number	Extension
( ) -	

Additional Entity/Business Telephone Number	Extension
( ) -	

Entity/Business Email Address	Additional Entity/Business Email Address

Provider Name: _____

NEW FORMAT! PLEASE REFER TO THE INSTRUCTIONS FOR DETAILED EXPLANATIONS!

Make a photocopy of this page if more space is needed to list owners in items A and B

SECTION V(a) – INFORMATION ON ALL OWNERS

A. Individuals and Entities/Businesses with Direct Ownership

List all individual owners or entities/businesses that have any direct stake/shareholder/ownership/or controlling interest of 5% or greater in the disclosing Entity/Business

*Fill out section V(b) for each **Individual**. Fill out both item B and Section V(c) for each **Entity/Business** listed below.*

Individuals or Entities/Businesses with Ownership	% of Ownership
1)	
2)	
3)	
4)	
5)	
6)	
7)	

B. Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business

List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business. Identify the owners of that Entity/Business and their % of ownership below. *The disclosing Entity/Business cannot be listed as an owner.

*Fill out section V(b) for each **Individual** and Section V(c) for each **Entity/Business** listed below*

Entity/Business/Organization with a direct ownership Interest listed in item A	Owners of the Entity/Business identified on the left	% of ownership in Entity/Business identified on the left	% of ownership in the disclosing Entity/Business
1.	a.		
	b.		
	c.		
	d.		
2.	a.		
	b.		
	c.		
	d.		
3.	a.		
	b.		
	c.		
	d.		
4.	a.		
	b.		
	c.		
	d.		
5.	a.		
	b.		
	c.		
	d.		

*The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if Individual A owns 10% of the stock in a corporation which owns 80% of the stock in the disclosing entity. Individual A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if Individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, Individuals B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

Provider Name: _____

Make a photocopy and complete Section V(b) for each individual owner named in Section V(a)

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*

Title/Job Position within the disclosing Entity/Business	% ownership	Date of Birth MM/DD/YYYY	Social Security Number
			- -

Healthcare NPI *(if applicable)*

Street Address	City	State	Zip Code, +4 *(if known)*

Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*

Telephone Number	Extension	Email address
( ) -		

B. Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

☐ **Yes** ☐ **No**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*

C. Is the owner a U.S. citizen?

☐ **Yes** ☐ **No**

If no, provide Alien Verification _____

D. Does this owner reside outside the State of Louisiana?

☐ **Yes** ☐ **No**

If yes, has the owner been issued any Medicaid or Medicare provider numbers by the domicile state? ☐ **Yes** ☐ **No**

If yes, please provide the Domicile State Name and Provider Numbers.

Domicile State	Medicaid Provider Number	Medicare Provider Number
Domicile State	Medicaid Provider Number	Medicare Provider Number
Domicile State	Medicaid Provider Number	Medicare Provider Number
Domicile State	Medicaid Provider Number	Medicare Provider Number

Provider Name: ____________________________________

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: ____

E. Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business? ☐ **Yes** ☐ **No**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*
☐ Owner ☐ Agent ☐ Managing Employee ☐ Subcontractor			Relationship:		Job Title

Provider Name: ____________________________________

Make a photocopy of this page if more space is needed to respond to item F and G below

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: ____

F. Does this individual owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more? ☐ **Yes** ☐ **No**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name		Subcontractor Business Owner Name	
Subcontractor Address	City	State	Zip Code, +4 *(if known)*
Telephone Number ( ) -	Extension	Email address	

Subcontractor Business Name		Subcontractor Business Owner Name	
Subcontractor Address	City	State	Zip Code, +4 *(if known)*
Telephone Number ( ) -	Extension	Email address	

Subcontractor Business Name		Subcontractor Business Owner Name	
Subcontractor Address	City	State	Zip Code, +4 *(if known)*
Telephone Number ( ) -	Extension	Email address	

Subcontractor Business Name		Subcontractor Business Owner Name	
Subcontractor Address	City	State	Zip Code, +4 *(if known)*
Telephone Number ( ) -	Extension	Email address	

G. Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in Federal/State Funded healthcare program? ☐ **Yes** ☐ **No**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID #

Provider Name: _____

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER (continued)

Name of Individual Owner: _____

Check the appropriate Yes or No box regarding the questions below. Every item needs to have either a Yes or No check. Do not leave any blanks.		
H. Has the individual owner named above (ever):		
Been convicted of a criminal offense in any program under Medicare, Medicaid, and Titled Services in the Louisiana Medical Assistance Program?	☐ **Yes**	☐ **No**
Has any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?	☐ **Yes**	☐ **No**
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 U.S. Territory?	☐ **Yes**	☐ **No**
Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?	☐ **Yes**	☐ **No**
Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency?	☐ **Yes**	☐ **No**
Currently have any open or pending healthcare court cases?	☐ **Yes**	☐ **No**
Been denied malpractice insurance?	☐ **Yes**	☐ **No**
Has or had a felony conviction(s) of any type?	☐ **Yes**	☐ **No**

IF "YES" WAS ANSWERED TO ANY QUESTIONS LISTED ABOVE:

1. ***SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.***
2. ***ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.***

Provider Name: _____

Make photocopies of the next 2 pages to complete Section V(c) for each Entity/Business owner named in Section V(a) AND/OR make a photocopy of this page if more space is needed to respond to item E

SECTION V(c) – INFORMATION ON ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS

A. ENTITY/BUSINESS OWNER INFORMATION

DBA Name	Legal Name of Entity/Business	Tax ID Number *(required)*

Entity/Business Street Address - Primary Location	City	State	Zip Code, +4 *(if known)*
Entity/Business Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Additional PO Boxes Not Identified Above	City	State	Zip Code, +4 *(if known)*

Telephone Number	Extension	Fax Number	Extension
( ) -		( ) -	

Email Address of Entity/Business Contact Person	Entity/Business Website *(if applicable)*

B. Are there any business locations in addition to the location listed below? ☐ **Yes** ☐ **No**

If yes, provide the number of locations in the field to the right and complete the section(s) below for each additional location. _____

DBA Name of Additional Location	Tax ID Number *(required)*

Additional Location Street Address	City	State	Zip Code, +4 *(if known)*
Additional Location Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Additional PO Boxes Not Identified Above	City	State	Zip Code, +4 *(if known)*

Additional Location Phone Number	Extension	Additional Fax Number	Extension
( ) -		( ) -	

Additional Location Email Address

DBA Name of Additional Location	Tax ID Number *(required)*

Additional Location Street Address	City	State	Zip Code, +4 *(if known)*
Additional Location Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Additional PO Boxes Not Identified Above	City	State	Zip Code, +4 *(if known)*

Additional Location Phone Number	Extension	Additional Location Fax Number	Extension
( ) -		( ) -	

Additional Location Email Address

Provider Name: ______________________________

SECTION V(c) – INFORMATION ON ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: ______________________________

C. Has the disclosing Entity/Business owner used or previously been known by any name other than the Legal name or the Doing Business As (DBA) name? ☐ **Yes** ☐ **No**

If yes, list all names and Tax IDs below. Attach additional pages, if needed.

Name	Tax ID
Name	Tax ID
Name	Tax ID
Name	Tax ID

D. Does the Entity/Business owner have a business transaction with any subcontractor(s) for services amounting to $25,000 or more? ☐ **Yes** ☐ **No**

If yes, complete the section below for each subcontractor.

Subcontractor Business Name		Subcontractor Business Owner Name	
Subcontractor Address	City	State	Zip Code, +4 *(if known)*
Telephone Number ( ) -	Extension	Email address	

Subcontractor Business Name		Subcontractor Business Owner Name	
Subcontractor Address	City	State	Zip Code, +4 *(if known)*
Telephone Number ( ) -	Extension	Email address	

Subcontractor Business Name		Subcontractor Business Owner Name	
Subcontractor Address	City	State	Zip Code, +4 *(if known)*
Telephone Number ( ) -	Extension	Email address	

Subcontractor Business Name		Subcontractor Business Owner Name	
Subcontractor Address	City	State	Zip Code, +4 *(if known)*
Telephone Number ( ) -	Extension	Email address	

Provider Name: _____

SECTION V(c) – INFORMATION ON ENTITY/BUSINESS OWNER OF DISCLOSING ENTITY/BUSINESS (continued)

Name of Entity/Business Owner: _____

E. Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program? ☐ **Yes** ☐ **No**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Enrollments	
			State	ID #

Check the appropriate Yes or No box regarding the questions below.
Every item needs to have either a Yes or No marked.
Do not leave any blanks.

F. Has this Entity/Business (since its existence) – AND –

Any Entity/Business affiliated with the same Tax ID number – AND –

Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since of those programs) as follows:

Been convicted of a criminal offense in any program under Medicare, Medicaid, and Titled Services in the Louisiana Medical Assistance Program?	☐ **Yes**	☐ **No**
Has any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?	☐ **Yes**	☐ **No**
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 U.S. Territory?	☐ **Yes**	☐ **No**
Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?	☐ **Yes**	☐ **No**
Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency?	☐ **Yes**	☐ **No**
Currently have any open or pending healthcare court cases?	☐ **Yes**	☐ **No**
Been denied malpractice insurance?	☐ **Yes**	☐ **No**
Has or had a felony conviction(s) of any type?	☐ **Yes**	☐ **No**

IF "YES" WAS ANSWERED TO ANY QUESTIONS LISTED ABOVE:

1. ***SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.***
2. ***ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.***

Provider Name: _____

Make a photocopy of this page if more space is needed to list individuals.

SECTION VI(a) – INFORMATION ON ALL MANAGING EMPLOYEES/AGENTS

List all AGENTS and INDIVIDUALS who are part of management.

Agent(s)/Member(s)/Officer(s)	Is this agent also an owner?	% ownership
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
Fill out Section VI(b) for each individual listed above unless the individual has already been reported in Section V.		

Managing Employee(s)	Is this managing employee also an owner?	% ownership
1.	☐ Yes ☐ No	
2.	☐ Yes ☐ No	
3.	☐ Yes ☐ No	
4.	☐ Yes ☐ No	
5.	☐ Yes ☐ No	
6.	☐ Yes ☐ No	
7.	☐ Yes ☐ No	
8.	☐ Yes ☐ No	
9.	☐ Yes ☐ No	
10.	☐ Yes ☐ No	
11.	☐ Yes ☐ No	
12.	☐ Yes ☐ No	
13.	☐ Yes ☐ No	
14.	☐ Yes ☐ No	
15.	☐ Yes ☐ No	
Fill out section VI(b) for each Individual listed above unless the individual has already been reported in Section V.		

Provider Name: _____

Make photocopies of the next 2 pages to complete Section VI(b) for each Entity/Business owner named in Section VI(a) AND/OR make a photocopy of this page if more space is needed to respond to items B and/or D

SECTION VI(b) – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

A. ☐ **AGENT** **– or –** ☐ **MANAGING EMPLOYEE**

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*

Title/Job Position within this entity/business	% ownership	Social Security Number (required)	Date of Birth (required) MM/DD/YYYY
		- -	

Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*

Physical Address	City	State	Zip Code, +4 *(if known)*

Telephone Number	Extension	Email Address
( ) -		

B. Has the agent or managing employee named above ever used or been known by any other name including married, maiden, hyphenated, or alias? ☐ **Yes** ☐ **No**

If yes, enter name(s) below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*

C. Is this agent or managing employee a U.S. Citizen? ☐ **Yes** ☐ **No**

If no, provide Alien Verification # _____

D. Is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this Entity/Business? ☐ **Yes** ☐ **No**

If yes, list all individuals and how they are related below. Attach additional pages if needed.

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*

Relationship:	Job Title:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*

Relationship:	Job Title

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*

Relationship:	Job Title:

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to item F below

Name of Agent or Managing Employee: _____

Check the appropriate Yes or No box regarding the questions below. Every item needs to have either a Yes or No check. Do not leave any blanks.		
E. Has the agent or managing employee named above (ever):		
Been convicted of a criminal offense in any program under Medicare, Medicaid, and Titled Services in the Louisiana Medical Assistance Program?	☐ **Yes**	☐ **No**
Has any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, nolo contendere, probation, board consent order, suspension, revocation, voluntary surrender of a license or certification?	☐ **Yes**	☐ **No**
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 U.S. Territory?	☐ **Yes**	☐ **No**
Has a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?	☐ **Yes**	☐ **No**
Been the subject of an investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency?	☐ **Yes**	☐ **No**
Currently have any open or pending healthcare court cases?	☐ **Yes**	☐ **No**
Denied malpractice insurance?	☐ **Yes**	☐ **No**
Has or had a felony conviction(s) of any type?	☐ **Yes**	☐ **No**

IF "YES" WAS ANSWERED TO ANY QUESTIONS LISTED ABOVE:

1. ***SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.***
2. ***ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.***

F. Does this agent or managing employee have ownership or controlling interested in any other Entity/Business participating in a Federal/State Funded healthcare program? ☐ **Yes** ☐ **No**

If yes, complete the section below.

Plan	**Doing Business As (DBA) Name**	**Tax ID**	**Plan Numbers for Enrollments**	
			State	**ID #**

Provider Name: _____

SECTION VII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE AUTHORIZED TO SIGN INTO LEGAL, BINDING DOCUMENTS ON BEHALF OF THIS PROVIDER, SUCH AS DIRECT DEPOSIT FORMS AND/OR CHANGES TO THE DISCLOSURE OF OWNERSHIP FORMS, etc.

List each person authorized to sign and identify their position in your practice.		
1.	☐ Owner ☐ Managing Employee	☐ Other: _____
2.	☐ Owner ☐ Managing Employee	☐ Other: _____
3.	☐ Owner ☐ Managing Employee	☐ Other: _____
4.	☐ Owner ☐ Managing Employee	☐ Other: _____
5.	☐ Owner ☐ Managing Employee	☐ Other: _____
6.	☐ Owner ☐ Managing Employee	☐ Other: _____
7.	☐ Owner ☐ Managing Employee	☐ Other: _____
8.	☐ Owner ☐ Managing Employee	☐ Other: _____
9.	☐ Owner ☐ Managing Employee	☐ Other: _____
10.	☐ Owner ☐ Managing Employee	☐ Other: _____

Please sign in blue ink (not black).

_____ _____

Printed Name of Authorized Representative | Signature of Authorized Representative *(sign in blue ink)*

_____ _____

Title/Position | Date of Signature MM/DD/YYYY

Provider Name: _____

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1) That the provider has disclosed all necessary information;
2) That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3) That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4) That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5) That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6) That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7) That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8) That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9) That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10) The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. (See Federal Regulations 42 CFR § 455.104(b)(1). A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. (See Federal Regulations 42 CFR § 455.104(b)(2). Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11) That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
- All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
- All Individuals acting as Board of Director;
- All Individual Corporate Officers, Directors, Partners, or Shareholders;
- All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.

12) I attest that I am a United States citizen or have legal status and work privilege in the US.
13) The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14) The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
- been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
- been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
- been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
- been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
- been convicted of any crimes.

15) The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16) The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17) I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs."
18) The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Printed Name of Authorized Representative	Signature of Authorized Representative *(sign in blue ink)*
Title/Position of Authorized Representative	Date of Signature MM/DD/YYYY