LOUISIANA DEPARTMENT OF HEALTH

gainwell

Emergency Louisiana Medicaid Packet for Individuals (CMS Expedited Screening)

Thank you for your assistance with our Louisiana Recipients who have been affected by the COVID-19 emergency. Your response is greatly appreciated. Please wait for an emailed or faxed confirmation of your enrollment in Louisiana Medicaid before submitting any claims.

Temporary Fee-for-Service emergency enrollments will be approved until the emergency declaration is lifted and will not be granted for an effective date earlier than March 1, 2020. Your temporary emergency enrollment may be inactivated no later than six (6) months after the emergency declaration has lifted. To remain enrolled or to become re-enrolled after this period, you can submit a Basic Provider Enrollment Packet for Individuals, available on www.lamedicaid.com under the Provider Enrollment link.

This enrollment is for the Fee-for-Service program only. For Healthy Louisiana (Managed Care) contracting and Provider Relations contact information, please visit http://ldh.la.gov/index.cfm/page/1461.

Refer to our web site frequently for updated information and/or application packets at www.lamedicaid.com. If you have any questions concerning the completion of this enrollment packet, please refer to the instructions included below and at www.lamedicaid.com prior to calling 225-216-6370.

Instructions: The following pages are required, along with a copy of your **TIN's IRS letter.** All fields are required unless otherwise noted. To determine the appropriate provider type, provider specialty, and additional requirements specific to your selected provider type, please review the provider-type specific checklists at:
www.lamedicaid.com > Provider Enrollment > Applications (top link) > Option 2 link.

To look up recipient (patient) eligibility and/or pharmacy claims history:
Go to Provider Log-In on www.lamedicaid.com. Enter your NPI and then enter your login ID and password. If you do not have a login, you'll be prompted to create one. After logging in, go to Medicaid Eligibility Verification System for recipient eligiblity and Clinical Data Inquiry (e-CDI) for pharmacy claims history. You'll need to enter the recipient's name and either DOB or SSN to use both features.

After completing and signing the application packet, please return using **one** of the below methods:

EMAIL: lamedicaid@molinahealthcare.com
FAX: (225) 216-6392
MAIL: Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

REQUIRED

Individual
EMERGENCY Louisiana Medicaid
PE-50 Provider Enrollment Form

Louisiana Medicaid Provider # (if known)

This enrollment packet is for a ☐ New Enrollment ☐ Reactivation ☐ Other (Please specify):

Type 1 Individual NPI

Requested Enrollment Effective Date (no earlier than 3/1/20):

A Individual and Practice Location

Provider Type (see instructions page) | Specialty (see instructions page)

Name of Individual (Last Name, First Name, Middle Name) | MD, DO, etc. | Telephone # ( ) - | Social Security # - -

Are you known by (or have you ever used) another name? ☐ Y ☐ N
If yes, ☐ Former or Maiden Name ☐ Professional Name ☐ Other (Describe):
If yes, please provide name(s) here:

DOB

Main Practice Street Address | Telephone # ( ) -

Practice City | State | Zip Code

County | License #, if applicable | License Issuing State, if applicable

Are you currently enrolled in Medicare? ☐ Y ☐ N

Are you currently enrolled in a Medicaid program in any state other than Louisiana? If yes, please provide state here: ☐ Y ☐ N

Are you a US citizen? ☐ Y ☐ N If no, do you have legal status and work privileges in the US? Attach verification if so. ☐ Y ☐ N

B Pay-To Information

Pay-To Name **(MUST match the first line on enclosed IRS documentation EXACTLY)** | IRS Reporting # (Federal Tax ID #)

Pay-To Mailing Address | Pay-To Mailing City | Pay-To Mailing State | Pay-To Mailing Zip Code

Attn To (optional) | Type 2 Organizational NPI (required if you have one)

C Group Linkage

***This section is required **only if** you are requesting to be **linked to an EXISTING Louisiana Medicaid professional group.**

Professional Group Name | Professional Group Louisiana Medicaid Provider #

D Contact Information

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

Contact Name: | Contact E-mail:

Contact Phone # ( ) - | Contact Fax # ( ) -

E Attestation of Information

I, the undersigned, certify the following

1. I have read the contents of this form 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 the individual named in Section A and I hereby legally bind myself 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.
5. If group linkage is requested, I attest that I am a medical professional who has a contractual agreement to see patients for the above named professional group(s). If applicable, I understand that upon request I must provide to LDH a copy of the written contractual agreement.
6. I understand that this enrollment is temporary and based on emergency needs.
7. I have read the PE-50 Provider Agreement Addendum (revision date 3/2017) and Ownership Disclosure Attestation (revision date 7/2015) available on lamedicaid.com and/or faxed to me at my request and I agree to/with all provisions contained therein, which are incorporated by reference into this provider agreement with the same force and effect as though fully set forth herein.

Individual Provider's Printed Name | **Individual Provider's Signature** | **Date of Signature**

<u>REQUIRED</u>

DISCLOSURE OF OWNERSHIP FOR INDIVIDUALS

Name of Individual Enrolling: ______________________________

Individual National Provider Identifier (NPI) (10 digits) | | | | | | | | | | |

A. Does the enrolling individual have any direct, indirect, or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in a Federal/State funded healthcare program(s)? ☐ Y ☐ N
If yes, complete the section below for each entity/business. Make a copy of this page if more space is needed.
If no, proceed to section F.

Plan (Name of Federal/State funded healthcare program that owned/controlling business is enrolled in)	**Doing Business As (DBA) Name and Address**	**Tax ID Number**	**% Ownership**	**Plan Enrollment**	
				State	**ID#**

B. Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed in item A above? ☐ Y ☐ N
If yes, complete the section below for each related individual. Make a copy of this page if more space is needed.

Full Name (First, Middle, and Last)	**Maiden Name**, if applicable	**Relationship**	**% Ownership**	**Date of Birth**	**Social Security #**

C. Is the enrolling individual the owner of the business/entity identified as the Pay-To Name and Tax ID # in Section B on the PE-50-I form (previous page)? ☐ Y ☐ N
<u>If no to this question, proceed to Section F.</u>
If yes to this question, answer the following question.

If yes, does this enrolling individual employ any agents or managing employees? ☐ Y ☐ N
If yes to this question, complete the section below for each agent or managing employee. Make a copy of this page if more space is needed.
If no to this question, proceed to Section F.

Full Name (First, Middle, and Last)	**Ever used or been known by any other name, including married, maiden, hyphen or alias?** (provide FULL other name)	**Title/Job Position within this Entity/Business**	**% Owner -ship**	**Date of Birth**	**Social Security #**	**Is this individual a US Citizen?** If no, provide alien verification #.

Individual National Provider Identifier: ____________________

D. If Yes to the second question of Section C, is this agent or managing employee related to any other individual owners, agents, managing employees, or subcontractor business owners associated with this entity/business? ☐ Y ☐ N

If yes, complete the section below for each related individual. Make a copy of this page if more space is needed.

Full Name (First, Middle, and Last)	**Maiden Name**, if applicable	**Relationship**	**% Ownership**	**Date of Birth**	**Social Security #**

E. If Yes to the second question of Section C, does this agent or managing employee have ownership or controlling interest in any other entity/business participating in a Federal/State funded healthcare program? ☐ Y ☐ N

If yes, complete the section below for each entity/business. Make a copy of this page if more space is needed.

Plan (Name of Federal/State funded healthcare program that owned/controlling business is enrolled in)	**Doing Business As (DBA) Name**	**Tax ID Number**	**Plan Enrollment**	
			State	**ID#**

F. Check the appropriate Yes or No box for the questions below. If Yes is answered to any question:

1) Submit a written statement providing the details on all occurrences.
2) Attach all official legal doucments regarding the occurrence, including any reinstatements.

Has the enrolling individual named above OR any agent/managing employee listed in Section C:

Enrolling Individual	**Agent/ Managing Employee from Section C (if applicable)**	
☐ Y ☐ N	☐ Y ☐ N	Ever been convicted of a criminal offense in any program under Medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program?
☐ Y ☐ N	☐ Y ☐ N	Ever had any disciplinary action taken against any license or certification held in any State or US Territory, including discipinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification?
☐ Y ☐ N	☐ Y ☐ N	Ever been denied enrollment, suspended, or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid, or other healthcare program(s) in any State or US Territory?
☐ Y ☐ N	☐ Y ☐ N	Currently have a negative balance or currently owes money to any State or Federal Funded program, including Medicaid and Medicare?
☐ Y ☐ N	☐ Y ☐ N	Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency?
☐ Y ☐ N	☐ Y ☐ N	Currently have any open or pending healthcare court cases?
☐ Y ☐ N	☐ Y ☐ N	Ever been denied malpractice insurance?
☐ Y ☐ N	☐ Y ☐ N	Currently has or ever had any type of felony conviction(s)?

G. Has this disclosure of ownership form been completed by an individual other than the enrolling provider? ☐ Y ☐ N

If yes, complete the section below for the individual completing this form. If no, you can leave this section blank.

Full Name (First, Middle, and Last)	**Maiden Name**, if applicable	**Social Security #**	**Date of Birth**
The person completing this form is: ☐ Staff ☐ Third Party/Independent Agent ☐ Other (Please specify):		**Telephone #** ( ) -	**E-mail**

REQUIRED unless you will be billing through a linked group

MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT FOR INDIVIDUALS

1. Medicaid Provider Number (if known)

2. Individual National Provider Identifier (NPI)

3. Name of Individual Enrolling: ______________________________

ACCOUNT INFORMATION
(All fields must be completed)

4. Account Type: *(Check One)* ☐ CHECKING ☐ SAVINGS

5. Is the account identified below located in the United States? ☐ Y ☐ N

   5a. If No, please identify the country of location: ______________________________

6. Attach or tape a copy of your Voided Check (Deposit Slips are not Acceptable)

TAPE OR ATTACH COPY OF VOIDED CHECK – NO STAPLES
DEPOSIT SLIPS ARE NOT ACCEPTED

If a voided check is unavailable, you may submit a letter on Bank Letterhead identifying the name associated with the account, the ABA Routing Number and the Account Number. The letter must be signed by a Bank Representative.