ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

(Louisiana Medicaid Program)

Basic Enrollment Packet for Individuals (With Instructions)

(Common Forms for All Individual Provider Types)

(Enrollment packet is subject to change without notice)

gainwell

To Whom It May Concern:

This is the Basic Enrollment Packet for Individual Professionals wanting 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 NPIs—both Type 1 Individual and Type 2 Organizational— needing 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: Only one NPI can be added/linked to one Medicaid provider number.

The Medicaid Program requires all providers to be state certified for claims to be processed. 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 shall continue as an enrolled provider subject to the provisions of MAPIL until either party terminates this contract.

The Provider Service Manuals are located at www.lamedicaid.com. Click on the Provider Tools found 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 this 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 with the 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.

BHSF PE-50 Form Instructions (Individual)

PREPARATION

Please read the instructions in its entirety before completing the form. Complete the form as an **original** document. The enrolling provider may want to keep a photocopy this form before submitting the original to Provider Enrollment. Inaccurate/Incomplete forms will result in the entire application being returned for completion.

GENERAL INFORMATION

A Medicaid provider number will be issued to the individual whose name appears in Section A of this form. It is the responsibility of this individual to maintain accurate information on the Louisiana Medicaid provider file by submitting updates (as needed) to the Provider Enrollment Unit.

An Individual Medicaid provider number can have only one (1) mailing address. Therefore, this address **MUST** be the address the enrolling individual wishes to receive correspondence from LDH or Gainwell regarding their Medicaid application or provider number.

Linkages of Professionals to Groups – an individual's provider number can be "linked" to a group provider number for purposes of billing as an attending provider for the specified group.

- **Active providers need only to submit a Link/Unlink and Working Relationship Form.**
- **New/Inactive/closed providers require a full enrollment application along with the Link/Unlink and Working Relationship Form found on the web in the Provider Type Specific Packet.**

Claims submitted under a group's National Provider Identifier (NPI), with an individual's NPI used as the attending provider, will be processed and adjudicated under the Group's NPI/Medicaid provider number.

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

Louisiana Medicaid Provider Number – enter the 7-digit Louisiana Medicaid provider number (if known). If this is a new enrollment, leave the boxes 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, or specify some other reason for the enrollment packet. A new enrollment is for an individual with no prior Louisiana Medicaid provider number. A re-validation of an existing enrollment is for an individual 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.

Type 1 Individual National Provider Identifier (NPI) – enter the enrolling provider's 10-digit NPI number. 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. An NPI number is required prior to enrollment, unless 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.

Requested Enrollment Effective Date – requested date for the activation of the Medicaid provider number. In some instances, this date can be retroactive as long as it the meets the timely filing policy. Attach a valid license that covers the requested activation date.

SECTION A – INDIVIDUAL INFORMATION & PRACTICE LOCATION

Provider Type Description and Code (Required) – review the following table and enter the provider description and code into this field. Entries of provider types other than those listed in this table will result in rejection of this application.

Provider Type Code – enter the code corresponding with the provider type of enrollment, from the table below:

Code	Description
AP	Art Therapy (Individual)
34	Audiologist
30	Chiropractor
93	Clinical Nurse Specialist (CNS)
91	Certified Registered Nurse Anesthetist (CRNA)
27	Dentist
29	EarlySteps (Audiologist, Psy, OT, PT, ST) (In-State Only)
HT	Hippotherapy (Individual)
MW	Midwife (Licensed)
MT	Music Therapy (Individual)
78	Nurse Practitioner (NP)
90	Nurse-Midwife (Certified)
37	Occupational Therapist (In-State Only)
AU	OPH Registered Dietician
57	OPH Registered Nurse
28	Optometrist
35	Physical Therapist (In-State Only)
20	Physician (MD)
94	Physician Assistant (PA) (In-State Only)
32	Podiatrist
31	Psychologist (In-State Only)
41	Registered Dietician
73	Social Worker (Licensed) (In-State Only)
39	Speech/Language Therapist
TH	Therapeutic Horseback Riding Therapy (Individual)
06	Waiver - NOW Professional (Registered Dietician/Psychologist/Social Worker) (In-State Only)

Specialty (required) – refer to the checklist in the Provider-Type Specific Packet for the possible Specialty Codes associated with requested enrollment provider type.

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

Name of Individual Enrolling – enter the individual's name in this field (must match the name on the license).

M.D., O.D., etc. – enter the abbreviation of the title held by the provider.

Area Code and Telephone Number and Extension (if applicable) - enter the telephone number at the practice location where the enrolling individual can be reached.

Social Security Number (required) – enter the social security number of the enrolling individual.

Pursuant to Louisiana Medicaid rules and regulations and 42 U.S.C. § 1320a-3, social security numbers are required for each individual for enrollment in Louisiana Medicaid. Not having a Social Security number on the application will result in a rejected application, needing correction.

Has the enrolling provider used or been known by another name? – check the appropriate box. If yes, check the appropriate type(s) of other name(s) and enter those name(s) used and known by.

Is the enrolling provider a U.S. citizen? – check the appropriate box. If no, answer the "Does the enrolling provider have legal status and work privileges in the U.S.?" question by checking the appropriate box.

Main Practice Street Address – enter the main practice location where the enrolling individual will be working. (For those providers who provide services at multiple locations, this address should be the address of the individual's main location.) Occasionally, there will be an instance when mail or a document or a correspondence may be sent to the Main Practice Street Address. If mail cannot be received at the Main 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 alternate delivery address for the physical location only.

Practice City – enter the city of the *Main Practice Street Address*.

Practice State – enter the state of the *Main Practice Street Address*.

Practice Zip Code – enter the zip code of the *Main Practice Street Address*.
Parish/County – enter the parish / county of the *Practice Street Address*, (for out-of-state providers, see county codes below).
Parish Code – enter the parish code of the physical location (see list below and enter appropriate code for the parish entered in the *Parish* field).

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

Out of State Providers (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, as follows:

Use the state code unless the practice location is in one of the trade-area counties. If the practice location is in one of the trade-area counties, be sure to use the appropriate county code (NOT the state code).

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, Walthall, Washington, Warren, Wilkinson	91
Arkansas	89	Ashley, Chicot, Columbia, Lafayette, Miller, Union	92
ALL OTHER STATES			**99**

State Status – check "In (0)" if the *Practice Street Address* is located within Louisiana or "Out (1)" if it is located outside Louisiana.
Location Type – check "Urban (1)" if the *Practice City* is an urban (city) location or "Rural (2)" if it is a rural (away from city centers) location.
License # - enter the professional (medical) license number for the person identified in the *Name of Individual Enrolling* field.
Does the enrolling provider currently hold (or have in the past held) a professional license in this or any other state? – check the appropriate box. If yes, list the state, type of license, and license numbers. If necessary, attach additional pages to the BHSF PE-50 form.
Medicare Number (Legacy) (optional) – enter the legacy Medicare Number if available.
Date of Birth – enter the date of birth for the individual. This is a required field, and the forms will be returned for correction if it is left blank.
UPIN (if known) – enter the Universal Provider Identification Number (UPIN) of the enrolling provider, if applicable. The NPI has replaced the UPIN as the required identifier for Medicare services.
Board Certification # (optional) - enter the number relating to the Board Certification of the enrolling provider– this number is issued by the certifying board and is included on the Board Certification certificate, optional. (Attach a copy of the certificate if this field is used).

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 being enclosed with the application. Do not abbreviate or add punctuation not found on the IRS documentation. If the Pay-To Name on the BHSF PE-50 **DOES NOT** match the IRS documentation exactly, the application may be returned for correcting.

IRS Reporting # – 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 the Employer Identification Number (EIN) / Tax ID Number (TIN) and the name registered to the EIN, is required.

Provider Mailing Address – enter the address to which all correspondences are to be mailed. **Provider Mailing City** – enter the city of the *Provider Mailing Address*.

Provider Mailing State – enter the state of the *Provider Mailing Address*.

Provider Mailing Zip – enter the zip code of the *Provider Mailing Address*.

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

Provider Year-End Date (optional) – Date of end of the fiscal year or the ending period used for calculating annual financial statements within an organization.

Type 2 Organizational NPI – If the Provider Pay-to Name is owned by the enrolling individual and that individual has a Type 2 Organizational 10-digit NPI number, enter that NPI number in the boxes provided. Claims will not automatically cross electronically from Medicare to Medicaid unless these NPI numbers are linked in the system.

SECTION C – CONTACT INFORMATION

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

Contact Phone # and Extension – enter the phone number of the person who may be contacted for additional information regarding this enrollment application.

Contact Fax # - enter the fax number 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 D – PROVIDER ATTESTATION OF INFORMATION

Read the information included in this section.

Printed Name of Individual Provider - print the name of the **individual provider** who is enrolling in Louisiana Medicaid.

Signature of Individual Provider – the individual provider who is enrolling in Louisiana Medicaid must sign the form. **Signatures must be original and in blue ink (not BLACK)** (stamped signatures and initials are not accepted)**.** Office Manager signatures are not accepted.

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

BHSF PE-50 Form (Individual)

Rev. 11/2024

All fields must be completed unless labeled as optional

Louisiana Medicaid Provider Number (if known)								
Type 1 Individual NPI										

This enrollment packet is for a:

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

NPI Tie Breaker (Taxonomy or Zip, +4)	**Requested Enrollment Effective Date** MM/DD/YYYY

A
Individual Information & Business Practice Location

See PE-50 Instructions to get your Provider Type Description and Provider Type Code		**See Provider-Type Specific Checklist**	
Provider Type Description (*required*)	Provider Type Code	Specialty Type (*required*)	Subspecialty (*if applicable*)

Name of Individual Enrolling (*Last Name, First Name, Middle Name*)	M.D., O.D., etc.	Social Security Number (*required)*

Area Code + Telephone Number:	Extension:

Has the enrolling provider used or been known by another name?

- ☐ Yes
- ☐ No

If yes, please enter other name(s) below:

- ☐ Former or Maiden Name
- ☐ Professional Name
- ☐ Other (*Describe*):

Is the enrolling provider a U.S. citizen? ☐ Yes ☐ No

If no, does the enrolling provider have legal status and work privileges in the U.S.? ☐ Yes ☐ No

Main Practice Street Address

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

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

Does the enrolling provider currently hold (or has in the past held) a professional license in this or any other state? ☐ Yes ☐ No

If yes, list the state, type of license, and license numbers. (*If necessary, attach additional page*):

Medicare Number (Legacy) (*optional*)	Date of Birth MM/DD/YYYY	UPIN (*if known*)	Board Certification # (*optional*)

B
Pay-To-Name and Mailing Address

Provider Pay-To-Name (**MUST match the first line on the IRS document EXACTLY)**	IRS Reporting Number

Provider Mailing Address	Provider Mailing City	Provider Mailing State	Provider Mailing Zip Code

Attn. or Other (*optional*)	Provider Year-End Date (*optional*) MM/DD/YYYY	Type 2 Organizational NPI (*required if you have one*):

C
Contact Information

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

Contact Name:	
Contact Phone Number:	Extension:
Contact Fax Number:	Extension:
Contact Email:	

D
Provider Attestation of Information

The undersigned enrolling provider certifies the following that:

1. The contents of this enrollment packet including the PE-50 Addendum and the information contained herein is true, correct, and complete;
2. It is the enrolling provider's 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. The signature of the enrolling provider legally binds this provider to this agreement; and
4. The Louisiana Medicaid files will be updated with information supplied on these forms.

Print the Name of the Individual Provider	**Signature of the Individual Provider (Sign in blue ink only)**	**Date of Signature** MM/DD/YYYY

PE-50
PROVIDER AGREEMENT ADDENDUM

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

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

Enrollment in Louisiana Medicaid

1. I have read the contents of this Louisiana Medical Assistance Program Enrollment Packet and the information supplied herein is true, correct and complete;
2. I understand that it is my responsibility to ensure that all information is kept up to date on the Louisiana Medicaid Provider File;
   - I must send a notice to the LDH Provider Enrollment section for any changes such as address, etc. Failure to do so may negatively affect attempts to revalidate the information and result in account closure.
   - Failure to maintain current information may result in payments being delayed or closure of the Medicaid provider number.
3. I understand that if my number is closed due to inaccurate information or inactivity, I will have to complete a new enrollment packet in its entirety to reactivate my provider number. A new application fee may be required for certain provider types.
4. I attest that I am a U.S. citizen or that I have legal status and work privilege in the U.S.
5. I understand that it is my responsibility to ensure that all my employees and/or authorized representatives are U.S. citizens or have legal status and work privilege in the U.S.
6. I understand that it is a violation if I fail to comply with any or all federal or state laws, regulations, policies, rules, criteria or procedures applicable to the Medical Assistance Program;
7. I understand that individuals who meet one or more of the following conditions may not be eligible to participate in the Medicaid program. I understand that it is my responsibility to immediately report to the Program Integrity Section 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
8. I understand that, as part of the Louisiana Medicaid enrollment/re-enrollment process, the Social Security Numbers of any person with an ownership or control interest in the disclosing entity, any managing employees or any agents must be disclosed; 42 CFR 455.104
   - I understand that failure to provide the Social Security Numbers will result in the rejection and/or denial of my enrollment or re-enrollment request.
9. I acknowledge that I have read and am 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.
10. I understand 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
11. I understand that all providers assessed as high risk are required to submit to fingerprint and background checks.

Providing Services to Louisiana Medicaid Recipients

12. I agree to conduct my 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;
13. I understand 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.
14. I understand that services and/or supplies provided by me must be medically necessary and medically appropriate for each individual patient based on needs presented on the date the service is provided and/or delivered;
15. I agree to charge no more for services to eligible recipients than is charged on the average for similar services to others;
16. I understand that as the provider I am held responsible for any and all claims submitted under any Louisiana Medicaid provider number issued to me;
17. I agree 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;
18. I agree to report and refund any discovered overpayments within sixty (60) days of discovery;
19. I agree 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;
20. I agree 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 by me as a Medicaid patient;
21. I agree to accept Medicaid payment for covered services as payment in full and not seek additional payment from any recipient for any unpaid portion of a bill, with the exception of state-funded spend-down Medically Needy recipients as indicated by the agency's form 110-MNP or any recipient co-payments as established by LDH;
22. I agree 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;
23. I agree 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;
24. I understand 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:
    a. 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, Department of Health and Hospitals, PO Box 91030, Baton Rouge, LA 70821-9030 or HHS Secretary, Washington, DC or both.
25. 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, I agree to 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 US HHS may specify. As an enrolled provider/entity, I understand that it is my obligation to inform all of my 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, I will be required to show evidence of compliance with this requirement.
26. 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

27. I have reviewed the Medicaid Direct Deposit (EFT) Authorization Agreement and the Medicaid Provider Requirements and Conditions as listed below and agree to this agreement:
    - I understand 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.
    - I understand that LDH may revoke this authorization at any time.
    - I hereby authorize the Louisiana Department of Health to present 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.
    - I certify 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 change this agreement.
    - I agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I further understand that the maintenance of account information on the Louisiana Medicaid files 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. I understand that such changes may not be able to be accommodated if less than 15 business days' notice is given.

Certification of Claims (Paper & Electronic)

28. I certify that all claims submitted to LDH, or its fiscal agent will be for medically necessary and needed services or supplies and these services and/or supplies will be rendered by an individual who is enrolled as a LDH Medicaid provider;
29. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate, and complete.

Printed Name of Individual Provider	Signature of Individual Provider

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:

- Individual providers must sign their own forms.
- Original signatures only; no stamps or copied signatures will be accepted. (Blue ink preferred –not black ink).
- If the individual provider is doing group billing only, then an EFT form should not be completed for the individual. Instead, an EFT form should be submitted (or already on file) only for the business or entity which the individual is linked to.
- 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. 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) is used to identify a business entity (9-digits).
3. 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.
4. Louisiana Medicaid Provider Number (7-digits)	The provider's 7-digit Louisiana Medicaid provider number.
5. Provider Contact Name	Name of a contact in the provider office for handling EFT issues.
6. Provider Contact Telephone Number and Extension	The telephone number and extension (if necessary) associated with the Provider Contact Name.
7. Provider Contact Email Address	An electronic mail address at which the health plan might contact the provider.
8. Financial Institution Name	The official name of the provider's financial institution.
9. 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.
10. 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.
11. 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).
12. 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.
13. Account Number Linkage to Provider Identifier	Check one: Provider Tax Identification Number (TIN), or National Provider Identifier (NPI).
14. Reason for submitting this form	Indicate the reason for submission of the form: New Enrollment, Re-validation of Existing Enrollment, Re-enrollment or Other.
15. 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**.
16. Signature of Individual Provider	Signature of individual provider in blue ink.
17. Printed Name of Individual Provider	The printed name of the individual provider.
18. 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. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) (9-digits) ☐☐☐☐☐☐☐☐☐

3. National Provider Identifier (NPI) (10-digits) ☐☐☐☐☐☐☐☐☐☐

4. Louisiana Medicaid Provider Number (7-digits) ☐☐☐☐☐☐☐

5. Provider Contact Name _____

6. Provider Contact Telephone Number _____
   - Extension _____

7. Provider Contact Email Address _____

8. Financial Institution Name _____

9. Financial Institution Routing Number (9 digits) ☐☐☐☐☐☐☐☐☐

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

11. Provider Account Number with Financial Institution ☐☐☐☐☐☐☐☐☐☐

12. Is the bank account you specified located in the United States? ☐ YES ☐ NO
    - If no, identify the country of location: _____

13. Account Number Linkage to Provider Identifier (check one): ☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

14. Reason for Submitting this form: ☐ New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment

15. Attach a voided check or a 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.**
    - I understand 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.
    - **I understand that LDH may revoke this authorization at any time.**
    - I hereby authorize 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.
    - I certify 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.
    - I agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I further understand that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility and failure to notify the Provider Enrollment Unit may result in Medicaid payments being electronically transmitted to incorrect accounts. I understand 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.

_____ _____

16. Signature of Individual Provider

17. Printed Name of Individual Provider

_____

18. 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 INDIVIDUALS)

INSTRUCTIONS

Prior to submitting electronic claims to Louisiana Medicaid, a seven-digit submit 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 individual 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 Individuals)

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.
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.)
Name of Individual Enrolling – enter the name of the individual enrolling or the 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 of the Contact Person.
Printed Name of the Individual Provider – print the name of the individual provider that is entering into a binding agreement with Louisiana Medicaid.
Signature of Individual Provider – enter the individual provider's signature. Note: The provider must sign the form, not an authorized representative or other agent.
Date of Signature – enter the date the provider signed the form.

Individual 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.
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.)
Name of Individual Enrolling – enter the name of the individual enrolling or the provider name associated with the Provider Number and NPI listed above.
Practice Street Address – enter the business location address of the provider name entered.
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 & 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 the Individual Provider – enter the individual provider's signature. Note: The provider must sign the form, not an authorized representative or other agent.
Printed Name of the Individual Provider – print the name of the individual provider that is entering 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 INDIVIDUALS)

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)

Name of Individual Enrolling: _____

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 for the Individual listed above and 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 ACKNOWLEDGEMENT

1. I 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, 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 my 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 42CFR447.10 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 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.
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 the Individual Provider	Signature of the Individual Provider
	Date of Signature MM/DD/YYYY

INDIVIDUAL
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)

Name of Individual Enrolling: _____

Full Practice Street Address: _____

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 the 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 the Individual Provider | Notary Public Signature

_____

Printed Name of the Individual Provider

Notary Seal or Notary Identification Number (required)

Instructions for Louisiana Medicaid Ownership Disclosure Information Individual

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.***

Please refer to the web sites listed on the page following these instructions for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

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

Section I – Enrolling Individual Information

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

NPI Type 1 – Individual – Enter your ten (10) digit Type 1 (Individual) National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov

Taxonomy/Tie Breaker, if applicable – Enter your Taxonomy Code or your ZIP+4 Tie Breaker, if applicable.

NPI Type 2 – Organizational, if applicable – Enter your ten (10) digit Type 2 (Organizational) NPI, if necessary.

Tax ID Number (only if self-incorporated) – Enter the nine (9) digit Tax ID number for this self-incorporated provider. In not self-incorporated, leave blank.

Social Security Number of Individual (required) – Enter the social security number of the enrolling individual.

Date of Birth – Enter the date of birth of the enrolling individual in the space provided.

This enrollment packet is for a – Check the appropriate box from among New Enrollment, Re-validation of existing enrollment, or Re-Enrollment.

Provider Type – Enter the Louisiana Medicaid Provider Type for the enrolling individual.

Enrolling Individual Provider Information - Enter the following in the spaces provided for the enrolling individual.

- First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable).
- Telephone Number and Extension
- Email Address
- Fax Number
- Provider's telephone number and extension to request medical records
- Main Practice Location Address
- Mailing Address/PO Box of Main Practice Location

Is the enrolling individual a U.S. citizen? – Check the appropriate box. If no, provide the Alien Verification number.

Do you practice in any location other than the one listed above? – Check the appropriate box. If yes, provide the following information for each practice location:

- DBA Name of practice location
- Medicaid Provider number
- Second Practice Mailing Address/PO Box
- Second Practice Location Address
- Second Practice Location phone number and extension
- Second Practice Location fax number and extension
- Second Practice Location Email address
- Repeat the information above for third, fourth and fifth practice locations, if applicable. If more practice locations exist, attach additional pages.

Section II – Enrolling Individual Additional Information

Has the enrolling individual listed in Section I ever:

A. Held a professional license in any state other than Louisiana? – Check the appropriate box. If yes, list the state(s) and Professional License Numbers in the spaces provided.

B. Practiced as a Medicare/Medicaid healthcare provider in any state other than Louisiana? – Check the appropriate box. If yes, list the state(s), Medicare Provider Numbers, and the Medicaid Provider Numbers in the spaces provided. Attach additional pages if needed.

C. Used or been known by any other name including married, maiden, hyphenated, or alias? – Check the appropriate box. If yes, enter the names in the spaces provided. Attach additional pages if needed.

D. Used or been known by any other incorporated or Doing Business As (DBA) names? – Check the appropriate box. If yes, list all DBA names, Legal Names and Tax IDs in the spaces provided. Attach additional pages if needed.

Section III – Enrolling Individual Criminal Conviction Disclosure

Has the enrolling individual owner named in Section I (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 IV – Enrollment in Healthcare Programs

Is the Social Security Number and/or Tax ID number(s) listed in Section I currently enrolled in any other Federal/State funded healthcare programs? – 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 and address, the Tax ID number/Social Security number, the Plan Numbers for Enrollments, and the location (state) of Enrollments. Attach additional sheets as needed.

Section V – Ownership of Entities/Businesses Enrolled in Federal/State Funded Healthcare Programs

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)? – Check the appropriate box. If yes, identify the applicable plan(s) and list the DBA Name(s) and address(es), the Tax ID(s), the Social Security Number(s), % ownership, the location (state) and the Plan Number(s) in the spaces provided.

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? – Check the appropriate box. If yes, enter the names of each individual, the relationship to the enrolling individual (i.e., spouse, parent, child, sibling), percentage of ownership, date of birth and social security number.

Section VI – Preparer information – Individual Completing the Disclosure of Ownership

Enter the following in the spaces provided for the preparer of this application.

- First Name, Middle Name, Maiden Name, Last Name, and Hyphenated Last Name (if applicable)
- Social Security Number
- Date of Birth
- Job Title
- Indicate if the person completing the form is self, staff, third party/independent agent or other. If other, please explain further.
- Physical Location Address
- Telephone Number - indicate the type of telephone number provided: work, home or cell
- Email Address
- Additional Telephone Number and Extension
- Additional Email Address

Section VII – Information on All Agents and Individuals Who Are Part of Management

If the enrolling individual is also the owner of the business/entity identified as the Provider Pay-to name and Tax ID in Section B on the form PE-50-I, this section must be completed.

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 VII 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 manager, business manager, administrator, director, or other individual who exercises operational or managerial 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. See Federal Regulation 42 CFR § 455.101.

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 VII Instructions:

A. **Does this enrolling individual employ any Agents or Managing employees?** – Check the appropriate Box. If yes, make one photocopy of Section VII for each agent or managing employee you report. If no, proceed to Section VIII.

B. **AGENT – or – MANAGING EMPLOYEE** – Check on 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, telephone number and extension, email address, primary physical location address and additional business location addresses and mailing addresses in the spaces provided. Attach additional sheets if needed.

C. **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 sheets if needed.

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

E. **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.

F. **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.

G. **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.

Reference Material for Louisiana Medicaid Ownership Disclosure
Information for an Individual

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 – INDIVIDUAL

Must be completed in its entirety

SECTION I – ENROLLING INDIVIDUAL INFORMATION

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

NPI Type I – Individual										
Taxonomy/Tie Breaker (if applicable)										

NPI Type 2 – Organizational (if applicable)										

Tax ID Number (only self-incorporated)										

Social Security Number of Individual (required)										

Date of Birth (required)			/			/				

This enrollment packet is for a: ☐ New Enrollment ☐ Re-enrollment ☐ Re-validation of existing enrollment	**Provider Type:**

A. ENROLLING INDIVIDUAL PROVIDER INFORMATION

First Name	Middle Name		
Maiden Name *(if applicable)*	Last Name	-	Hyphenated Last Name *(if applicable)*
Telephone Number of Enrolling Individual ( ) -			Extension
Email Address			
Fax Number ( ) -			Extension
Provider's Telephone Number to Request Medical Records ( ) -			Extension
Main Practice Location Address	City	State	Zip Code, +4 *(if known)*
Mailing Address/PO Box of Main Practice Location	City	State	Zip Code, +4 *(if known)*

B. Is the enrolling individual a U.S. Citizen? ☐ **Yes** ☐ **No**

If no, please provide Alien Verification #_____

Provider Name: _____

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

C. Do you practice in any location other than the one listed above? ☐ **Yes** ☐ **No**

If yes, complete the section below for each location.

DBA Name of Second Practice Location		Medicaid Provider Number	
Second Practice Mailing Address/PO Box	City	State	Zip Code, +4 *if known)*
Second Practice Location Address	City	State	Zip Code, +4 *(if known)*
Second Practice Location Phone Number ( ) -	Extension	Second Practice Location Fax Number ( ) -	Extension
Second Practice Location Email Address			

DBA Name of Third Practice Location		Medicaid Provider Number	
Third Practice Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Third Practice Location Address	City	State	Zip Code, +4 *(if known)*
Third Practice Location Phone Number ( ) -	Extension	Third Practice Location Fax Number ( ) -	Extension
Third Practice Location Email Address			

DBA Name of Fourth Practice Location		Medicaid Provider Number	
Fourth Practice Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Fourth Practice Location Address	City	State	Zip Code, +4 *(if known)*
Fourth Practice Location Phone Number ( ) -	Extension	Fourth Practice Location Fax Number ( ) -	Extension
Fourth Practice Location Email Address			

Provider Name: _____

DBA Name of Fifth Practice Location			Medicaid Provider Number
Fifth Practice Mailing Address/PO Box	City	State	Zip Code, +4 *(if known)*
Fifth Practice Location Address	City	State	Zip Code, +4 *(if known)*
Fifth Practice Location Phone Number ( ) -	Extension	Fifth Practice Location Fax Number ( ) -	Extension
Fifth Practice Location Email Address			

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to all items below

SECTION II – ENROLLING INDIVIDUAL ADDITIONAL INFORMATION

Has the enrolling individual listed in Section I, ever:

A. Held a professional license in any state other than Louisiana?	☐ **Yes** ☐ **No**
B. Practiced as a Medicare/Medicaid healthcare provider in any other than Louisiana? *If yes to either item A or B, complete the section below.*	☐ **Yes** ☐ **No**

Domicile State:	Medicare Provider Number:	Medicaid Provider Number:	Professional License #

C. Used or been known buy another 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)*
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name *(if applicable)*

D. Used or been known by any other incorporated or Doing Business As (DBA) names? ☐ **Yes** ☐ **No**
If yes, list all names and Tax IDs below. Attach additional pages if needed.

DBA Name	Legal Name	Tax ID
DBA Name	Legal Name	Tax ID
DBA Name	Legal Name	Tax ID
DBA Name	Legal Name	Tax ID

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to Section IV below

SECTION III – ENROLLING INDIVIDUAL CRIMINAL CONVICTION DISCLOSURE

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.		
Has the enrolling individual named in Section I (ever):		
Been convicted of a criminal offense in any program under Medicare, Medicaid, and Titled Services in the Louisiana Medical Assistance Program?	☐ **Yes**	☐ **No**
Had any disciplinary action taken against any license or certification held in any State or U.S. Territory, including disciplinary action, 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 any type of felony conviction(s)?	☐ **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.***

SECTION IV – ENROLLMENT IN HEALTHCARE PROGRAMS

Is the Social Security Number and/or Tax ID Number(s) listed in Section I currently enrolled in any other Federal/State funded healthcare programs? ☐ **Yes** ☐ **No**

If yes, complete the section below.

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

Provider Name: _____

Make a photocopy of this page if more space is needed to respond to items A and B below

SECTION V – OWNERSHIP OF ENTITIES/BUSINESSES ENROLLED IN FEDERAL/STATE FUNDED HEALTHCARE PROGRAMS

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)? ☐ **Yes** ☐ **No**

If yes, complete the section below.

Plan	Doing Business As (DBA) Name and Address	Tax ID/SSN	% ownership	Plan Numbers for Enrollments	
				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? ☐ **Yes** ☐ **No**

If yes, list all individuals and how they are related (i.e., spouse, parent, child, sibling) below. Attach additional pages if needed.

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

Relationship:	% ownership	Date of Birth MM/DD/YYYY	Social Security #
			- -

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

Relationship:	% ownership	Date of Birth MM/DD/YYYY	Social Security #
			- -

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

Relationship:	% ownership	Date of Birth MM/DD/YYYY	Social Security #

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

Relationship:	% ownership	Date of Birth MM/DD/YYYY	Social Security #

Provider Name: _____

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

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

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

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

☐ Self ☐ Staff ☐ Third Party/Independent Agent ☐ Other: _____

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

Telephone Number ☐ Work ☐ Home ☐ Cell ( ) -	Extension

Additional Telephone Number ☐ Work ☐ Home ☐ Cell ( ) -	Extension

Email Address	Additional Email Address

Provider Name: _____

Make photocopies of the next 2 pages to complete Section VII for each agent or managing employee AND make a photocopy of this page if more space is needed to respond to items C and E below*

SECTION VII – INFORMATION ON ALL AGENTS AND INDIVIDUALS WHO ARE PART OF MANAGEMENT

If the enrolling individual is also the owner of the business/entity identified as the Provider Pay-To Name and Tax ID in Section B on the form PE-50-I, this section must be completed.

A. Does this enrolling individual employ any Agents or Managing employees? ☐ **Yes** ☐ **No**

If yes, complete the following information for each agent or managing employee. If no, proceed to Section VIII.

B. ☐ **AGENT** **-or-** ☐ **MANAGING EMPLOYEE**

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

Title/Job Position within this entity/business	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
( ) -		

Additional business location address	City	State	Zip Code, +4 *(if known)*
Mailing address for above location	City	State	Zip Code, +4 *(if known)*

Additional business location address	City	State	Zip Code, +4 *(if known)*
Mailing address for above location	City	State	Zip Code, +4 *(if known)*

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

Provider Name: ______________________________________

Section VII Continued

Name of Agent or Managing Employee: ____

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

If no, provide Alien Verification # ______________________________________

E. 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		

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 G 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.		
F. Has the agent or managing employee named above (ever):		
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, 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 any type of felony conviction(s)?	☐ **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.***

G. Does this agent or managing employee have ownership or controlling interest 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 VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That I have disclosed all necessary information;
2. That I am the individual identified in Section I and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That I have reviewed the information on this Individual Disclosure form and attest that it is true, accurate and complete;
4. That I understand 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 individual already participates, a termination of the provider agreement or contract with LDH or the Secretary, as appropriate;
5. That I understand that a denial or termination of the provider agreement or contract with LDH or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That I understand that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to LDH or the Secretary may be prosecuted under applicable federal or state laws;
7. That I understand it is my responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That I understand that the failure to maintain current and correct information may result in payments being delayed or closure of my Medicaid provider number;
9. That I understand if my number is closed due to inaccurate information, I will have to complete a new Provider Enrollment Packet in its entirety to reactivate my provider number;
10. I understand 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 I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, I 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 and I understand that it is my responsibility to ensure that all my managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
13. I understand that it is my responsibility to ensure that I have disclosed on this form if I, or 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.
14. I understand that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), I am required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
15. I understand that I shall report any of the above conditions to the Department of Health (LDH), and once enrolled, I understand that upon discovery of any of the above conditions, it is my responsibility to report them immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
16. 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.
17. I understand that I am being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." I understand that this criminal statute means that if I, or any managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or been terminated from participation in the Medicare, Medicaid, or any other Federally or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. I also understand that "participation" includes providing any services which will be billed, directly or indirectly, to Medicaid, 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 Louisiana's Medicaid Program. I also understand that this new 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 Individual Provider | Signature of Individual Provider *(sign in blue ink)*

_____

Date of Signature MM/DD/YYYY