PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

NOW PROFESSIONAL

(LINKING PROFESSIONALS TO HHA, PCA OR SIL)

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION
REGARDING WAIVER ENROLLMENTS

The effective date for this enrollment will be the day the application is actually worked by Provider Enrollment.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be made to the provider regarding automatic closure.

If at any time during enrollment as a Waiver Medicaid provider, the provider has a change of physical address, then the provider must first obtain an updated license indicating the new address, and then submit notification of the change of address along with a copy of the updated license to Gainwell Provider Enrollment.

GENERAL POLICY INFORMATION:

Waiver service providers are required to comply with both policy and program requirements located on the Louisiana Department of Health (LDH) Office for Citizens with Developmental Disabilities (OCDD) website and the Louisiana Medicaid provider manuals linked below.

Louisiana Medicaid Provider Manuals:
https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

LDH/OCDD website:
https://ldh.la.gov/index.cfm/subhome/11/n/8

NOW Professional Waiver Services Program

REQUIRED DOCUMENTS FOR ENROLLMENT

The following checklist shows all required documents that MUST be submitted to enroll with Fee For Service (FFS) Louisiana Medicaid. Please make certain to complete each required form in its entirety to avoid processing delays.

* Form is included in the **Basic Enrollment Packet for Individuals**.

** Form is included in this packet.

Completed	Document Name
**	**1.** The NOW Professional Waiver Services Provider Enrollment Form (NOW-1).
*	**2.** Louisiana Medicaid Ownership Disclosure Information Forms.
	3. Printout of online medical license verification from the governing license board of your profession. This verification must contain the license numbers, the effective date of issuance, and the status of the license. A temporary permit is only good until the expiration date.
**	**4.** Link/Unlink and Working Relationship Form.
	5. To report **"Specialty"** for this provider type on **Section A of the PE-50**, please use Code **4R** (Registered Dietician), **4D** (Psychologist), or **4E** (Social Worker).

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Original Signatures Required – Please Do NOT Use Black Ink

Louisiana's Medicaid Program
NOW PROFESSIONAL WAIVER SERVICES

Provider Number: (Leave Blank If Applying For New Number)							
Individual Provider Name:							
National Provider Identifier:							
Provider Street Address:							
Provider City:							
Provider State:		Provider Zip:					
Provider Phone Number:		Fax Number:					
Social Security Number:							
Professional License Number (attach copy of license):							
Specialty (refer to attached lists):	**Registered Dietician (4R)**	**Psychologist (4D)**	**Social Worker (4E)**				
Requested Effective Date:							
Provider Signature:		Date of Signature:					

PROVIDER VERIFICATION FOR DELIVERY OF NOW WAIVER SERVICES

I hereby certify under oath that all statements I have made on this application and the attachments thereto are true and correct. I affirm I have a minimum of one-year post-licensure experience in my field of expertise and I hold a current Louisiana License for the Professional Type indicated:

Registered Dietician (4R) Psychologist (4D) Social Worker (4E)

PROVIDER VERIFICATION FOR CONSULTATION SERVICE FOR NOW WAIVER PROGRAM

I hereby certify under oath that all statements I have made on this application and the attachments thereto are true and correct. I affirm I have a minimum of one-year post-licensure experience in my field of expertise and I hold a current Louisiana License for the Professional Type indicated:

Registered Dietician (4R) Psychologist (4D) Social Worker (4E)

I hereby certify that all information is true and that I have a minimum of one-year experience in my field of expertise and hold a current Louisiana License.

Print Individual Provider's Name	**Individual Provider's Signature**	**Date**

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Louisiana Medicaid
Group Link/Unlink and Working Relationship Form

PURPOSE

This form is used when an individual provider is requesting to be linked to a Professional Group or Entity. The form permits Linkage/Unlinkage for two separate professional groups. When linking to a group, the estimated number of hours is required. The form also serves as documentation that a working relationship exists between an individual and a professional group. For this form to be valid, an **ORIGINAL SIGNATURE AND DATE ARE REQUIRED.**

Individual Provider Name:			
Individual Provider Number:	LA Medicaid Provider #	National Provider Identifier (NPI)	
Professional Group Name:			
Professional Group Provider Number:	LA Medicaid Provider #	National Provider Identifier (NPI)	
LINK	Effective Date	UNLINK	Termination Date
Approximate Number of Hours Working at this Entity Per Week (required)			
Professional Group Name:			
Professional Group Provider Number:	LA Medicaid Provider #	National Provider Identifier (NPI)	
LINK	Effective Date:	UNLINK	Termination Date:
Approximate Number of Hours Working at this Entity Per Week (required)			
Contact Person for questions regarding this form:			
Contact Person Phone Number:			

WORKING RELATIONSHIP AGREEMENT

I am a medical professional who has a written contractual agreement to see patients for the above named professional group(s). I have recorded the approximate number of hours to be worked at each group per week in the space(s) provided above. (I understand that upon request I must provide LDH a copy of the written contractual agreement.)

Print Individual Provider's Name	**Individual Provider's Signature**	**Date**

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
225-216-6370