# PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

## (Louisiana Medicaid Program)

## Physicians (Group)

**(Enrollment packet is subject to change without notice.)**

# GENERAL INFORMATION FOR THE PHYSICIAN GROUP PROVIDER TYPE

Two or more professionals working together, providing services for 20 or more hours per week, may enroll as a Physician Group with Louisiana Medicaid.

A combination of the following professionals may form or link to a Physician Group:

- Physicians
- Doctors of Osteopathy
- Physician Assistants
- Dentists
- Chiropractors
- Podiatrists
- Nurse Practitioners
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialists
- Audiologists

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

- **Open professional individual providers require only Group Link/Unlink and Working Relationship Form**
- **New, Inactive, or Closed professional individual providers require an entire enrollment application as well as the group Link/Unlink and Working Relationship Form.**

Claims submitted under the group number, with a professional individual's number included as the attending provider, will be processed and the remittance will be sent directly to the group's mailing address. **It is not necessary for the individual's mailing address to be the same as the Group's mailing address for these Remittance Advice notices to be sent to the group, if billed correctly.**

When a professional individual is linking to a group as an "attending only" (not being paid individually by Medicaid), then the EDI Contract, Direct Deposit Form, and voided check are not required for this individual.

# Physicians – Group
## 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 Entities/Businesses**.

** Form is included in this packet.

| Completed | | Document Name |
|---|---|---|
| ☐ | * | 1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form. |
| ☐ | * | 2. PE-50 Addendum – Provider Agreement Forms (three pages). |
| ☐ | * | 3. Medicaid Direct Deposit (EFT) Authorization Agreement Form. |
| ☐ | * | 4. Louisiana Medicaid Ownership Disclosure Information Forms. |
| ☐ | * | 5. **(If submitting claims electronically) Completed** Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form **And** Power of Attorney Form (if applicable). |
| ☐ | | 6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited **(deposit slips are not accepted**). |
| ☐ | | 7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records (**W-9 forms are not accepted**). |
| ☐ | ** | 8. OFS Form 24, if applicable. |
| ☐ | | 9. Copy of CLIA certificate, if applicable. |
| ☐ | | 10. To report "Specialty" for this provider type on Section A of the PE-50, please use 70 (group). |
| ☐ | | 11. Report the following Subspecialties in Section A of the PE-50 of the Enrollment form, if it applies to this group:<br>- Use 2U for Independent Diagnostic Testing Facility (IDTF)<br>- Use 7M for Retail Convenience Clinics<br>- Use 7N for Urgent Care Clinics |
| ☐ | ** | 12. Link/Unlink and Working Relationship Form for all currently-enrolled professional individuals to be linked to this group. |
| ☐ | | 13. If the professional individuals being linked to this group are not currently enrolled in Louisiana Medicaid, then a full individual enrollment application is required for those individuals. |

**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**

# STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS

Dear Provider:

It is the policy of the Bureau of Health Services Financing that the Medicaid Program will only pay for in-office performance of certain laboratory and diagnostic services which are billed by physicians if the following conditions are met:

1. The physician has completed and has on file with Louisiana State Medicaid Program, Provider Enrollment Unit a completed OFS Form 24.
2. The completed OFS Form 24 fully describes the laboratory or diagnostic equipment required to perform these tests.
3. The OFS Form 24 information is updated as needed.

Our policy towards laboratory or diagnostic services that are performed outside of a physician office remains unchanged. Physicians may not be reimbursed for laboratory or diagnostic services ordered for their patients if these services are performed outside of their office. Only the performer of a test may seek reimbursement for these services. Any interpretive service by the attending physician is reimbursed through the physician visit payment.

The OFS Form 24 requirements only pertain to: 1) those participating physicians who own or lease laboratory or diagnostic testing equipment that is located in their office or place of practice and 2) for which use the physician will be submitting a claim to the Medicaid program.

Example 1: Dr. Jones is an individual practitioner who owns or leases a SMA-12, EKG monitor and X-Ray equipment. Dr. Jones wishes to perform laboratory and diagnostic services on Medicaid patients in his office and bill the Medicaid Program for these laboratory or diagnostic services. Dr. Jones must complete the OFS Form 24.

Example 2: Drs. Smith, Jones, Doe, and Rae are a group practice. As a group they own or lease laboratory and diagnostic equipment. It is their desire to use this equipment in treating Medicaid recipients, and they will bill the Medicaid Program for these services. If each physician is individually enrolled in the Medicaid Program, each physician in the group must complete the OFS Form 24, even though the descriptive information will be identical. If the physicians are enrolling as a group, only one OFS Form 24 is required as long as all members of the group are indicated.

Example 3: An individual or group practitioner utilizes an external source for laboratory or diagnostic tests. The individual or group practitioner would not complete the OFS Form 24, as they would not bill the Medicaid Program directly.

A Louisiana OFS Form 24 is enclosed for completion and submittal where applicable. Return the completed form to:

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

Sincerely,

Provider Enrollment Unit

# OFS Form 24 (Diagnostic and/or Laboratory Equipment)

**Provider Number (7 digits):** ☐☐☐☐☐☐☐

**NPI (10 digits):** ☐☐☐☐☐☐☐☐☐☐

**Provider Name:** _____

**Provider Address:** _____

**Diagnostic and/or Laboratory Equipment**

| Make | Model | Serial # | Capabilities |
|---|---|---|---|
| | | | |

List names of individuals who will be performing the diagnostic and/or laboratory tests in the spaces below:

| | |
|---|---|
| 1. | 2. |

**I certify the above is accurate and true.**

Signature of Authorized Representative: _____

Print Name of Authorized Representative: _____

Date of Signature: _____

**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**

# Louisiana Medicaid

# Link/Unlink and Working Relationship Form

Copy this form for additional space as needed

***PURPOSE***

This form allows one individual to link to and/or unlink from two (2) separate entities/businesses.
This form also serves as documentation that a working relationship exists between an Individual and an Entity.

| | | | |
|---|---|---|---|
| Individual Provider Name: | | | |
| Individual Provider Number | LA Medicaid Provider # | National Provider Identifier (NPI) | |
| Entity Name: | | | |
| Entity 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) | | | |
| Entity Name: | | | |
| Entity 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 contractual agreement to see patients for the above-identified entity(s). I recorded the approximate number of hours working per week for the entity(s) identified 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 of Signature**

**Original Signatures Required – Please Do NOT Use Black Ink**

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