THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

(Louisiana Medicaid Program)

Third Party Billing Agent/Submitter Registration Form

(Subject to change without notice)

General Information

For Medicaid purposes, the Provider and the Submitter require a one to one relationship on the Medicaid file. It is only when the Submitter number is linked to the Medicaid Provider number that claims can be successfully submitted electronically to Medicaid.

The NPI is the driving force for the Medicaid provider number regarding electronic claims submission. It is critical that the NPI used to submit claims is the exact NPI loaded to the file for that particular Medicaid provider. (This includes Taxonomy and Tie Breakers.)

The Louisiana Medicaid Provider number is a 7-digit number beginning with either a 1 or a 2.

- For Individual Professionals - The Provider number will follow the Individual throughout their life time (per Provider Type)
- For Entities/Businesses – The Provider number will be retained even with a Change of Ownership. Only with special approval from DHH will a provider number change within a specified provider type due to an ownership change. (The only exception to this rule is for the Pharmacy Provider Type).

The Louisiana Medicaid Submitter number is also a 7-digit number that always begins with 450.

- This number is used to logon to the EDI system.
- It is not a billing number

To register for a 450 Third Party Biller/Submitter number

- Third Party Contractors, Clearinghouses and/or Billing Agents must complete a Third Party Biller/Submitter PT-21 Packet.
- Additionally, a 2-page EDI contract and Power of Attorney Form are required from either a currently enrolled provider or from an Individual or Entity/Business that has submitted an enrollment application to become enrolled in Medicaid. These forms are included in the PT-21 enrollment packet.
- The EDI contract and Power of Attorney form must be signed by the actual Individual, if the Medicaid is assigned to a Professional Individual or an Authorized Representative if the Medicaid belongs to Entity/Business.
- Original signatures are required.

Notification

- When a Medicaid provider is linked to a Third Party Biller/Submitter, a written notice will be sent to the mailing address on that provider’s file and will not be sent to the Third Party. It is the responsibility of the provider to notify the Third Party.
- Notification cannot be faxed or emailed.

General

- New Submitter numbers require testing with the EDI Department. Successful completion of testing allows submitters to obtain authorization for access to HIPAA 835 electronic remittance advices.
- Once Submitters have tested, are approved and the Submitter file established, a new Submitter number can be used to submit claims for any date of service.
- New Submitter numbers become effective the day the number is added to the provider’s file. A retro effective date for the Submitter number is not required to bill for a retro date of service.

Note

- If Third Party Billers/Agents are contracted to provide service for a Medicaid provider, they must obtain any needed information directly from that provider. Gainwell will not supply information from the provider file to a Third Party Biller.

Provider Enrollment

- Provider Enrollment works on a 3-week turn around time frame.
- The Medicaid file holds a maximum of 3 Submitter number per provider number.
- Current policy is to close old Submitter numbers when adding a new Submitter number to a provider file, unless Provider Enrollment is otherwise notified.
- Only the Submitter number loaded on the 1st segment in the Bill Center (called the 1st Bucket), can retrieve 835 transactions.

Third Party Billing Agent/Submitter
CHECKLIST OF FORMS TO BE SUBMITTED

Completed	Document Name
*	1. Completed Third Party Billing Agent/Submitter Registration Form.
*	2. Disclosure of Ownership Form.
*	3. Must have one completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form from a Client that is either currently enrolled with Louisiana Medicaid or have submitted an application to be enrolled in Louisiana Medicaid – that accompanies this Registration packet. (Choose the appropriate EDI Contract as it reflects the Client's enrollment with Medicaid - either an Individual provider type (Professional) or an Entity/Business provider type.
*	4. Medicaid Electronic Media Limited Power of Attorney (EDI Power of Attorney) Form from the Client that signed the above EDI Contract.

*These forms are available **here**.

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED.

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

PT-21
Revised 04/23

Third Party Billing Agent/Submitter
Louisiana Medicaid Registration Form

Issued: 07/12

Louisiana Medicaid Submitter # (if known)

Registering for: ☐ New Information ☐ Update to existing information ☐ Reactivation ☐ Other (Please specify): ☐ Change of Ownership (CHOW)

A Entity/Business Information & Location

"Doing Business As" Name

Area Code & Telephone # ( ) -

Street Address

City

State LA

Zip Code +4 -

Parish/County

Parish/County Code

State Status Location ☐ In-State (0) ☐ Out-of-State (1)

Location Type ☐ Urban (1) ☐ Rural (2)

B IRS Name & Mailing Address

Business Name Registered with the IRS # (MUST match the first line on the IRS document EXACTLY)

Mailing Address

Mailing City

Mailing State LA

Mailing Zip Code +4 -

IRS Reporting # -

C Contact Information

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

Contact Person:

Contact Phone # ( ) -

Contact Fax # ( ) - **Contact Email**:

D Certification of Information

I, the undersigned, certify the following

1. **The information contained herein is true, correct, and complete;**
2. **It is my responsibility to notify Provider Enrollment whenever the above information changes;**
3. **That payment of claims will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.**

Print the Name of the Authorized Representative | **Authorized Representative's Signature** | **Date of Signature MM/DD/YYYY**

Sign in blue ink only.

Louisiana Medicaid Ownership Disclosure Information

Please note: It is recommended that the Internet be used to report ownership information instead of filling out the form that follows.

- **Using the Provider Ownership Enrollment web application to report ownership data eliminates rejection of enrollment application due to improperly reported ownership data.**

To use the Provider Ownership Enrollment web application, please go to www.lamedicaid.com and click on the "Provider Enrollment" link on the left-hand sidebar. Then click on the "Applications for New Enrollments, Reactivations, and Change of Ownership" link.

- **If you use the web application to register ownership information, DO NOT complete or submit the form.**

After reporting your ownership information on the Louisiana Medicaid web site, you must print and sign the signature page that the application provides for you, and submit the signature page along with the other enrollment documents identified on the appropriate checklist to:

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

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

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

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address: **http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=%2Findex.tpl**

1) Section 100 – Purpose:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.1&idno=42

2) Section 101 – Definitions:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.2&idno=42

3) Section 102 - Determination of ownership or control percentages:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.3&idno=42

4) Section 103 – State plan requirement
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.4&idno=42

5) Section 104 – Disclosure by Medicaid providers: Information on ownership and control:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.5&idno=42

6) Section 105 - Disclosure by providers: Information related to business transactions:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.6&idno=42

7) Section 106 – Disclosure by providers: Information on persons convicted of crimes:
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=542354d38660bc5d10ec28ec5061e2b6&rgn=div8&view=text&node=42:4.0.1.1.13.2.136.7&idno=42

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 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: http://www.law.cornell.edu/uscode/42/1320a-3.html

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

MAPIL Louisiana R.S., Title 46:437.1-14. http://www.legis.state.la.us/lss/lss.asp?doc=100852

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://www.doa.louisiana.gov/osr/reg/register.htm

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

Instructions for Louisiana Medicaid Ownership Disclosure Information Entity/Business

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

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

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

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

Louisiana Medicaid Provider Number – Enter your seven (7) digit Medicaid provider number, if known. If this application is for a new Medicaid provider number, leave this field blank.
Taxpayer ID Number – Enter the nine (9) digit Tax ID number for this provider.
National Provider Identifier (NPI) – Enter your ten (10) digit National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Update to Current Enrollment, Re-Validation, Re-Enrollment or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.
Provider Type – Enter the Louisiana Medicaid Provider Type for this Entity/Business.
Primary Telephone Number(s) of Disclosing Entity/Business - Enter the area code and telephone number(s) at the street address of this Entity/Business.
Doing Business As (DBA) Name – Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the Entity/Business license.
Legal Name of Disclosing Entity/Business – Enter the legal name of the Entity/Business in the space labeled "Legal Name of Entity/Business."
Primary Disclosing Entity/Business Street Address, City, State, Zip - Enter the physical business street address of the Entity/Business requesting enrollment. Enter the city, state and zip code of the physical business street address.
Primary Disclosing Entity/Business Mailing Address/PO Box, City, State, Zip – Enter the mailing address or PO Box of the Entity/Business requesting enrollment. Enter the city, state and zip code of the mailing address.
Additional Post Office Boxes Not Identified Above – Enter any additional Post Office Boxes for the Entity/Business that are stand-alone or not associated with any business location.
Disclosing Entity/Business Telephone Number to Request Medical Records – Enter the area code and telephone number(s) that the Entity/Business uses to answer requests for medical records.
Disclosing Entity/Business Primary Fax Number – Enter the area code and fax number(s) of this Entity/Business.
Email Address of Entity/Business contact person - Enter the email address of the contact person who should receive official LDH notices.
Entity/Business Website – Enter the web address of the Entity/Business website if applicable.

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

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

C. **Identify how this disclosing Entity/Business is registered with the Internal Revenue Service – Select only 1 of the categories.** Multiple selections may result in a rejection for clarification.
Privately owned or Non-profit Providers Only – Identify the type of Entity/Business as it is registered with the Internal Revenue Service (IRS). Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of Entity/Business in the space(s) provided. Optional: May add comments in the space provided. Continue to Section II.
OR
Louisiana Government Providers Only – Identify the type of Entity/Business if Louisiana government owned. Select only one from among City and/or Parish, Department of Children and Family Services (DCFS), Office of Behavioral Health (OBH), Office of Public Health (OPH), Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), Villa, Other LDH agency, Local Education Agency (LEA), Louisiana State University (LSU), or Other State-owned entity. Check the appropriate box and complete the applicable fields.

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

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

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

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

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

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

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

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

SECTION V – OWNERSHIP INFORMATION

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

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

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

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

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

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

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

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

SECTION V(a) – INFORMATION ON ALL OWNERS

***NEW FORMAT! Please read these directions in detail*.**

A. **Individuals & Entities/Businesses with Direct Ownership** –List all individual owners or entities/businesses that have any direct stake/shareholding/ownership/ or controlling interest of 5% or greater in the disclosing Entity/Business. Add additional pages if needed.
NOTE: Section V(b) must be completed for each individual listed. Item B and Section V(c) must be completed for each entity/business listed.

B. **Individuals and Entities/Businesses with an Indirect Ownership Stake of 5% or more in the disclosing Entity/Business** –
First column: List all Entity/Business/Organizations identified in item A that have direct ownership in the disclosing Entity/Business in the first column. The disclosing Entity/Business cannot list itself as an owner.
Second column: Name all owners of the entity/business listed in the first column.
Third column: Indicate the percent of ownership each owner has in the entity/business in the first column.
Fourth column: Indicate the percent ownership each owner has in the disclosing Entity/Business. This percent of indirect ownership in the disclosing Entity/Business is determined by multiplying the percentages of ownership in e

ach entity. For example, if individual A owns 10% percent of the stock in a corporation which owns 80% of the stock in the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if individual B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.
Add additional pages if needed.
NOTE: Section V(c) must be completed for each Entity/Business listed and Section V(b) must be completed for each individual listed.

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Under Federal Regulations, a provider must disclose to the Medicaid agency, prior to enrolling, the name and address of each person who is a managing employee of the provider (General Manager, Business Manager, Administrator or other individual who exercises operational or managerial control or conducts day to day operations of the agency) as well as the name and address of any person who is an agent of the provider, which is any person with authority to obligate or act on behalf of the disclosing entity. See Federal Regulations 42 CFR § 455.106(a)(1)(2) at http://www.access.gpo.gov/nara/cfr/waisidx_01/42cfr455_01.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION VII – AUTHORIZED REPRESENTATIVES

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

Printed Name of Authorized Representative – print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.
Title/Position of Authorized Representative – indicate the Authorized Representative's relationship to the entity or business (e.g., owner, administrator, agent, managing employee, billing manager, etc.).
Signature of Authorized Representative – the authorized representative must sign the form. Signatures must be original and in blue ink (stamped signatures and initials are not accepted). Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.
Date of Signature – enter the date this agreement was signed.

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

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

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

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address**:** http://url.ie/ywri

MAPIL Louisiana R.S., Title 46:437.1-14. http://url.ie/yw45

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://url.ie/yw46

Louisiana Update January/February 2009: http://url.ie/yw47

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: http://tinyurl.com/ne58pwb

Social Security Act 1128 a: http://tinyurl.com/3lnj2z9

Provider Name: _____

LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION – ENTITY/BUSINESS

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

SECTION I – DISCLOSING ENTITY/BUSINESS PROVIDER INFORMATION

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

Taxpayer ID Number										

National Provider Identifier (NPI)										

This enrollment packet is for a

☐ New Enrollment ☐ Update to Current Enrollment ☐ Re-Validation ☐ Re-Enrollment	☐ Change of Ownership (CHOW) _____ _____ Date of CHOW MM/DD/YYYY Current Medicaid Provider Number
Provider Type:	Primary Telephone Number of Disclosing Entity/Business ( ) -

Doing Business As (DBA) Name	Legal Name of Disclosing Entity/Business		
Primary Disclosing Entity/Business Street Address	City	State LA	Zip+4
Primary Disclosing Entity/Business Mailing Address/PO Box	City	State LA	Zip+4
Additional Post Office Boxes Not Identified Above	City	State LA	Zip+4
Disclosing Entity/Business Telephone number to request medical records ( ) -	Disclosing Entity/Business Primary Fax Number ( ) -		
Email Address of Entity/Business contact person	Entity/Business Website (if applicable)		

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

If yes, complete the section below.

DBA Name of Corporate Office			
Corporate Office Street Address	City	State LA	Zip+4
Corporate Office Mailing Address/PO Box	City	State LA	Zip+4
Additional Post Office Boxes Not Identified Above	City	State LA	Zip+4
Corporate Office Phone Number ( ) -	Corporate Office Fax Number ( ) -		
Corporate Office Email address			

Provider Name: _____

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

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

☐ If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Medicaid Provider #, if applicable		
Additional Location Street Address	City	State LA	Zip +4
Additional Location Mailing Address/PO Box	City	State LA	Zip +4
Additional Post Office Boxes Not Identified Above	City	State LA	Zip +4
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State LA	Zip +4
Additional Location Mailing Address/PO Box	City	State LA	Zip +4
Additional Post Office Boxes Not Identified Above	City	State LA	Zip +4
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

DBA Name of Additional Location	Medicaid Provider #		
Additional Location Street Address	City	State LA	Zip +4
Additional Location Mailing Address/PO Box	City	State LA	Zip +4
Additional Post Office Boxes Not Identified Above	City	State LA	Zip +4
Additional Location Phone Number ( ) -	Additional Location Fax Number ( ) -		
Additional Location Email address			

Provider Name: _____

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

C. Identify how this disclosing Entity/Business is registered with the Internal Revenue Service

Select only one (1) – multiple selections may result in a rejection for clarification

Privately Owned or Non-profit Providers Only

☐ **Sole Proprietorship**

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

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

In the (current) Articles of Incorporation: How many stakeholders/individual owners are identified? _____

How many Board of Director members are identified? _____

How many officers are identified? _____

☐ **Limited Liability Corporation (LLC)**
In the (current) Articles of Organization: How many members are identified? _____

How many managing employees are identified? _____

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

Comments: _____

Louisiana Government Providers Only

☐ **CITY and/or PARISH**

☐ **DCFS**

☐ **LDH**
☐ OBH ☐ OPH
☐ OAAS ☐ OCDD
☐ Villa ☐ Other _____

☐ **LEA (Local Education Agency)**

☐ **LSU**
Hospital -_____

☐ **Other State-owned entity:** _____

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

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

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

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

Provider Name: _____

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

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

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

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

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

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

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

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

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

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

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

SECTION IV - 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):

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

Entity/Business Address	Entity/Business City	Business State	Business Zip +4
		LA	

Entity/Business Telephone Number ( ) -	Entity/Business Email Address

Additional Entity/Business Telephone Number(s) ( ) -	Additional Entity/Business Email Address(es)

Provider Name: _____

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

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

SECTION V(a) – INFORMATION ON ALL OWNERS

A. Individuals & Entities/Businesses with Direct Ownership

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

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

Individuals or Entities/Businesses with ownership	% of ownership
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

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

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

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

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

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

Provider Name: ______________________________________

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

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

A. INDIVIDUAL OWNER INFORMATION

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

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

Healthcare NPI (if applicable)

Street Address	City	State LA	Zip Code +4
Mailing Address/PO Box	City	State LA	Zip Code +4

Telephone Number - -	Email address

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

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

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

C. ☐ Yes ☐ No Is this owner a U.S. citizen? If no, provide Alien Verification ___________________________

D. ☐ Yes ☐ No Does this owner reside outside the State of Louisiana?

☐ Yes ☐ No If yes, has this owner been issued any Medicaid or Medicare provider numbers by the domicile state?
If yes, please provide the Domicile State name and Provider Numbers.

Domicile State: LA	Medicaid Provider Number:	Medicare Provider Number:
Domicile State: LA	Medicaid Provider Number:	Medicare Provider Number:

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

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

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

Provider Name: _____

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

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

Name of Individual Owner: _____

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

If yes, complete the section below for each subcontractor.

Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State LA	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State LA	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State LA	Zip Code
Telephone Number - -	Email address		
Subcontractor Business Name	Subcontractor Business Owner Name		
Subcontractor Address	City	State LA	Zip Code
Telephone Number - -	Email address		

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

If yes, complete the section below.

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

Provider Name: _____

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

Name of Individual Owner: _____

Check the appropriate yes or no box regarding the questions below.
Every item needs to have either a yes or no check.
Do not leave any blanks.

H. Has the individual owner named above (ever):

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

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. SUBMIT A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

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

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

A. ENTITY/BUSINESS OWNER INFORMATION

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

Entity/Business Street Address – Primary Location	City	State	Zip +4
		LA	
Entity/Business Mailing Address/PO Box	City	State	Zip +4
		LA	
Additional Post Office Boxes Not Identified Above	City	State	Zip +4
		LA	

Telephone Number	Fax Number
( ) -	( ) -

Email address of Entity/Business contact person	Entity/Business Website (if applicable)

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

If yes, provide the number of locations in the box to the left and complete the section(s) below for each additional location:

DBA Name of Additional Location	Tax ID Number

Additional Location Mailing Address/PO Box	City	State	Zip +4
		LA	
Additional Location Street Address	City	State	Zip +4
		LA	
Additional Post Office Boxes Not Identified Above	City	State	Zip +4
		LA	

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

Additional Location Email address

DBA Name of Additional Location	Tax ID Number

Additional Location Mailing Address/PO Box	City	State	Zip +4
		LA	
Additional Location Street Address	City	State	Zip +4
		LA	
Additional Post Office Boxes Not Identified Above	City	State	Zip +4
		LA	

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

Additional Location Email address

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

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

Name		Tax ID	
Name		Tax ID	
Name		Tax ID	

Provider Name: ______________________________________

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

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

Name of Entity/Business Owner: ____

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

Subcontractor Business Name		Subcontractor Business Owner Name		
Subcontractor Address	City		State LA	Zip Code +4
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address	City		State LA	Zip Code +4
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address	City		State LA	Zip Code +4
Telephone Number - -	Email address			
Subcontractor Business Name	Subcontractor Business Owner Name			
Subcontractor Address	City		State LA	Zip Code +4
Telephone Number - -	Email address			

E. ☐ **Yes** ☐ **No** **Is this Entity/Business and Tax ID currently listed in Section I currently enrolled in a Federal/State Funded healthcare program?**
If yes, complete the section below.

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

Provider Name: _____

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

Name of Entity/Business Owner: _____

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

IF 'YES' IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

Provider Name: _____

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

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

List all AGENTS and INDIVIDUALS who are part of management.

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

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

Provider Name: _____

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

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

A. ☐ AGENT– or – ☐ MANAGING EMPLOYEE

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

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

Mailing Address/PO Box	City	State	Zip Code +4
		LA	
Physical Address	**City**	**State**	**Zip Code +4**
		LA	

Telephone Number - -	Email address

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

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

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

C. ☐ Yes ☐ No Is this agent or managing employee a U.S. citizen? If no, provide Alien Verification # _____

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

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 F below**

Name of Agent or Managing Employee: _____

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

IF YES IS ANSWERED TO ANY QUESTION LISTED ABOVE:

1. PROVIDE A WRITTEN STATEMENT PROVIDING THE DETAILS ON ALL OCCURRENCES.

2. ATTACH ALL OFFICIAL LEGAL DOCUMENTS REGARDING THE OCCURRENCE, INCLUDING ANY REINSTATEMENTS.

F. ☐ Yes ☐ No Does this agent or managing employee have ownership or controlling interest in any other Entity/Business participating in a Federal/State Funded healthcare program?
If yes, complete the section below.

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

Provider Name_____

SECTION VII – AUTHORIZED REPRESENTATIVES

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

Note: Every person listed below must be disclosed in the Disclosure of Ownership forms.

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

Please sign in blue ink (not black)

Printed Name of Authorized Representative

Signature of Authorized Representative
(sign in blue ink)

Title/Position

Date of Signature MM/DD/YYYY

SECTION VIII – PROVIDER SIGNATURE

With my signature below, I attest:

1. That the provider has disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7. That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(b)(1).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(b)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US.
13. The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14. The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
15. The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16. The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation.
18. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

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

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

INSTRUCTIONS

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

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

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

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Gainwell. (Leave blank if applying for new Provider Number.) **National Provider Identifier (NPI)** – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.

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

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

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

Contact Phone Number – enter the phone number of Contact Person.

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

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

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

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

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

Entity/Business Medicaid Electronic Media Limited Power of Attorney (EDI Power of Attorney)—submit only if provider will be using a Third Party Biller or Clearinghouse

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Gainwell. (Leave blank if applying for a new Provider Number.) **National Provider Identifier (NPI)** – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.

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

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

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

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

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

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

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

Enter City, State and Date of Notarization

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

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

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

If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized. Please complete the enclosed *MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY (EDI POWER OF ATTORNEY)* in its entirety to be mailed with your completed EDI Contract.

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

Louisiana Medicaid Provider Number (7 digits)

4	**5**	**0**				

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

National Provider Identifier (NPI) (10 digits)

DBA Name of Enrolling Business/Entity: _____

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

Name of Contact Person: _____

Contact Phone Number: ( ) -

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 Lousiana Medicaid to gather this information, complete the following, if applicable:

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

4	5	0				

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

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

4	5	0				
4	5	0				

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

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

1. The providers attest that all information supplied with this Agreement is true, accurate and complete.
2. On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 17 below. This is done in consideration for the Louisiana Department of Health (LDH), Bureau of Health Services Financing's (BHSF) processing of provider claims, as well as other valuable considerations.
3. All published specifications set forth shall be met as to every entry sought to be processed. The effective date for EDI submission will be set by Provider Enrollment once the contract has processed.

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

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

PT-21
(Revised: 5/2023)

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

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

Louisiana Medicaid Provider Number (7 digits)	Submitter Number (7 digits) (leave blank if applying for new number) — **4 5 0**
National Provider Identifier (NPI) (10 digits)	Billing / Submitter Agent Business Name:
Doing Business As Name of Enrolling Entity (Provider Name):	Billing / Submitter Agent Contact Person:
Business/Practice Address:	Billing / Submitter Agent Phone Number: ( ) -

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 for the provider type for magnetic tape, diskette, or telecommunication submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

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

Signature of Authorized Representative

Notary Public Signature

Print Name of Authorized Representative

Notary Seal or Notary Identification Number (required)