PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

PHARMACY

(Enrollment packet is subject to change without notice.)

Pharmacy

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
All Providers	
*	1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
*	2. PE-50 Addendum – Provider Agreement Form (three pages).
*	3. Medicaid Direct Deposit (EFT) Authorization Agreement Form.
*	4. Louisiana Medicaid Ownership Disclosure Information Forms.
*	5. **(If submitting claims electronically)** 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). **NOTE: The EDI forms are only required if the Pharmacy will be processing claims for Durable Medical Equipment (DME) services.**
	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. Copy of Pharmacy license issued by the Louisiana Board of Pharmacy. **(In-state providers only)**
	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 87 (Other).
**	10. Point-of-Sale Forms (7 pages).
Out-of-State Providers (Additional Document Requirements)	
**	11. Out-of-State Pharmacy Enrollment Amendment (two pages).
	12. Submit justification that supports the criteria selected on the Out-of-State Pharmacy Enrollment Amendment.
	13. If applying for Medicare Crossovers, the provider must be enrolled with Medicare prior to requesting enrollment with Louisiana Medicaid.
	14. Copy of Nonresident Louisiana Pharmacy Permit.

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

Provider Name	Provider # (for Gainwell Use only)

POINT-OF-SALE CERTIFICATION

I certify that all Point-of-Sale (POS) claims are rendered by a legally qualified person, that the charge is within the Louisiana Department of Health's prescription package policy, and that the payment has not been previously received.

I have retrieved the online Provider Manual at www.lamedicaid.com, have read and understand all published regulations, Prescription Drug Services Manual and Provider Updates concerning pharmaceutical payments and agree that all POS services adhere to all requirements.

I also agree to keep such records as are necessary or required to disclose fully the extent of POS services provided to individuals under the State's Title XIX plan and to furnish all information regarding any payments claimed for providing such POS services as the Louisiana Department of Health or the Medicaid Fraud Control Unit may request for five (5) years from the date of services.

With my signature below, I attest that I am an authorized representative of this entity and, as such, have the authority to enter into a provider agreement with Louisiana Medicaid.

According to the Medical Assistance Program Integrity Law (MAPIL) cited as La. R.S. 46:437, I will notify Louisiana Medicaid Provider Enrollment prior to any change in ownership.

I understand that payment and satisfaction of the claims will be from federal and state funds and that any false or misleading claim statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

ALL SIGNATURES MUST BE ORIGINAL AND IN BLUE INK.

Authorized Representative (print)	Authorized Representative Title
Authorized Representative Signature	Date of Signature
Pharmacist-in-Charge Signature	PIC License Number

(If the provider is a corporation or partnership, a statement certifying the above authorized representative must be attached to the POS Certification and Enrollment Amendment)

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

Provider Name	Provider # (for Gainwell Use only)

STATE OF LOUISIANA
MEDICAID PHARMACY POINT-OF-SALE AGREEMENT

This Pharmacy Point-of-Sale (POS) Agreement (hereinafter Agreement), made and entered into this ________ day of ________________, 20 ____, by and between the Louisiana Department of Health (hereinafter Agency), acting in its own right as the Agency responsible for administering the Medical Assistance Program (Title XIX of the Social Security Act) In and by ________________________________(hereinafter Provider).

In consideration of the mutual promises and covenants contained herein and other good and valuable consideration, the pharmacy agrees to provide said services in accordance with the following terms and conditions.

1. This Agreement is in addition to the Provider Enrollment Application between the Agency and Provider, including, but not limited to the right of the Agency or its representatives to perform audit functions or the requirement that the Provider maintain the original prescription on file.

2. Provider shall submit to the Agency, through the fiscal agent (hereinafter Agent), for Louisiana Medicaid, via a POS device, claims for prescriptions dispensed to Louisiana Medicaid beneficiaries.

3. The Provider shall safeguard the Medicaid program against abuse in its utilization of claims entry through the POS system.

4. The Provider shall correctly enter the claims data, monitor the data, and certify that the data entered is correct.

5. The Provider shall reverse any claim which is adjudicated (submitted for payment) and then not dispensed to a Medicaid beneficiary.

6. The Provider shall allow the Agency access to claims data and assure that transmission of claims data is restricted to authorized personnel so as to preclude erroneous payment by the Agent resulting from carelessness or fraud.

7. The Provider shall allow the Director of the Agency or any of its designees and representatives of the Office of the Attorney General Medicaid Fraud Control Unit to review and copy all records free of charge.

8. The Provider shall abide by all Federal and State statutes, rules, regulations and manuals and provider updates governing the Louisiana Medicaid Program and those conditions as set out in the State of Louisiana, Department of Health Medicaid Provider Agreement entered into previously.

9. The Provider agrees to charge no more for Medicaid services than is charged to the general public.

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

Authorized Representative (print)	Authorized Representative Title
Authorized Representative Signature	Date of Signature

(If the provider is a corporation or partnership, a statement certifying the above authorized representative must be attached to the POS Certification and Enrollment Amendment)

Provider Name	Provider # (for Gainwell Use only)

PHARMACY POINT-OF-SALE AMENDMENT

INDEPENDENT PHARMACY OWNERSHIP INFORMATION

(Less than 10 Medicaid enrolled pharmacies under common ownership)

Summary of Ownership Information
*If the pharmacy is owned by a corporation, please list the individual owners of the corporation and their percentage of interest in the corporation.

Owner Name	% Ownership

Please note that if there has been a 50% or more change in ownership since the Board of Pharmacy issued your original permit, a new Board of Pharmacy permit and Louisiana Medicaid provider number are required!

(Please attach additional pages if needed.)

Owner Contact Information

Owner 1
Name ______________________ Phone ______________________
Address ______________________ Fax ______________________
City, State, Zip ______________________ Email ______________________

Owner 2
Name ______________________ Phone ______________________
Address ______________________ Fax ______________________
City, State, Zip ______________________ Email ______________________

Owner 3
Name ______________________ Phone ______________________
Address ______________________ Fax ______________________
City, State, Zip ______________________ Email ______________________

Owner 4
Name ______________________ Phone ______________________
Address ______________________ Fax ______________________
City, State, Zip ______________________ Email ______________________

Owner 5
Name ______________________ Phone ______________________
Address ______________________ Fax ______________________
City, State, Zip ______________________ Email ______________________

Provider Name	Provider # (for Gainwell Use only)

PHARMACY POINT-OF-SALE AMENDMENT

CHAIN PHARMACY OWNERSHIP INFORMATION

(10 or more Medicaid enrolled pharmacies under common ownership)

Corporate Information:

Corporate Name	
Address 1	
Address 2	
City	
State	
Zip	

Financial Contact:

Name	
Phone	
Fax	
Email	

Provider Name	Provider # (for Gainwell Use only)

PHARMACY POINT-OF-SALE AMENDMENT

LA Pharmacy Permit # ______________________ *PLEASE ATTACH A CURRENT COPY OF THE PERMIT*

*Out-of-state pharmacies that DO NOT mail or deliver to the state of Louisiana - please submit the pharmacy permit of your home state.

**Out-of-state pharmacies that DO mail and/or deliver to the state of Louisiana - please submit copies of both your Louisiana permit and the permit of your home state.

Medicare # ______________________ Tax ID # ______________________

NPI # ______________________ NCPDP # ______________________

Contact Information

Store Phone ______________________ Store Fax ______________________

Store Email ______________________ Disaster Phone ______________________

Physical Address	Billing Address	Mailing Address

Services Provided (check all that apply):

Retail	IV Therapy	Group Home	Nursing Home	Specialty	Compound
	IV Exclusive	Group Home/ICF/IID	Nursing Home Exclusive	Specialty Exclusive	Compound Exclusive

Please list below all nursing homes, group homes, ICF/IID facilities that your pharmacy services:

Facility 1

Name ______________________ Approx. # Medicaid Beneficiaries ______________________

Address ______________________ Consultant PD ______________________

City, State, Zip ______________________

Facility 2

Name ______________________ Approx. # Medicaid Beneficiaries ______________________

Address ______________________ Consultant PD ______________________

City, State, Zip ______________________

Facility 3

Name ______________________ Approx. # Medicaid Beneficiaries ______________________

Address ______________________ Consultant PD ______________________

City, State, Zip ______________________

Facility 4

Name ______________________ Approx. # Medicaid Beneficiaries ______________________

Address ______________________ Consultant PD ______________________

City, State, Zip ______________________

Provider Name	Provider # (for Gainwell Use only)

PHARMACY POINT-OF-SALE AMENDMENT

In the past twelve (12) months, has there been a change of ownership for your pharmacy?

Yes (attach Disclosure of Ownership Information) No

Please list ownership interest in any other pharmacies. (Attach additional pages if necessary)

Not applicable

Owner Name	Pharmacy Name	Pharmacy Address	Medicaid Provider #

340 B

☐ Yes ☐ No Is the Medicaid Provider number listed above a 340 B contracted pharmacy?

If yes, does your pharmacy carve out Medicaid beneficiaries? ☐ Yes ☐ No

(Medicaid policy does not allow 340 B contract pharmacies to submit 340 B claims.)

Technology / Services Provided

Software Vendor ________________________ Electronic Switch Vendor ________________________

☐ Yes ☐ No Does your pharmacy use Bar Code technology to scan drugs before being dispensed / filled?
☐ Yes ☐ No Does your pharmacy provide drugs via mail order if requested by the beneficiary?
☐ Yes ☐ No Does your pharmacy provide a delivery service?
☐ Yes ☐ No Is your pharmacy capable of accepting electronic prescriptions (excluding faxes)?
☐ Yes ☐ No Is your pharmacy associated with the sole distribution of a drug?

If yes, please list:____

Percentage of Business

__________ Approximately what percentage of your total business is Fee for Service Medicaid?

__________ Approximately what percentage of your total business is Medicaid Managed Care Organizations (Aetna Better Health, AmeriHealth Caritas, Healthy Blue, Humana Healthy Horizons, Louisiana Healthcare Connections, and United Healthcare Community Plan)?

__________ What is the total number of prescriptions dispensed during the prior State Fiscal Year (July – June) (including Medicaid, cash, and other payors)?

Wholesalers

Please list the wholesaler(s) your pharmacy uses. MUST BE COMPLETED.

1. ________________________
2. ________________________
3. ________________________

Store Hours

Monday-Friday	am	to	pm	closed		Other (ex. 24 hr? available prn?) Please explain:
Saturday	am	to	pm	closed		
Sunday	am	to	pm	closed		

Provider Name	Provider # (for Gainwell Use only)

PHARMACY POINT-OF-SALE AMENDMENT

Employee Information

Please provide full-time and part-time employee information that is current as of today's date. Attach additional pages as needed.

Pharmacist in Charge

Name		Board of Pharmacy License #	
Pharmacist Medicaid #		Pharmacist NPI #	
Medication Admin Registration #		Disease State Certification # & Date of Certification	

Pharmacist 1

Name		Board of Pharmacy License #	
Pharmacist Medicaid #		Pharmacist NPI #	
Medication Admin Registration #		Disease State Certification # & Date of Certification	

Pharmacist 2

Name		Board of Pharmacy License #	
Pharmacist Medicaid #		Pharmacist NPI #	
Medication Admin Registration #		Disease State Certification # & Date of Certification	

Pharmacist 3

Name		Board of Pharmacy License #	
Pharmacist Medicaid #		Pharmacist NPI #	
Medication Admin Registration #		Disease State Certification # & Date of Certification	

Pharmacist 4

Name		Board of Pharmacy License #	
Pharmacist Medicaid #		Pharmacist NPI #	
Medication Admin Registration #		Disease State Certification # & Date of Certification	

Pharmacy Technicians

Name	Board of Pharmacy License #

Remittance Advice Reviewer

Name	
Title	
Phone	
Fax	
Email	

Provider Name: ___________________________________

OUT-OF-STATE PHARMACY ENROLLMENT AMENDMENT

Louisiana Medicaid will not routinely enroll an out-of-state pharmacy. There are set criteria that must be met for an out-of-state pharmacy to be enrolled in Louisiana Medicaid.

Enrollment Criteria

Please indicate the reason(s) for requesting enrollment in Louisiana Medicaid and submit the documentation indicated:

Out-of-state Pharmacy providers will be allowed continuous Medicaid enrollment for Crossover claims if the out-of-state enrollment criteria is not met. The out-of-state pharmacy must be enrolled in Medicare prior to enrolling in Louisiana Medicaid. When enrolling in the Medicaid program, the out-of-state Pharmacy must indicate that crossover billing is requested and submit a copy of their Medicare certification letter. This is # 1 below.

If services are provided to a Louisiana Medicaid beneficiary in accordance with the criteria 2 and 3 detailed below, the pharmacy provider will be allowed to obtain a Medicaid provider number to secure payment of the claim. However, this Medicaid provider number will only be active to finalize the claim at issue, not to allow the out-of-state pharmacy to maintain continuous and active enrolled provider status. In no event can an out-of-state Medicaid provider number be active for more than thirteen months to secure payment of a single claim.

Continuous enrollment will be allowed with the criteria 4 and 5 detailed below when services are not available in Louisiana or by a previously enrolled provider.

1. To receive reimbursement for Medicare crossover claims. Submit a copy of the Medicare Certification eligibility notice.

2. It is the general practice for residents of a particular locality to use medical resources in the medical trade areas outside the state (Please indicate appropriate state and county codes on PE-50 page 1).

3. The health of the beneficiary would be endangered if he undertook travel or if care and services are postponed until he/she returns to the state of Louisiana. Submit a letter explaining / describing the care, service, or resource in detail.

4. Services or supplementary resources rendered that were not / are not available in Louisiana. Submit a letter explaining / describing the care, service, or resource in detail.

5. Prescriptions filled on an emergency basis due to an accident or illness. Submit a letter explaining / describing the care, service, or resource in detail.

Beneficiary Verification

This information will be used to verify that the beneficiary was enrolled in Louisiana Medicaid at the time the services were rendered and to help determine if the services provided meet the out-of-state enrollment criteria.

Beneficiary Name	Beneficiary Medicaid ID #	Date of Service

Provider Name: ___________________________________

OUT-OF-STATE PHARMACY ENROLLMENT AMENDMENT

Authorized Representative (print)	Authorized Representative Title
Authorized Representative Signature	Date of Signature

Original Signatures Required – Please Do NOT Use Black Ink

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