PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Dental
(Group)

(Enrollment packet is subject to change without notice.)

Dental – Group

REQUIRED DOCUMENTS FOR ENROLLMENT

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

*Form is included in the **Basic Enrollment Packet for Entities/Businesses**.

**Form is included in this packet.

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

Original Signatures Required – Please Do NOT Use Black Ink

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

GENERAL ENROLLMENT GUIDELINES
IN THE LOUISIANA MEDICAID PROGRAM
DENTAL GROUPS AND INDIVIDUAL DENTIST

General Information: A dentist must enroll as a Louisiana Medicaid dental provider in order to receive reimbursement from the Medicaid Program for dental services performed on eligible Medicaid recipients. Individual dentists not enrolled in the Louisiana Medicaid program may not use the name and/or provider number of an enrolled dentist in order to bill Medicaid for services rendered.

Dental Groups: For Louisiana Medicaid purposes, a dental group consists of two or more dentists offering dental services to the Louisiana Medicaid recipient population. Dental groups must be enrolled in the Louisiana Medicaid program prior to rendering services to a Medicaid recipient.

Dental groups must complete an enrollment packet for the group, which includes information for the group as well as the individual dentists comprising the group.

When billing, the group must bill for services rendered by the individual providers using the group name and group provider number. On these claims, the individual dentist's provider number would be entered as the attending dentist on the claim form. The attending dentist must sign and date the claim form. Dentists should use the American Dental Association claim form when billing Medicaid for services rendered.

A dentist, using his individual provider number, cannot bill the Louisiana Medicaid program for services rendered under a group that is enrolled in the Louisiana Medicaid program. If the group chooses not to enroll as a Louisiana Medicaid provider, the individual dentist must enroll and bill the Medicaid program for services performed in the group using the individual provider number.

Individual Dentists: The Louisiana Medicaid Program will assign only one provider number per individual provider type. For this reason, an individual dentist may have only one "Pay To" address regardless of the number of locations where individual services are rendered. For example, if an individual dentist practices at multiple locations, Medicaid payments will be sent to only one address for all services provided.

However, if an individual dentist practices with an enrolled group and maintains a private practice, the group must bill for services performed in the group setting and the individual dentists must bill for services rendered in the private practice. This is the only situation in which payment for services provided by one dentist would be made to more than one address. Payment would be made to the group at its address and to the individual dentist at the private address.

ALL CHANGES OF ADDRESS, GROUP AFFILIATION, CONTRACT STATUS, ETC. MUST BE REPORTED IN WRITING TO:

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159
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Louisiana Medicaid
Group Link/Unlink and Working Relationship Form

PURPOSE

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

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

WORKING RELATIONSHIP AGREEMENT

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

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

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
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225-216-6370