PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

PSYCHOLOGIST

(Enrollment packet is subject to change without notice.)

PSYCHOLOGICAL SERVICES UNDER MEDICAID

PLEASE REVIEW THIS PAGE TO DETERMINE WHAT TYPE OF PSYCHOLOGICAL SERVICES FOR WHICH YOU WISH TO ENROLL BEFORE PROCEEDING WITH THE APPLICATION PROCESS.

Psychological services under the Medicaid program are available to eligible Medicaid beneficiaries under the following programs:

1) **Medicare "Cross-Over" Claims**
   These services are provided to individuals who are dually eligible for both Medicare and Medicaid.

2) **Residential Option Waiver (ROW)**

PSYCHOLOGIST

REQUIRED DOCUMENTS FOR ENROLLMENT

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

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

Completed	Document Name
☐ *	1. Individual 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. **(If requesting new submitter number)** EDI Annual Certification Of Electronically-Submitted Medicaid Claims Form.* (not required for crossovers only).
☐	7. 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**).
☐	8. 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**).
☐	9. Copy of current medical license from governing license board of your profession. If requesting retroactive coverage, a license must be submitted that covers that time period. A temporary permit is only good until the expiration date.
☐	10. To prescribe Buprenorphine and/or Buprenorphine-Naloxone containing products, copy of Controlled Substance Registration Certificate showing the DEA number. (Otherwise, prescriptions for these products will not be payable in the Pharmacy program)
☐	11. To report **"Specialty"** for this provider type on Section A of the PE-50, enter one of the following: 62 Medicare Crossover Only or 4W ROW
☐	12. Report the following "**Subspecialty"** in Section A of the PE-50 of the Enrollment form, if applicable: 6G Medical Psychologist
☐	13. If enrolling to provide ROW services, the Provider Verification for ROW Services Form (included in this packet) is to be notarized and mailed to OCDD. Verification of OCDD's approval is required prior to enrollment.

For Group Linkages:

☐ **	14. Group Link/Unlink and Working Relationship Form. Must complete number of working hours per week on this form.

Original Signatures Required – Please Do NOT Use Black Ink

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

Louisiana Medicaid
Group Link/Unlink and Working Relationship Form

PURPOSE

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

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

WORKING RELATIONSHIP AGREEMENT

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

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

Original Signatures Required – Please Do NOT Use Black Ink

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

Provider Verification for ROW Services

PURPOSE

This form confirms that the individual specified below wishes to provide ROW Services to Louisiana Medicaid beneficiaries, and attests that the individual has provided paid services to person(s) with developmental disabilities through the OCDD program for a minimum of one year as a Dietician, Occupational Therapist, Physical Therapist, Psychologist, Speech Therapist, or Social Worker.

Individual Provider Number:	**LA Medicaid Provider #** (leave blank if new applicant) ☐☐☐☐☐☐☐	**National Provider Identifier (NPI)** ☐☐☐☐☐☐☐☐☐☐
Individual Provider Name:		
Physical Address:		
Professional Category (choose one):	Dietician ☐ OT ☐ PT ☐ PSY ☐ ST ☐ SW ☐	
Contact Person for questions regarding this form:		
Contact Person Phone Number:		

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct, and
- that I can receive reimbursement for services provided only to those persons within the Residential Options Waiver (ROW), and
- that all Professional Services provided to ROW participants must be prior authorized before services are rendered, and
- that as a Professional providing services to ROW participants, I have one year paid experience working with people with developmental disabilities as outlined in the ROW Provider Manual, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____, State of

on the ____ day of _____, 20 ____.

_____ _____

Print Individual Provider's Name | Notary Public Signature

_____

Individual Provider's Signature

Notary Seal or Notary Identification Number (required)

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