# PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

## (Louisiana Medicaid Program)

## Podiatrist (Individual)

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

# GENERAL INFORMATION FOR THE INDIVIDUAL PODIATRIST PROVIDER TYPE

Individual Podiatrists may link to the following groups (as long as the group has a Louisiana Medicaid entity/business type Provider Number):

- **Podiatrist Group**
- **Professional Services Group**
- **Rural Health Clinic (RHC)**
- **Federally Qualified Health Clinic (FQHC)**

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

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

The number of groups a professional individual can link to is limited. It is very important that all professional individuals terminating their relationship with a group notify Provider Enrollment. Provider Enrollment can then unlink the professional individual from the specified group, allowing the professional individual to be linked to other groups in the future.

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

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

# Podiatrist – Individual

## 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. 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 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. |
| ☐ ** | 9. OFS Form 24, if applicable. |
| ☐ | 10. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 48 (Podiatrist). |

**For Group Linkages:**

| | |
|---|---|
| ☐ ** | 11. Completed Group Link/Unlink and Working Relationship Form. Must complete number of working hours per week on this form. |

**Out of State Enrollment:**

| | |
|---|---|
| ☐ | 12. Submit an original claim with the application for the initial date of service. This claim must meet timely filing guidelines. Subsequent claims must be submitted directly to Gainwell claims processing once the provider has received confirmation via mail of successful enrollment in Louisiana Medicaid. |

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

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

# STATE OF LOUISIANA
# DEPARTMENT OF HEALTH

Dear Provider:

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

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

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

The OFS Form 24 requirements only pertain to: 1) Those participating practitioners who own or lease laboratory or diagnostic testing equipment located in their office or place of practice and 2) The practitioners submit claims to the Medicaid program.

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

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

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

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

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

Sincerely,

Provider Enrollment Unit

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

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

**NPI (10 digits):** ☐☐☐☐☐☐☐☐☐☐

**Provider Name:** _____

**Provider Address:** _____

**Diagnostic and/or Laboratory Equipment**

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

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

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

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

Signature of Authorized Representative: _____

Print Name of Authorized Representative: _____

Date of Signature: _____

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

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

# Louisiana Medicaid
# 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**