PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Physical Therapist (Group)

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION FOR THE PHYSICAL THERAPIST GROUP PROVIDER TYPE

Two or more Physical Therapists working together, providing services for 20 or more hours per week, may enroll as a Physical Therapist Group with Louisiana Medicaid.

Only a Physical Therapist may link to Physical Therapist Groups.

- **Physical Therapist Assistants may NOT enroll in Medicaid.**

Linkages of Physical Therapist Individuals to Groups – a physical therapist's individual provider number can be "linked" to a group provider number for purposes of billing as an attending provider for the specified group.

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

Claims submitted under the group number, with an individual physical therapist'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.**

When an 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 for this individual.

Physical Therapist – 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**.

**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. 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 Physical Therapist 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

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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