PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid)

Physical Therapist (Individual)

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION

Provider Enrollment works on a three-week turnaround time frame. If enrollment requirements are not met, the entire application will be returned for correction and would need to be re-submitted once the corrections are made. Any re- submission of the enrollment packet is subject to an additional three-week turnaround period.

No billing for 18 months will result in an automatic closure of this provider number, which will require a new enrollment application in order to be re-activated. No notification will be sent to the provider regarding the automatic closure.

Physical Therapy Assistants are not eligible to enroll in Louisiana Medicaid.

Individual Physical Therapist and Therapy Groups may enroll in Medicaid. Therapist may bill as individual therapist or they may link to the following provider groups/ provider types (as long as the group has a Louisiana Medicaid business/entity provider number):

- Federally Qualified Health Centers
- Rural Health Clinics
- Shared Living – PT11 (Provider Verification for Wavier services required)
- Substitute Family Care – PT84 (Provider Verification for Wavier services required)

If a professional Individual is linking to an Entity/Business as an 'Attending' only (not being paid individually by Medicaid), then the EDI Contract, Direct Deposit Form, and voided check are not required.

Early Steps Provider Enrollment:
Individual Physical Therapist enrolling as an Early Steps Provider refer to the PT 29 – Early Steps Provider Type Specific Checklist/Packet.

ATTENTION!!

Providers are required to comply with all requirements contained in:

1. The provider manuals located at:

https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

And

2. The information located on the LDH/OCDD website at

https://ldh.la.gov/index.cfm/subhome/11/n/8

Physical Therapist

CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Gainwell Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Individual Physical Therapist provider:

Completed	Document Name
*	1. Completed Individual Louisiana Medicaid PE-50 Provider Enrollment Form.
*	2. Completed PE-50 Addendum – Provider Agreement Form (two pages).
*	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
*	4. Completed Louisiana Medicaid Ownership Disclosure Information Form for Individual.
*	5. If submitting claims electronically - Completed 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. Printout of the online license verification from the governing license board of your profession. This verification must contain the license numbers, the effective date of issuance, and the current status of the license. A temporary permit is only good until the expiration date.
	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 65 (Physical Therapy).

For Group Linkages:

**	10. Completed Link/Unlink and Working Relationship Form.

For ROW Services:

**	11. Completed Link/Unlink and Working Relationship Form.
**	12. Provider Verification Form for ROW Services.
	13. To report "Sub-specialty" for this provider type on Section A of the PE-50 please use Code 4W (Waiver Services).

For Children's Choice Waiver Services:

**	14. Provider Verification Form for Children's Choice Waiver Therapy Services.
	15. To report "Subspecialty" for this provider type on Section A of the PE-50, select all services you will provide of the following Subspecialty codes: Aquatic Therapy (7R), Art Therapy (7T), Music Therapy (7V), Art and Music Therapy (7U), Sensory Integration (7X), Therapeutic Horseback Riding (7Y), and/or Hippotherapy (7Z)
	16. Submit a copy of the appropriate certification that supports the Subspecialty chosen from # 15 above.

*These forms are available in the **Basic Enrollment Packet for Individuals**.

**These forms are included here.

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT. ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS)

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

Revised 5/23

Louisiana Medicaid
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:	MM/DD/YYYY	☐ UNLINK	Termination Date:	MM/DD/YYYY
Approximate Number of Hours Worked at this Group Per Week, if linking. **(required)**					
Professional Group Name:					
Professional Group Provider Number:	LA Medicaid Provider #		National Provider Identifier (NPI)		
☐ LINK	Effective Date:	MM/DD/YYYY	☐ UNLINK	Termination Date:	MM/DD/YYYY
Approximate Number of Hours Worked at this Group Per Week, if linking. **(required)**					
Contact Person for questions regarding this form:					
Contact Person Phone Number:	( ) -				

WORKING RELATIONSHIP AGREEMENT

I am a medical professional who has a 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 DHH a copy of the written contractual agreement.)

Print Individual Provider's Name **Individual Provider's Signature** **Date** **MM/DD/YYYY**

Original signature only – colored ink (please don't use black ink)

Mail Completed Forms To: Gainwell Technology Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159

Provider Verification for Children's Choice Waiver Services

PURPOSE

This form confirms that the individual specified below wishes to provide Children's Choice Waiver Services to Louisiana Medicaid recipients, 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 Occupational Therapist, Physical Therapist, Speech Therapist, Psychologist, and Certified Behavioral Analyst.

Additional documentation/ credentials required for Therapy Services: Certification/ Registration as Art Therapist, Certification/Registration as Aquatic Therapist, Certification/ Registration as Music Therapist, Certification/ Registration as Hippo Therapist, Certification/ Registration in Therapeutic Horseback Riding, Certification/ Registration in Sensory Integration, Psychologist Certification/ Registration in Applied Behavioral Analysis –based Therapy, Certified Behavioral Analyst with Certification/ Registration in Applied Behavioral Analysis –based Therapy.

Individual Provider Number:	**LA Medicaid Provider #** (leave blank if new applicant)	**National Provider Identifier (NPI)**
Individual Provider Name:		
Physical Address:	LA	
Professional Category (choose one):	OT ☐ PT ☐ ST ☐ PSY ☐ CBA ☐	
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 Children's Choice Waiver (CCW), and
- that all Professional Services provided to Children's Choice Waiver (CCW) participants must be prior authorized before services are rendered, and
- that as a Professional providing services to Children's Choice Waiver (CCW) participants, I have one year paid experience working with people with developmental disabilities as outlined in the Children's Choice Waiver (CCW) 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

Original signature only – colored ink (please don't use black ink)

Notary Seal or Notary Identification Number (required)

Complete this form in its entirety and mail the original to:

Gainwell Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159

Provider Verification for ROW Services

PURPOSE

This form confirms that the individual specified below wishes to provide ROW Services to Louisiana Medicaid recipients, 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:	LA	
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

Original signature only – colored ink (please don't use black ink)

Notary Seal or Notary Identification Number (required)

Complete this form in its entirety and mail the original to:

Gainwell Provider Enrollment Unit PO Box 80159, Baton Rouge, LA 70898-0159