# PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

## (Louisiana Medicaid Program)

## Speech Therapist (Group)

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

# GENERAL INFORMATION FOR THE SPEECH THERAPIST GROUP PROVIDER TYPE

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

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

**Linkages of Speech Therapist Individuals to Groups** – a speech 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 speech therapist individual providers require only the Group Link/Unlink and Working Relationship Form**
- **New, Inactive, or Closed speech 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 speech 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.

# Speech 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. 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. 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 Speech 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 Link/Unlink and Working Relationship Form

Copy this form for additional space as needed.

***PURPOSE***

This form allows one individual to link to and/or unlink from two (2) separate entities/businesses.
This form also serves as documentation that a working relationship exists between an Individual and an Entity.

| | | | |
|---|---|---|---|
| Individual Provider Name: | | | |
| Individual Provider Number | LA Medicaid Provider # | National Provider Identifier (NPI) | |
| Entity Name: | | | |
| Entity 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) | | | |
| Entity Name: | | | |
| Entity 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 contractual agreement to see patients for the above-identified entity(s). I recorded the approximate number of hours working per week for the entity(s) identified 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 of Signature**

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

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