PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Speech Therapist (Individual)

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION

Non active billing will result to deactivation of the Medicaid provider number. To be reinstated, a provider must meet all enrollment requirements

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

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

- Speech Therapist Groups
- Federally Qualified Health Centers
- Rural Health Clinics
- American Indian/Native Alaskan "638" Facilities
- 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 Speech Therapists enrolling as an Early Steps Provider refer to the PT 29 – Early Steps Provider Type Specific Checklist/Packet.

GENERAL POLICY INFORMATION

Waiver service providers are required to comply with both policy and program requirements located on the Louisiana Department of Health (LDH) Office for Citizens with Developmental Disabilities (OCDD) website and the Louisiana Medicaid provider manuals linked below.

Louisiana Medicaid Provider Manuals located at:
https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm

LDH/OCDD website: at
https://www.ldh.la.gov/OCDD

Please note Louisiana Medicaid will not reimburse you for waiver services provided to participants who are not enrolled in one of the waiver programs.

Speech Therapist - 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**.
**Form is included here.

Completed		Document Name
☐	*	1. Individual Louisiana Medicaid PE-50 Provider Enrollment Form.
☐	*	2. PE-50 Addendum – Provider Agreement Form (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. 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 71 (Speech Therapy).

For Group Linkages:

☐	**	10. Group Link/Unlink and Working Relationship Form.

For ROW Services:

☐	**	11. Group 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 "Sub-specialty" for this provider type on Section A of the PE-50, select all services you will provide of the following Subspecialty codes: Therapeutic Horseback Riding (7Y) and/or Hippotherapy (7Z).
☐		16. Submit a copy of the appropriate certification that supports the Subspecialty chosen from #15 above.

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

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

225-216-6370

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 Hippotherapist, 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:		
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 service 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

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

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:		
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 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:
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PO Box 80159
Baton Rouge, LA 70898-0159
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