PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Rehabilitation Center

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION
FOR PROVIDER ENROLLMENT

PT 65 - Rehabilitation Centers may only enroll in Louisiana Medicaid (Fee-For-Service) if they are enrolled with Medicare as a Rehabilitation Agency or a Comprehensive Outpatient Rehabilitation Facility (CORF).

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

Upon completion of the Medicaid enrollment process, providers will automatically be added to the Freedom of Choice listing in a web-based program called Provider Locator Tool. This enables public users to search for Medicaid and/or Home and Community Based Service providers who accept Louisiana Medicaid.

Providers enrolled as type 65 (Rehabilitation Center) are allowed to provide services in accordance with applicable rules, regulations and policies as specified below:

- To Non-Waiver Medicaid Recipients:
    - Rehabilitation Center Services

- To OAAS Community Choices Waiver Recipients:
    - Skilled Maintenance Therapies (OT, PT, ST)

Rehabilitation Center

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.

NOTE: PT 65 – Rehabilitation Center providers MUST be enrolled with Medicare as Rehabilitation Agency or a Comprehensive Outpatient Rehabilitation Facility (CORF) prior to requesting enrollment in Louisiana Medicaid (Fee-For-Service).

*Form is included in the **Basic Enrollment Packet for Entities/Businesses**.

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. 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 Code 75 (Other Medical Care).
☐		*9.* Notarized *"Provider Attestation for OAAS Community Choices Waiver Skilled Maintenance Therapy and Nursing Services"* form.
☐		10. To report "Sub-Specialty" for this provider type to provide one or more of the 4 Community Choices Waiver Skilled Maintenance Therapies on Section A of the PE-50, please **use <u>one</u> of the following codes**: **<u>6T</u>** (Community Choices Waiver – Physical Therapy) **<u>7H</u>** (Community Choices Waiver – Occupational Therapy) **<u>7G</u>** (Community Choices Waiver – Speech/Language Therapy) **<u>3E</u>** (Community Choices Waiver – Physical Therapy & Occupational Therapy) **<u>3F</u>** (Community Choices Waiver – Physical Therapy & Speech/Language Therapy) **<u>3H</u>** (Community Choices Waiver – Occupational Therapy & Speech/Language Therapy) **<u>3L</u>** (Community Choices Waiver – Physical Therapy, Occupational Therapy & Speech/Language Therapy) **<u>3R</u>** (Community Choices Waiver – All Skilled Maintenance Therapies)

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 Attestation for Community Choices Waiver
Skilled Maintenance Therapy and Nursing Services

PURPOSE

This form confirms that the provider specified below wishes to provide one or more of the Skilled Maintenance Therapy services and/or nursing services under the Community Choices Waiver program, and attests that the provider will conform to prior approval and reimbursement regulations and policies and that licensed Occupational Therapist, Physical Therapist, and/or Speech Therapist, personnel (as applicable) used will have one full year of verifiable experience working with the elderly.

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 ☐ Nursing ☐	
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 Community Choices Waiver; and
- that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare; and
- that failure to exhaust these above referenced third party payer sources may subject this/my Medicaid enrolled agency to recoupment of funds previously paid by Medicaid; and
- that all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered; and
- that as a provider of services to Community Choices Waiver participants, any licensed therapist used will have one full year of verifiable experience working with the elderly, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

_____ _____ _____

Print Authorized Representative's Name | Signature of Authorized Representative | Date of Signature

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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

PT-65 Rehabilitation Center
Rev. 06/2024

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