PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Social Worker (Individual)

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION

- The effective date for ROW Services, is the date of enrollment approval.

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

Assistants are not eligible to enroll in Louisiana Medicaid.

- Individual Social Worker providers may enroll in Louisiana Medicaid for:
  - NOW Professional Provider (see PT 06 – NOW Professional Provider Type Specific Checklist/Packet)
  - Medicare Crossover payments
  - Residential Options Waiver (ROW)
  - Both Medicare Crossover payments and ROW

- Social Workers may enroll and bill as an Individual Social Worker for the ROW program or they may choose to link to and bill through the following Provider Type agencies:
  - PT11 – Shared Living
  - PT84 – Substitute Family Care – Waiver (Host Home)

- Individual Social Workers enrolled for Medicare Crossovers may link to Medicaid-enrolled Rural Health Clinics, Federally Qualified Health Centers, School Based Health Centers, Mental Health Clinics, and/or, Mental Health Rehabilitation Agencies (PT77) but not Medicaid-enrolled Groups or any other program within Louisiana Medicaid (except in the case of ROW services).

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:
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.

Social Worker

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**.

**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 Code 73 (Social Worker).

For Linkage to RHC & FQHCs only:

☐	**	9. Link/Unlink and Working Relationship Form (if applicable).

For ROW Services:

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

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:
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 beneficiaries, 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):	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

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