PROVIDER TYPE SPECIFIC

PACKET/CHECKLIST

(Louisiana Medicaid Program)

Mental Health Clinic

(Enrollment packet is subject to change without notice.)

Mental Health Clinic

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: Only Local Governing Entities (LGEs) can enroll with Fee-For-Service Medicaid as a Mental Health Clinic (PT-74) – AND - only for Medicare Cross-overs and QMB Claims. The provider MUST be enrolled with Medicare prior to requesting enrollment in Louisiana Medicaid (Fee-For-Service).

*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. 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. Copy of the Behavioral Health Service Provider License issued by the Health Standards section from Louisiana Department of Health.
☐	9. On **Section A** of the PE-50 Form, in the **Specialty Code** space write in **'70'** (Group/Clinic) and leave the **Subspecialty Code** space **'blank'**.
☐	10. On **Section D** of the PE-50 Form, in the **Provider Type Description** space write in **'Mental Health Clinic'** and in the **Provider Type Code** space write in **'74'.**

TO LINK INDIVIDUAL PROFESSIONALS:

** ☐	11. Link/Unlink and Working Relationship Form for currently enrolled professional individuals needing to link to this Mental Health Clinic. The following individuals may link to a Mental Health Clinic – if their Specialty is Psychiatric: Physicians (PT-20), Nurse Practitioner (PT-78), Psychologist or Medical Psychologist (PT-31), Social Worker (PT-73), Physician Assistant (94), and Clinical Nurse Specialist (93). If any individual is not enrolled or active in Medicaid, then a full Individual Enrollment Application is required, in addition to the Group Link/Unlink form.

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