PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Rural Health Clinic (Provider-Based)

(Enrollment packet is subject to change without notice.)

Rural Health Clinic (RHC), Provider-Based
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 79 – RHC providers MUST be enrolled with Medicare as an RHC 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 Medcaid 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 Rural Health Clinic (RHC) License issued by the Health Standards Section, from Louisiana Department of Health.
☐	9. Cop of CLIA certificate, if applicable.
☐ **	10. Existing Provider Information Form.
☐ **	11. Attestation of Provider's 340B Program Status form.
☐ **	12. Facility Survey.
☐ **	13. Link/Unlink and Working Relationship Form for currently enrolled professional individuals linking to this RHC. a. Linkage of a Primary care individual is required. b. If any individual is not currently enrolled in Medicaid, a full Individual Enrollment application is required, in addition to this Linkage Form
☐ **	14. OFS Form 24, if applicable.
☐	15. On **Section A** of the PE-50 Form, in the **Specialty Code** space, choose the appropriate code for this enrolling Entity: Code **'94'** (Rural Health Clinic) – **OR** – Code '**9L'** (RHC/FQHC OPH Certified School Based Health Center - SBHC) a. If the Specialty Code 9L is selected, submit a copy of the documentation confirming designation as a SBHC from either: i. ASHI (Adolescent School Health Initiative) - OR - ii. OPH (Office of Public Health) On **Section A** of the PE-50 Form, in the **Subspecialty Code** space, leave it blank.

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

EXISTING PROVIDER INFORMATION FORM

Please print name of the RHC: _____

List all Louisiana Medicaid Providers (individual AND entity-type) currently billing Louisiana Medicaid at this time and prior to the issuance of a RHC Medicaid provider number.

Provider Name	NPI Number	Provider Number

Signature of Authorized Representative: _____

Print Name of Authorized Representative: _____

Date of Signature: _____

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Louisiana Medicaid
Attestation of Provider's 340B Status

Provider Name: _____

Provider NPI Number: ☐☐☐☐☐☐☐☐☐☐

Contact Information

Name: _____

Address: _____

Contact Number: _____

Email: _____

In applying for enrollment with Louisiana Medicaid for _____(entity name), I hereby attest, by signing below, that this entity's status in the 340B Drug Pricing Program is accurate as indicated below:

(Check one)

1. ☐ Enrolled in the US Federal Government 340B Pricing Program
2. ☐ Pending enrollment in US Federal Government 340B Pricing Program
3. ☐ Not enrolled in US Federal Government 340B Pricing Program

Signature of Authorized Representative: _____

Printed Name of Authorized Representative: _____

Date of Signature: _____

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Facility Survey

Provider Name:	**NPI #:**	**Or Medicaid #:**
Provider Type:		
City:		
Parish:		
Telephone Number:	**E-mail Address:**	
Individual Completing Survey:	**Job Title:**	

*******Complete all questions in the survey, indicate yes, no, and the # of providers*******

Primary Care Services			
Please indicate which services are provided from the choices below:	**YES**	**NO**	**COMMENTS**
Family Medicine			
Internal Medicine			
Obstetrics			
Gynecology			
Pediatrics			
Geriatrics			
Lab Test			
X-Rays			
Other (Please Specify)			
Are any of these services contracted out?			
Name of Each Contracted Service		**Medicaid Provider Number**	
1.			
2.			
3.			
Please indicate the availability of staff from the choices below:	**YES**	**NO**	**# of Providers**
Physician			
Physician Assistant			
Nurse Practitioner			
Licensed Practical Nurse			
Clinical Nurse Specialist			
Registered Nurse			
Nurse Midwife			
Lab Technician			
X-Ray technician			
Other (Please Specify) Medical Assistants			
Name of Each Provider		**Medicaid Provider Number**	
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Facility Survey

Dental Services			
	YES	NO	COMMENTS
Does your facility provide dental services?			
Please indicate which services are provided from the choices below:	**YES**	**NO**	**COMMENTS**
Diagnostic			
Preventive			
Restorative			
Endodontic			
Periodontal			
Prosthodontics			
Oral Surgery			
Other (Please Specify)			
Are any of these services contracted out?			
Name of Each Provider		**Medicaid Provider Number**	
1.			
2.			
3.			
4.			
5.			
Please indicate the availability of staff from the choices below:	**YES**	**NO**	**# of Providers**
Dentist			
Expanded Duty Dental Assistant			
Dental Assistant			
Dental Lab Technicians			
Other (Please Specify)			
COMMENTS:			

Mental Health Services			
	YES	NO	COMMENTS
Does your facility provide Mental Health Services?			
Please indicate which services are provided from the choices below:	**YES**	**NO**	**COMMENTS**
Evaluations			
Assessments			
Treatment			
Counseling			
Medication management			
Injections			
Other (Please Specify)			
Please indicate the availability of staff from the choices below:	**YES**	**NO**	**# of Providers**
Psychiatrist			
Clinical Psychologist			

Facility Survey

Psychiatric Nurse Practitioner			
Licensed Clinical Social Worker			
Other (Please Specify)			

Name of Each Provider	Medicaid Provider Number
1.	
2.	
3.	
4.	
5.	

By signing below as the signature authority for this facility, I certify that the information above is complete, accurate, true, and factual.

Signature and Title: **Date:**

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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

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STATE OF LOUISIANA DEPARTMENT OF HEALTH
OFS Form 24

Dear Provider:

It is the policy of the Bureau of Health Services Financing that the Medicaid Program only pay for in-office performance of certain laboratory and diagnostic services billed by practitioners if the following conditions are met:

1. The practitioner completed and has on file, with the Louisiana State Medicaid Program Provider Enrollment Unit, a completed OFS Form 24.
2. The completed OFS Form 24 fully describes the laboratory or diagnostic equipment required to perform these tests.
3. The OFS Form 24 information is updated as needed.

Our policy towards laboratory or diagnostic services performed outside of a practitioner's office remains unchanged. Practitioners may not be reimbursed for laboratory or diagnostic services ordered for their patients, if these services are performed outside of their office. Only the performer of a test may seek reimbursement for these services. Any interpretive service by the attending practitioner is reimbursed through the practitioner's visit payment.

The OFS Form 24 requirements only pertain to:

1. Those participating practitioners who own or lease laboratory or diagnostic testing equipment located in their office or place of practice - and -
2. The practitioners submit claims to the Medicaid program.

Example 1: Dr. Jones is an individual practitioner who owns or leases a SMA-12, EKG monitor and X-Ray equipment. Dr. Jones wishes to perform laboratory and diagnostic services on Medicaid patients in his office and bill the Medicaid Program for these laboratory or diagnostic services. Dr. Jones must complete the OFS Form 24.

Example 2: Drs. Smith, Jones, Doe, and Rae are a group practice. As a group they own or lease laboratory and diagnostic equipment. It is their desire to use this equipment in treating Medicaid beneficiaries, and they will bill the Medicaid Program for these services. If each practitioner is individually enrolled in the Medicaid Program, each practitioner in the group must complete the OFS Form 24, even though the descriptive information will be identical. If the practitioners are enrolling as a group, only one OFS Form 24 is required as long as all members of the group are indicated.

Example 3: An individual or group practitioner utilizes an external source for laboratory or diagnostic tests. The individual or group practitioner would not complete the OFS Form 24, as they would not bill the Medicaid Program directly.

Sincerely,

Provider Enrollment Unit

OFS Form 24 (Diagnostic and/or Laboratory Equipment)

Provider Number (7 digits): ☐☐☐☐☐☐☐

NPI (10 digits): ☐☐☐☐☐☐☐☐☐☐

Provider Name: _____

Provider Address: _____

Diagnostic and/or Laboratory Equipment

Make	Model	Serial #	Capabilities

List names of individuals who will be performing the diagnostic and/or laboratory tests in the spaces below:

1.	2.

I certify the above is accurate and true.

Signature of Authorized Representative: _____

Print Name of Authorized Representative: _____

Date of Signature: _____

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