PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Certified Nurse - Midwife (Individual)

(Enrollment packet is subject to change without notice.)

Certified Nurse – Midwife

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. Copy of current medical license from governing license board of your profession (RN and APRN license). If requesting retroactive coverage, a license must be submitted that covers that time period. A temporary permit is only good until the expiration date.
☐		9. Copy of the certification from the American Midwifery Certification Board (formerly known as ACNM Certification Council, Inc.)
☐	**	10. Nurse-Midwife PE-50 Supplement Form.
☐		11. To report **"Specialty"** for this provider type on **Section A of the PE-50, please use Code 16 (OB-GYN).**

For Group Linkages:

☐	**	12. Link/Unlink and Working Relationship 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

Nurse-Midwife PE-50 Supplement Form

I hereby certify that I am a member of a physician-directed health care team.

The following is a complete listing of the physician(s) who direct the health care team(s) with which I practice:

Physician Name	**Louisiana Medicaid vendor #** (if applicable)

When practicing and billing Louisiana's **Medicaid Program** for my services, I hereby agree to comply with Section 3709 of the Louisiana Administrative Code (the *Nurse Practitioner Act*), which requires that a nurse-midwife must work "…as a member of a physician-directed health care team."

_____ _____ _____

Individual Provider's Signature License # Date

_____

Print Name of Individual Provider

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**

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