PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Certified Registered Nurse Anesthetist (CRNA) (Group)

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION FOR THE CNRA GROUP PROVIDER TYPE

- Only CNRAs may link to CNRA Groups—no Physician providers may do so.

- If a CNRA and a Physician are forming a group, the group must be a Physician Group (not a CNRA Group).

Certified Registered Nurse Anesthetist (CRNA) – Group

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 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. To report "**Specialty"** for this provider type on **Section A of the PE-50, please use 70 (group).**
☐ **	9. OFS Form 24 (if applicable)
☐ **	10. Link/Unlink **and** Working Relationship Form for all currently enrolled in Louisiana Medicaid.
☐	11. If the professional individuals being linked to this group are not currently enrolled in Louisiana Medicaid, then a full individual enrollment application is required for those individuals.

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

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

Dear Provider:

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

1. The physician has completed and has on file with 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 that are performed outside of a physician office remains unchanged. Physicians 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 physician is reimbursed through the physician visit payment.

The OFS Form 24 requirements only pertain to: 1) those participating physicians who own or lease laboratory or diagnostic testing equipment that is located in their office or place of practice and 2) for which use the physician will be submitting a claim 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 recipients, and they will bill the Medicaid Program for these services. If each physician is individually enrolled in the Medicaid Program, each physician in the group must complete the OFS Form 24, even though the descriptive information will be identical. If the physicians 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.

A Louisiana OFS Form 24 is enclosed for completion and submittal where applicable. Return the completed form to:

Gainwell Provider Enrollment Unit
P.O. Box 80159
Baton Rouge, LA 70898-0159
225-216-6370

Sincerely,
Provider Enrollment Unit

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 that the above is a true and accurate listing of diagnostic and/or laboratory equipment in my office.

Signature* Date

* Acceptable signatures are as follows: individual professionals must sign their own forms. Only an authorized representative may sign for groups, businesses, or entities. Original provider signature is required **(no stamps or initials).**

COPY PAGE IF ADDITIONAL SPACE IS NEEDED
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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**

Original Signatures Required – Please Do NOT Use Black In

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Baton Rouge, LA 70898-0159
225-216-6370