PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Certified Registered Nurse Anesthetist (CRNA) (Individual)

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION FOR THE INDIVIDUAL CRNA PROVIDER TYPE

- An individual CRNA holding a temporary permit cannot be enrolled until the permanent license is received.

- Individual CRNA providers may link to the following groups:
    - CRNA Group
    - Physician Group

Linkages of Professionals to Groups – an individual's provider number can be "linked" to a group provider number for purposes of billing as an attending provider for the specified group.

- **Active providers only require Group Link/Unlink and Working Relationship Form.**
- **New/Inactive/closed providers require a completed application and the Group Link/Unlink and Working Relationship Form.**

Claims submitted under the group number, with an individual's number included as the attending provider, will be processed and the remittance will be sent directly to the group's mailing address. ***It is not necessary for the individual's mailing address to be the same as the Group's mailing address for these Remittance Advice notices to be sent to the group, if billed correctly.***

Certified Registered Nurse Anesthetist (CRNA) (Individual)

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. Printout of online medical license verification from the governing license board of your profession. This verification must contain the license numbers (RN and APRN), the effective date of issuance, and the current status of the license.
☐	9. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 05 (Anesthesia).

For Group Linkages:

☐ **	10. Group Link/Unlink and Working Relationship Form.

Out of State Enrollment:

☐	11. Submit an original claim with the application for the initial date of service. This claim must meet timely filing guidelines. Subsequent claims must be submitted directly to Gainwell claims processing once the provider has received confirmation via mail of successful enrollment in Louisiana Medicaid.

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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