



PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Clinical Nurse Specialist (Individual)

(Enrollment packet is subject to change without notice.)

Clinical Nurse Specialist

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.

^{**}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.
*	 (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).
	 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.
	 Copy of certification as a Clinical Nurse Specialist by the Louisiana State Board of Nursing. The certification must correspond with the specialty identified on the PE-50 (see item 12, below).
	10. Verification of prescriptive authority, if applicable.
	11. Must have Collaborative Practice Agreement available for review, upon request.
	12. To report "Specialty" for this provider type on Section A of the PE-50, please refer to the attached Specialty and Sub-specialty Code List.

For Group Linkages:

**	13. Group 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

^{*}Form is included in the Basic Enrollment Packet for Individuals.

Specialty and Sub-Specialty Code List

For Clinical Nurse Specialists

Specialty Code	Sub-specialty Code	LSBN Specialty Description
01		Home Health Nursing
02		Medical Surgical Nursing
08		Maternal Child Nursing
26		Child and Adolescent Psychiatric and Mental Health Nursing or
		Adult Psychiatric and Mental Health Nursing
37		Pediatric Nursing
37	1C	Acute and Critical Care, Neonatal
37	1E	Acute and Critical Care, Pediatrics
41	2G	Gerontological Nursing
41	2J	Oncology
44		Community Health Nursing

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	LA Medicaid Provider #			National F	Provider	Identifier	(NPI)			
Number:										
Professional Group										
Name:										
Professional Group	LA Medicaid Provide	er #		National F	Provider	Identifier	(NPI)			
Provider Number:										
LINK	Effective Date	., .,	- ""	UNLINK		Termin	ation Da	te		
Approximate Number of Hours W	orking at this									
Entity Per Week (required)										
Drofossional Craws										
Professional Group Name:										
Professional Group	LA Medicaid Provide	Medicaid Provider #			National Provider Identifi					
Provider Number:										
LINK	Effective Date:			UNLINK		Termin	ation Da	te:		
Approximate Number of Hours W	orking at this									
Entity Per Week (required)										
Contact Person for questio Contact Person Phone Nun		n:								
Contact Person Phone Nur	iibel:									
ORKING RELATIONSHIP A	AGREEMENT									
am a medical professional	who has a written co	ntractual agre	eement t	o see patien	ts for th	e above n	amed pr	ofess	sional	group(s)
have recorded the approxi						-	ce(s) pro	vided	l abov	re. (I
nderstand that upon requ	est I must provide LD)H a copy of t	he writte	en contractu	al agree	ment.)				
rint Individual Provider's N	Name	Individual Provider's Signature					Date			
	Original Signatures Required – Please Do NOT Use Black Ink									
	Please su	Please submit all required documentation to:								
			an eu uo	cumentatio	n to:					
		nwell Provid								

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

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