PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

American Indian/Native Alaskan "638" Facilities

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION FOR THE AMERICAN INDIAN/NATIVE ALASKAN "638" FACILITIES PROVIDER TYPE

- **Medicaid is first payor.**
- **Only American Indians or Native Alaskans can have services billed under this provider type; services to non-Tribal Medicaid recipients may not be billed under this provider type.**

American Indian/Native Alaskan "638" Facilities

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 95 – American Indian/Native Alaskan "638" Facility providers MUST be enrolled with Medicare prior to requesting enrollment in Louisiana Medicaid (Fee-For-Service).

* Form is included in the **Basic Enrollment Packet for Entities/Businesses**.

** Form is included in this packet.

Completed	Document Name
☐ *	1. Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
☐ *	2. PE-50 Addendum – Provider Agreement Form (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 Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable.
☐	9. Verification that the enrolling facility is designated as a "638" facility by submitting one of the following: Copy of letter from Indian Health Services approving the enrolling facility as a "638" facility. **-or-** Copy of the Federal Register that identifies the enrolling tribal entity as eligible for funding and services from the Bureau of Indian Affairs.
☐ **	10. Signed Provider Type 95 Attestation Form indicating that no services will be billed for non-Tribal Medicaid recipients.
☐ **	11. Completed Link/Unlink and Working Relationship Form for any individual Physician, Dentist, Nurse Practitioner and/or Physician Assistant who performs services at this enrolling facility and who is currently enrolled with Louisiana Medicaid. (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.)
☐	12. Copy of the license issued by the appropriate Governing Board for any Psychologist, Social Worker or Pharmacist who performs services at this enrolling facility.
☐	13. To report "Specialty" for this provider type on Section A of the PE-50, please use Code: **- 2T (American Indian / Native Alaskan).**

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

Provider Name _____ NPI: _____

Provider Type 95 Attestation Form

American Indian "638" facilities are required to adhere to all provider enrollment standards established by the Louisiana Medicaid Program. A detailed outline of the comprehensive provider requirements can be found in Chapter Thirty-Nine of the Medicaid Services Manual for American Indian "638" Clinics, which is accessible at www.lamedicaid.com.

The attestation below is an essential requirement of the Louisiana Medicaid provider enrollment process for "638" clinics. It must be submitted, along with an original signature and date, to the Gainwell Technologies Provider Enrollment (PE) Section as part of your Provider Type 95 PE packet.

By signing this form, I confirm, on behalf of _____ (name of 638 Clinic), that the clinic seeks reimbursement solely from Louisiana Medicaid for services rendered to Medicaid-eligible tribal members and individuals statutorily eligible under 25 U.S.C. §1680c(a) for treatment at an Indian Health Services (IHS) facility.

Additionally, we acknowledge that this attestation is required documentation for the Provider Type 95 enrollment packet.

_____	_____	_____
Printed Name of Tribal Health Director/Administrator	Signature of Tribal Health Director/Administrator	Date of Signature

Louisiana Medicaid Link/Unlink and Working Relationship Form

Copy this form for additional space as needed.

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)	
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 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 of Signature**

Original Signatures Required – Please Do NOT Use Black Ink

Please submit all required documentation to:
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