



**PROVIDER TYPE SPECIFIC
PACKET/CHECKLIST**

(Louisiana Medicaid Program)

Behavior Intervention

(Enrollment packet is subject to change without notice)

GENERAL INFORMATION FOR THE BEHAVIOR INTERVENTION PROVIDER TYPE

An Applied Behavior Analyst may have only ONE Medicaid provider number, only ONE Pay-To name, only ONE Pay-To address and only ONE Direct Deposit. If an Applied Behavior Analyst works for multiple Entities/Businesses, it is not possible for the different Entities/Businesses to be reimbursed separately through that one Applied Behavior Analyst's Medicaid provider number.

The Behavior Intervention Provider Type has been established for Applied Behavior Analysts who work for multiple Entities/Businesses. This provider type will function as a 'Group'.

If an Applied Behavior Analyst works for more than one Entity/Business, all of the Entities/Businesses must enroll as a Behavior Intervention Provider Type for these Entities/Businesses to be reimbursed directly for the services rendered by the Applied Behavior Analyst.

At this time, only an Applied Behavior Analyst can link to a Behavior Intervention Provider Number.

The Applied Behavior Analyst Individual is linked to the Entity/Business's Behavior Intervention provider number and the billing is done per the Entity/Business provider number using the Individual's Applied Behavior Analyst's provider number as the 'Attending'.

The Entity/Business that enrolls as a Behavior Intervention Provider, must complete the Basic Packet for Entities/Businesses and the Behavior Intervention Provider Type Specific Packet.

When submitting a Behavior Intervention Provider application, it must be accompanied by an enrollment application from an Applied Behavior Analyst who is not currently enrolled with Medicaid – **or** - a Group Link/Unlink and Working Relationship Form from an Applied Behavior Analyst currently enrolled.

Other General Information for provider types functioning as Groups:

Linkages of Individuals to Entities/Businesses – an Individual's provider number is "linked" to an Entity/Business provider number for purposes of billing as an 'Attending' provider for the specified Entity/Business.

The Entity/Business Provider number becomes the Billing provider and the Applied Behavior Analyst's Individual's provider number becomes the Attending Provider number on the claim. Reimbursement and the Remittance Advices are made under the Entity/Business provider number.

When an Individual is linking to a group as an "attending only" (not being paid individually by Medicaid), they are not required to complete the EDI Contract, Direct Deposit Form, or submit a voided check. All these forms are required for the Entity/Business that enrolls.

Behavior Intervention Provider Type CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Gainwell Provider Enrollment Unit in order to enroll in the Louisiana Medicaid Program as a Behavior Intervention Provider:

Completed	Document Name
<input type="checkbox"/> *	1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.
<input type="checkbox"/> *	2. Completed PE-50 Addendum – Provider Agreement Form.
<input type="checkbox"/> *	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.
<input type="checkbox"/> *	<p>4. Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business. (Only the Disclosure of Ownership portion of this enrollment packet can be done online by choosing Option 1.)</p> <p>Option 1 Provider Ownership Enrollment Web Application. Go to www.lamedicaid.com and click on the Provider Enrollment link on the left sidebar. After entering ownership information online, the user is prompted to print the Summary Report; the authorized agent must sign page 3 of the Summary Report and include both pages 2 and 3 with the other documents in this checklist.</p> <p style="text-align: center;">-or-</p> <p>Option 2: If you choose not to use the Provider Ownership Enrollment web application, then submit the hardcopy Louisiana Medicaid Ownership Disclosure Information Forms for Entity/Business.</p>
<input type="checkbox"/> *	5. (If submitting claims electronically) Completed 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).
<input type="checkbox"/>	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) .
<input type="checkbox"/>	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) .
<input type="checkbox"/>	8. To report "Provider Type" on Section A of the PE-50, please use BI (Behavior Intervention).
<input type="checkbox"/>	9. To report "Specialty" for this provider type on Section A of the PE-50, please use 70 (group).
<input type="checkbox"/> **	10. Completed Link/Unlink and Working Relationship Form for the Applied Behavior Analyst linking to this Entity/Business.
<input type="checkbox"/>	<p>NOTE: If the Applied Behavior Analyst linking to this group is not currently enrolled in Louisiana Medicaid, then a full Individual Applied Behavior Analyst enrollment application must be submitted with this Behavior Intervention application.</p> <p>If the Applied Behavior Analyst is already an enrolled Individual, then only the Link/Unlink and Working Relationship Form is needed with the Behavior Intervention packet.</p>

*These forms are available in the **Basic Enrollment Packet for Businesses/Entities**.

**Forms are included here.

ATTACHED FORMS.FOR ENROLLMENT. ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WI PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS) – DO NOT SUBMIT COPIES OF THE TH

Please submit all required documentation to:
Gainwell Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Louisiana Medicaid 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 Number:					LA Medicaid Provider #					National Provider Identifier (NPI)				
Professional Group Name:														
Professional Group Provider Number:					LA Medicaid Provider #					National Provider Identifier (NPI)				
<input type="checkbox"/> LINK	Effective Date:	MM/DD/YYYY			<input type="checkbox"/> UNLINK	Termination Date:	MM/DD/YYYY							
Approximate Number of Hours Worked at this Group Per Week, if linking. (required)														
Professional Group Name:														
Professional Group Provider Number:					LA Medicaid Provider #					National Provider Identifier (NPI)				
<input type="checkbox"/> LINK	Effective Date:	MM/DD/YYYY			<input type="checkbox"/> UNLINK	Termination Date:	MM/DD/YYYY							
Approximate Number of Hours Worked at this Group Per Week, if linking. (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 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 DHH a copy of the written contractual agreement.)

Print Individual Provider's Name

Individual Provider's Signature

Date MM/DD/YYYY

Original signature only – colored ink (please don't use black ink)

Mail Completed Forms To: Gainwell Technology Provider Enrollment Unit, PO Box 80159, Baton Rouge, LA 70898-0159