Provider Enrollment Change Request for Community Choices Waiver Services
for Provider Type 44 (Home Health Agency)

If your agency is currently enrolled as Medicaid provider type 44 (Home Health Agency) use this form to become a provider of Community Choices Waiver services as identified below.

Complete all applicable information as indicated below and return to:

Gainwell Technology Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Provider Number:	**LA Medicaid Provider #**		**National Provider Identifier (NPI)**
Provider Name:			
Physical Address:			LA
Contact Person for questions regarding this form:			
Contact Person Phone Number:	**( ) -**		

Provider Sub-Specialty(s) to add	**Additional Required Documents**
To provide one or more of the 4 Skilled Maintenance Therapies, select <u>one</u> of the following codes: ☐ 6T (– Physical Therapy) ☐ 7H (– Occupational Therapy) ☐ 7G (– Speech/Language Therapy) ☐ 3D (– Respiratory Therapy) ☐ 3E (– Physical Therapy & Occupational Therapy) ☐ 3F (– Physical Therapy & Speech/Language Therapy) ☐ 3G (– Physical Therapy & Respiratory Therapy) ☐ 3H (– Occupational Therapy & Speech/Language Therapy) ☐ 3J (– Occupational Therapy & Respiratory Therapy) ☐ 3K (– Speech/Language Therapy & Respiratory Therapy) ☐ 3L (– Physical Therapy, Occupational Therapy & Speech/Language Therapy) ☐ 3M (– Physical Therapy, Occupational Therapy & Respiratory Therapy) ☐ 3N (– Physical Therapy, Speech/Language Therapy & Respiratory Therapy) ☐ 3Q (– Occupational Therapy, Speech/Language Therapy & Respiratory Therapy) ☐ 3R (– All Skilled Maintenance Therapies)	Completed and notarized *"Provider Verification for Community Choices Waiver Skilled Maintenance Therapy and Nursing Services <u>for Provider Type 44</u>"* (Form is included here)
To provide Nursing Services select the following code: ☐ 8N (– Nursing)	Completed and notarized *"Provider Verification for Community Choices Waiver Skilled Maintenance Therapy and Nursing Services <u>for Provider Type 44</u>"* (Form is included here)
To provide Personal Assistance Services select the following code: ☐ 5W (– Personal Assistance Services)	Not Applicable
To provide Nursing Services <u>AND</u> Personal Assistance Services select the following code: ☐ 9A (– Nursing **<u>AND</u>** Personal Assistance Services)	Completed and notarized *"Provider Verification for Community Choices Waiver Skilled Maintenance Therapy and Nursing Services <u>for Provider Type 44</u>"* (Form is included here)

Print Authorized Representative's Name

Signature of Authorized Representative

Date of Signature MM/DD/YYYY

Complete this form in its entirety. Original signature required – blue ink only

Provider Verification for Community Choices Waiver
Skilled Maintenance Therapy and Nursing Services <u>for Provider Type 44</u>

PURPOSE

This form confirms that the provider specified below wishes to provide one or more of the Skilled Maintenance Therapy services and/or nursing services under the Community Choices Waiver program, and attests that the provider will conform to prior approval and reimbursement regulations and policies and that licensed Occupational Therapist, Physical Therapist, Speech Therapist, and/or Respiratory Therapist personnel (as applicable) used will have one full year of verifiable experience working with the elderly.

Provider Number:	**LA Medicaid Provider #** ☐☐☐☐☐☐☐ **National Provider Identifier (NPI)** ☐☐☐☐☐☐☐☐☐☐
Provider Name:	
Physical Address:	LA
Professional Category (choose all that apply):	OT ☐ PT ☐ ST ☐ RT ☐ Nursing ☐
Contact Person for questions regarding this form:	
Contact Person Phone Number:	( ) -

I hereby affirm under oath that all statements I have made on this application and the attachments thereto are:

- True and correct; and
- that I can receive reimbursement for services provided only to those persons within the Community Choices Waiver; and
- that Medicaid Community Choices Waiver is the payer of last resort in accordance with federal regulation 42 CFR 433.139 which requires states to deny (cost avoid) Medicaid claims until after the application of available third party benefits and that third parties include but are not limited to private health insurance, casualty insurance, worker's compensation, estates, trusts, tort proceeds and Medicare; and
- that failure to exhaust these above referenced third party payer sources may subject this/my Medicaid enrolled agency to recoupment of funds previously paid by Medicaid; and
- that all Professional Services provided to Community Choices Waiver participants must be prior authorized before services are rendered; and
- that as a provider of services to Community Choices Waiver participants, any licensed therapist used will have one full year of verifiable experience working with the elderly, and
- I understand that violation of this oath shall constitute cause sufficient for the refusal or revocation of enrollment in Medicaid.

Print Authorized Representative's Name	Signature of Authorized Representative	Date of Signature MM/DD/YYYY
_____	_____	_____

THUS DONE AND PASSED BEFORE ME, Notary, in the City of _____, State of _____on the _____ day of _____, 20____.

_____

Notary Public Signature

Notary Seal or Notary Identification Number (required)

Complete this form in its entirety. Original signature required – blue ink only