PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Licensed Professional Counselor (Individual)

(Enrollment packet is subject to change without notice.)

GENERAL INFORMATION FOR THE INDIVIDUAL PHYSICIAN PROVIDER TYPE

Licensed Professional Counselor (PT-AK) may only enroll in Louisiana Medicaid (Fee-For-Service) for Medicare Cross-Over and QMB claims. The provider MUST be enrolled with Medicare prior to requesting enrollment in Louisiana Medicaid (Fee-For-Service).

Individual Licensed Professional Counselors may link to the following groups (as long as the group has a Louisiana Medicaid business/entity type Provider Number):

- Physician Group
- Rural Health Clinics
- Federally Qualified Health Centers
- Mental Health Clinics
- Mental Health Rehab Centers

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

- **Currently enrolled professional individual providers require only Group Link/Unlink and Working Relationship Form.**
- **New, Inactive, or Closed professional individual providers require an entire enrollment application as well as the Group Link/Unlink and Working Relationship Form.**

The number of groups a professional individual can link to is limited. It is very important that all professional individuals terminating their relationship with a group notify Provider Enrollment. Provider Enrollment can then unlink the professional individual from the specified group, allowing the professional individual to be linked to other groups in the future.

Claims submitted under the group's NPI, with a professional individual's NPI 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.

If a professional individual is linking to a group as an attending only (not being paid individually by Medicaid), then the EDI Contract, Direct Deposit Form, and voided check are not required.

Licensed Professional Counselor – 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.

NOTE: Licensed Professional Counselor (PT-AK) may only enroll in Louisiana Medicaid (Fee-For-Service) for Medicare Cross-Over and QMB claims.
The provider MUST be enrolled with Medicare prior to requesting enrollment in Louisiana Medicaid (Fee-For-Service).

* Form is included in the **Basic Enrollment Packet Individuals**.

** Form is included in this packet.

Completed	Document Name
☐ *	1. Individual 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) 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).
☐	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 current medical license from governing license board of your profession. If requesting retroactive coverage, a license must be submitted that covers that time period.
☐	9. To report "**Specialty**" for this provider type on Section A of the PE-50, please use code **8E (CSoC/Behavioral Health)**.
☐	10. To report "**Sub-Specialty**" for this provider type on Section A of the PE-50, please use one of the following codes: **6X - Pregnancy & Postpartum MH** **6Y - Pregnancy & Postpartum SUD** **6Z - Pregnancy & Postpartum MH & SUD**

For Group Linkages:

☐ **	11. Completed Link/Unlink and Working Relationship Form. Must complete number of working hours per week on this form.

Out of State Enrollment:

☐	12. 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**

Original Signatures Required – Please Do NOT Use Black Ink

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