LOUISIANA DEPARTMENT OF HEALTH

gainwell

PROVIDER TYPE SPECIFIC PACKET/CHECKLIST

(Louisiana Medicaid Program)

Limited Medicaid Enrollment – EHR Incentive Program (Individual)

(Enrollment packet is subject to change without notice)

Limited Medicaid Enrollment – EHR Incentive Program – Individual
CHECKLIST OF FORMS TO BE SUBMITTED

The following checklist shows all documents that must be submitted to the Gainwell Enrollment Unit in order to enroll in the Louisiana Medicaid Program as an Individual Limited Medicaid Enrollment – EHR Incentive Program provider:

Completed	Document Name
☐ **	1. Completed Individual Limited Medicaid Enrollment Form.
☐ **	2. CompletedLimited Medicaid Enrollment– Provider Agreement Form.
☐ **	3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form and voided check
☐	4. For Magellan providers, a copy of the executed Magellan Provider Participation Agreement. For medical managed care providers, a copy of official documentation that demonstrates a contractual relationship with a medical managed care entity.
☐	5. To report "Specialty" for this provider type on Section A of the Limited Medicaid Enrollment form, use Code 80 – Doctors of Osteopathic Medicine, 8P Physician (Medical Doctor M.D.), 37 – Physician (Pediatrician), 66 – Dentist, 88 – Optometrist, 9S – Optical Supplier, 79 – Nurse Practitioner, 16 – Certified Nurse-Midwife, 2R – Physician Assistant.
☐	6. To report "Subspecialty" for this provider type on Section A of the Limited Medicaid Enrollment form, use the appropriate codes as follows: 4M – EHR Incentive Behavioral Health (Magellan) or 4Y – EHR Incentive Medical Managed Care (Bayou Health).

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**These forms are included here.

PLEASE USE THIS CHECKLIST TO ENSURE THAT ALL REQUIRED ITEMS ARE SUBMITTED WITH YOUR APPLICATION FOR ENROLLMENT.
ATTACHED FORMS MUST BE SUBMITTED AS ORIGINALS WITH ORIGINAL SIGNATURES (NO STAMPED SIGNATURES OR INITIALS).

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

State of Louisiana (PT IP – Limited Medicaid Enrollment – EHR Incentive Program)

Instructions for PT IP Limited Medicaid Enrollment

PREPARATION

Please read the instructions in their entirety before completing forms. Complete all forms as an **original** document. The completed form may be photocopied for your records. Inaccurate/Incomplete forms will be returned to you for completion.

GENERAL INFORMATION

A Medicaid provider number will be issued to the individual whose name appears in Section A of this form. It is the responsibility of this individual to maintain accurate information on the Louisiana Medicaid provider file through submitting updates (as needed) to the Provider Enrollment Unit.

An individual Medicaid provider number can have only one (1) mailing address. Therefore, this address **MUST** be the address that the individual wishes to receive any correspondence mailed out to this individual number from LDH or Gainwell .

All fields on the Limited Enrollment Application form **MUST** be completed unless they are labeled as optional.

Louisiana Medicaid Provider Number – enter your 7-digit Louisiana Medicaid provider number (active or inactive) in the boxes, one digit per box. If you are filing for a new enrollment, leave this blank.

This enrollment packet is for – check the appropriate box to indicate if this application is for a new Medicaid Limited enrollment, to re-enroll an inactive Medicaid Limited enrollment provider, or specify some other reason for the enrollment packet. A new enrollment is for an individual with no prior Medicaid provider number. A re-enrollment is for a provider who has had a Medicaid Limited enrollment provider number in the past but whose number is closed.

Type 1 Individual National Provider Identifier (NPI) – enter your 10-digit NPI number in the boxes, one digit per box. Visit https://nppes.cms.hhs.gov for more information on obtaining an NPI. You are required to have an NPI number prior to enrollment (unless you are classified as an atypical provider).

SECTION A – INDIVIDUAL INFORMATION & PRACTICE LOCATION

Provider Type Description/Code: Enter PT IP (Electronic Health Record)
Provider Types – Enter one of the following:

19 Doctors of Osteopathic Medicine
20 Physician - Medical Doctor (MD)
Pediatrician
27 Dentist
28 Optometrist
75 Optical Supplier
78 Nurse Practitioner
90 Certified Nurse Midwife
94 Physician Assistant

Specialty – Enter one of the following:

80 Doctors of Osteopathic Medicine
8P Physician (Medical Doctor M.D.)

37 Physician (Pediatrician)
66 Dentist
88 Optometrist
9S Optical Supplier
79 Nurse Practitioner
16 Certified Nurse-Midwife
2R Physician Assistant

Subspecialty – Enter one of the following:

4M EHR Incentive Behavioral Health (Magellan)
4Y EHR Incentive Medical Managed Care (Bayou Health)

Name of Individual Enrolling – enter the individual's name in this field.
M.D., O.D., etc. – enter the abbreviation of the professional title held by the provider.
Area Code and Telephone # - enter the telephone number at the practice location where the enrolling individual can be reached.
Social Security Number – enter the social security number of the enrolling individual.
Are you known by or have you ever used another name? – check yes or no; if yes, check the appropriate type(s) of other name and enter the other name(s) by which you have been known.
Main Practice Street Address – enter the main practice location where the enrolling individual will be working. (For those providers who provide services at multiple locations, this address should be the address of the individual's main location.) Occasionally, there will be an instance when mail or a document or a correspondence may be sent to the Main Practice Street Address. If mail cannot be received at the Main Practice Street Address because there is no receptacle and the postal carrier will not bring the mail inside the building, include a brief note that explains the problem and provides an alternative delivery address for the physical location only.
Practice City – enter the city in which your *Main Practice Street Address* is located.
Practice State – enter the state in which your *Main Practice Street Address* is located.
Practice Zip Code – enter the zip code in which your *Main Practice Street Address* is located.
Parish/County – enter the parish / county in which your *Practice Street Address* is located (for out-of-state providers, see county codes below).
Parish Code – enter the parish code of your physical location (see list below and enter appropriate code for the parish entered in the *Parish* field).

Acadia	01	E. Baton Rouge	17	Madison	33	St. Landry	49
Allen	02	E. Carroll	18	Morehouse	34	St. Martin	50
Ascension	03	E. Feliciana	19	Natchitoches	35	St. Mary	51
Assumption	04	Evangeline	20	Orleans	36	St. Tammany	52
Avoyelles	05	Franklin	21	Ouachita	37	Tangipahoa	53
Beauregard	06	Grant	22	Plaquemines	38	Tensas	54
Bienville	07	Iberia	23	Pointe Coupee	39	Terrebonne	55
Bossier	08	Iberville	24	Rapides	40	Union	56
Caddo	09	Jackson	25	Red River	41	Vermillion	57
Calcasieu	10	Jefferson	26	Richland	42	Vernon	58
Caldwell	11	Jefferson Davis	27	Sabine	43	Washington	59
Cameron	12	Lafayette	28	St. Bernard	44	Webster	60
Catahoula	13	Lafourche	29	St. Charles	45	W. Baton Rouge	61
Claiborne	14	LaSalle	30	St. Helena	46	W. Carroll	62
Concordia	15	Lincoln	31	St. James	47	W. Feliciana	63
DeSoto	16	Livingston	32	St. John	48	Winn	64

Out of State Providers (Use the chart below to determine the county/state codes)

Bordering states with counties identified as a "trade-area" to Louisiana have specific county codes that must be used, as follows:

Use the state code unless your practice location is in one of the trade-area counties. If your practice location is in one of the trade-area counties, be sure to use the appropriate county code (NOT the state code).

State	State Code	Trade-Area County	County Code
Texas	87	Cass, Harrison, Jefferson, Marion, Newton, Orange, Panola, Sabine, Shelby	90
Mississippi	88	Adams, Amite, Claiborne, Hancock, Issaquena, Jefferson, Marion, Pearl River, Pike, Walthall, Washington, Warren, Wilkinson	91
Arkansas	89	Ashley, Chicot, Columbia, Lafayette, Miller, Union	92
ALL OTHER STATES			**99**

State Status – check "In (0)" if your *Practice Street Address* is located within Louisiana or "Out (1)" if it is located outside Louisiana.
Date of Birth – enter the date of birth for the individual. This is a required field and the forms will be returned for correction if it is left blank.

SECTION B – PAYEE NAME AND MAILING ADDRESS

Payee Name – the name the provider designates to receive their incentive payment.
Payee Mailing Address – enter the address to which all payee correspondences is to be mailed.
Payee Mailing City – enter the city in which your *Payee Mailing Address* is located.
Payee Mailing State – enter the state in which your *Payee Mailing Address* is located.
Payee Mailing Zip – enter the zip code in which your *Payee Mailing Address* is located.
Attn or Other (optional) – this information can be used to help get your mail delivered to a complex address (i.e., a certain person, department, floor, a particular area or section, etc.)

SECTION C – CONTACT INFORMATION

Contact Name – enter the name of the person who may be contacted for additional information regarding this enrollment application.
Contact Phone # – enter the phone number of the person who may be contacted for additional information regarding this enrollment application.
Contact Fax # - enter the fax number of the person who may be contacted for additional information regarding this enrollment application.
Contact Email – enter the email address of the person who may be contacted for additional information regarding this enrollment application.

SECTION D – PROVIDER ATTESTATION OF INFORMATION

Read the information included in this section.
Print the Name of the Individual Provider - print the name of the **individual provider** who is requesting Limited Medicaid Enrollment for participation in the EHR Incentive Program.
Individual Provider's Signature – the **individual provider** who is requesting Limited Medicaid Enrollment for participation in the EHR Incentive Program must sign the form. **Signatures must be original, blue ink preferred (not BLACK)** (stamped signatures and initials are not accepted)**.** Office Manager signatures are not accepted.
Date of Signature – enter the date this agreement was signed.

ALL PROVIDERS MUST COMPLETE THIS FORM IN ITS ENTIRETY – INACCURATE/ INCOMPLETE FORMS WILL BE RETURNED TO THE MAILING ADDRESS FOR CORRECTION

BHSF Form Limited Enrollment Application

Louisiana Medicaid Limited Enrollment Form for Participation in the EHR Incentive Program (Individual)

Initiated 10/13

All fields must be completed unless labeled as optional

Louisiana Medicaid Provider # (active or closed)

This enrollment packet is for:
- ☐ New Medicaid Limited Enrollment
- ☐ Medicaid Limited Re-enrollment
- ☐ Other (Please specify):

Type 1 Individual NPI

A Individual Information & Business Practice Location

See PT IP - Limited Medicaid Enrollment instructions to get your Provider Type Description and Provider Type Code

See Provider-Type Specific Checklist

Provider Type Description	Provider Type Code	Specialty Type	Subspecialty -Required

Name of Individual Enrolling (Last Name, First Name, Middle Name)	M.D., O.D., etc.	Area Code & Telephone #	Social Security # (required)
		( ) -	- -

Are you known by (or have you ever used) another name? ☐ Y ☐ N ☐ Former or Maiden Name ☐ Professional Name ☐ Other (Describe):
If yes, please enter name(s) here:

Managed Care Organization Name (check one):

☐ Amerihealth Caritas Louisiana ☐ Amerigroup of Louisiana ☐ Louisiana Healthcare Connection ☐ United Healthcare of Louisiana ☐ Community Health Solutions of America ☐ Magellan SMO

Main Practice Street Address

Practice City	State	Zip Code

Parish/County	Parish/County Code	State Status ☐ In (0) ☐ Out (1)		

	Date of Birth		

B Payee Name and Mailing Address

Designated Payee Name

Payee Mailing Address	Payee Mailing City	Payee Mailing State	Payee Mailing Zip Code

Attn or Other (Optional)	

C Contact Information

The following person may be contacted for additional information regarding this enrollment application:

Contact Name:

Contact Phone #
( )

Contact Fax # Contact email:

D Provider Attestation of Information

I, the undersigned, certify the following

1. I have read the contents of this Limited Medicaid Enrollment Packet for participation in the EHR Incentive Program and the information contained herein is true, correct, and complete;
2. I understand that it is my responsibility to maintain current information on the Louisiana Medicaid Limited Enrollment file and failure to do so may result in delayed payment;
3. I am the individual named in Section A and I legally bind into this agreement through my signature below; and
4. I understand that the Louisiana Medicaid Limited Enrollment file will be updated with information supplied on these forms.

Use colored ink (not black) to eliminate the concern of copied signatures.

Print the Name of the Individual Provider **Individual Provider's Signature** **Date of Signature**

LA MEDICAID LIMITED ENROLLMENT FOR PARTICIPATION IN THE EHR INCENTIVE PROGRAM
ADDENDUM – PROVIDER AGREEMENT

Provider Name _____

I, the undersigned, certify and agree to the following:

Enrollment in Louisiana Medicaid Limited Enrollment for Participation in the EHR Incentive Program

1. I have read the contents of this Louisiana Medicaid Limited Enrollment packet for participation in the EHR Incentive Program and the information supplied herein is true, correct and complete;
2. I understand that it is my responsibility to ensure that all information is kept up to date on the Louisiana Medicaid Limited Enrollment Provider File;
3. I understand that failure to maintain current information may result in payment being delayed.
4. I understand that if my number is closed due to inaccurate information or my relationship with the Managed Care Organization is terminated, sanctioned, and/or changed in any way, I will have to complete a new enrollment packet in its entirety to reactivate my Medicaid Limited Enrollment provider number;
5. I attest that I am a U.S. citizen or that I have legal status and work privilege in the U.S.
6. I understand that it is my responsibility to ensure that all my employees and/or authorized representatives are U.S. citizens or have legal status and work privilege in the U.S.
7. I understand that it is my responsibility to ensure that neither I, nor any owner(s), manager(s), employee(s), agent(s) or affiliate(s) are not now or have ever been:
   - denied enrollment;
   - suspended, or excluded from Medicare, Medicaid or other Health Care Programs in any state;
   - employed by a corporation, business, or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or other Health Care Programs in any state;
   - convicted of any crimes.

   I will report any of the above conditions to Program Integrity at the Department of Health and Hospitals prior to enrolling in Louisiana Medicaid Limited Enrollment or upon discovery once enrolled.
8. I agree to conduct my activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL Louisiana R.S. Title 46, Chapter 3, Part VI-A) as required to protect the fiscal and programmatic integrity of the medical assistance programs;
9. I understand that as the provider I am held responsible for any and all EHR Incentive Payments issued to me;
10. I agree to maintain all records for six (6) years in order to demonstrate my eligibility for an EHR incentive payment and to furnish information regarding those records to the DHH Secretary and contract auditors working on their behalf, the Louisiana Attorney General, or the Medicaid Fraud Control Unit.
11. I agree to report and refund any discovered overpayments;
12. I agree to adhere to the published regulations of the Department of Health and Hospitals (DHH) Secretary and the Bureau of Health Services Financing, including, but not limited to, those rules regarding recoupment.
13. I agree to adhere to the federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the federal Department of Health and Human Services, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA;
14. I understand the Louisiana Medicaid Program must comply with Department of Health and Human Services (DHHS) regulations promulgated under Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; and the American Disabilities Act of 1990 which require that:
    - No person in the United States shall be excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of age, color, handicap, national origin, race or sex under any program or activity receiving Federal financial assistance.

    Under these requirements, Louisiana's Department of Health and Hospitals, Bureau of Health Services Financing cannot pay for medical care or services unless such care and services are provided without discrimination based on age, color, handicap, national origin, race or sex. Written complaints of non-compliance should be directed to Secretary, Department of Health and Hospitals, PO Box 91030, Baton Rouge, LA 70821-9030 or DHHS Secretary, Washington, DC or both.

-Continued-

15. The Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requiements in 1902(a)(68) of the Social Security Act, set forth in that subsection and as the Secretary of the US Department of Health and Human Services may specify. As an enrolled provider/entity, it is your obligation to inform all of your employees and affiliates of the provisions of the Federal False Claims Act, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. When monitored or audited, you will be required to show evidence of compliance with this requirement.

Medicaid Direct Deposit (EFT) Authorization Agreement

I have reviewed the Medicaid Direct Deposit (EFT) Authorization Agreement and the Medicaid Provider Requirements and Conditions as listed below and agree to this agreement:

- I understand that payment will be from federal funds; and any false statements or documents, or concealment of a material fact, may be prosecuted under applicable federal and state laws.
- I understand that DHH may revoke this authorization at any time.
- I hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account and the depository name referenced on the EFT Authorization Agreement form.
- I certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature below is authorized by the stated Board of Directors to enter into or change this agreement.
- I agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I further understand that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility and failure to notify the Provider Enrollment Unit as noted may result in incentive payments being electronically transmitted to incorrect accounts. I understand that such changes may not be able to be accommodated if less than 15 business days' notice is given.

Print Name of Individual Provider

Signature of Individual Provider

Date of Signature

LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

INSTRUCTIONS

1. Medicaid Provider Number:	Enter your **FULL 7-DIGIT** Louisiana Medicaid Provider Number, if known **(Only one provider number per form)**
2. National Provider Identifier (NPI)	Enter the 10-digit National Provider Identifier
3. Name of Individual Enrolling:	Enter the name of the individual to enroll as a Louisiana Medicaid Provider
4. Contact Person	Enter the name of the person designated as the contact for Medicaid direct deposit issues on behalf of the provider. **Not a bank representative.**
5. Contact Person's Phone Number:	Enter the phone number through which we may contact the individual listed in number 4 above.
6. Account Type	Check the appropriate block (only one) to indicate the type of account ***(savings or checking only***) to which the direct deposit will be transferred.
7. Reason for Change in Account Information	For a new enrollment, leave as is.
8. Country of Bank	Circle "Y" if the account is from a bank located in the United States; circle "N" if the bank is not located in the U.S. If "N" is specified, enter the name of the country in which the bank is located.
9. Voided Check:	Tape a copy of a voided check showing the ABA routing number and account number. *Deposit slips are not accepted.* If a voided check is unavailable, a letter on bank letterhead identifying the name associated with the account, the ABA routing number, the account number, and the type of account may be substituted.
10. Print Name of Individual Enrolling	Plainly print the name of the individual enrolling.
11. Signature of Individual Enrolling and Date	Sign the form and enter the date the form was signed. **ORIGINAL SIGNATURES ONLY; NO STAMPS OR COPIED SIGNATURES WILL BE ACCEPTED. INDIVIDUAL PROVIDERS MUST SIGN THEIR OWN FORMS. (BLUE OR COLORED INK PREFERRED – NOT BLACK INK).**

Please be sure to complete this form in its entirety. It will not be accepted for processing and will be returned to you if any field is incomplete.

BHSF PE-DD1
(Revised 11/10)

INDIVIDUAL
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

1. Medicaid Provider Number (7 digits)

2. National Provider Identifier (NPI) (10 digits)

3. Name of Individual Enrolling: _____

4. Contact Person: _____

5. Contact Person's Phone Number: _____

ACCOUNT INFORMATION
(All fields must be completed)

6. Account Type: *(Check One)*
☐ CHECKING ☐ SAVINGS

7. Reason for change in account information:

8. Is the account identified below located in the United States? ☐ Y ☐ N

8a. If No, please identify the country of location. _____

9. Attach Copy of Voided Check (Deposit Slips are not Acceptable)

If Change of Ownership (CHOW) occurred, an entire enrollment packet is required.
Direct Deposit Info is not to be updated before the CHOW is processed.

TAPE COPY OF VOIDED CHECK HERE – NO STAPLES
DEPOSIT SLIPS ARE NOT ACCEPTED

*** To avoid interruption in payment, DO NOT close current account with the bank until a new direct deposit form has been processed.***

If a voided check is unavailable, you may submit a letter on Bank Letterhead identifying the name associated with the account, the ABA Routing Number and the Account Number. The letter must be signed by a Bank Representative.

* **Attach a voided check (deposit slip not acceptable) showing account number and routing (ABA) number**. Original signature required (stamped signature or initials not accepted).

- o I understand that the incentive payment I am seeking will be paid from federal funds. Any false statements or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws. I understand that DHH may revoke this authorization at any time.
- o I hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account and depository named above. These credits will pertain **only to direct deposit transfer payments** that the payee has rendered for Medicaid services.
- o I certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature below is authorized by the stated Board of Directors to enter into this agreement.
- o I agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I further understand that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility and failure to notify the Provider Enrollment Unit as noted may result in incentive payments being electronically transmitted to incorrect accounts. I understand that such changes may not be able to be accommodated if less than 15 business days' notice is given.

10. Print Name of Individual Enrolling _____ 11. Signature of Individual Enrolling _____ Date _____

BE SURE THAT ALL FIELDS ARE COMPLETE

Revised 01/09