



# Louisiana Medicaid Management Information System (LMMIS)

## Provider Enrollment Portal Application User Manual For Fee For Service Facility

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Prepared By Technical Communications Group

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## TABLE OF CONTENTS

1.0	OVE	RVIEW		1
2.0	ACCI	ESSING	G THE APPLICATION	1
	2.1	Louis	siana Web Site Registration	1
	2.2	Loa I	n	1
3.0	STAF		۶.	
•.•	31	What	If Any of the Pre-populated Data is Wrong?	2
	0.1	311	Name Change	2
		3.1.2	Changing Provider Type and Specialty	
	32	Navio	ation Tabs	3
	33	Contr	rol Buttons	U
	0.0	331	Previous	
		332	Next	
		3.3.3	Save Progress	5
4.0	ΤΑΧ		/	
5.0	PRAC	CTICE	ADDRESS	8
6.0	ΜΔΙΙ		AY-TO ADDRESS	ğ
7 0	OWN	FRSHI	P DISCI OSURE	0 10
1.0	7 1	Facili	tv	10
		7.1.1	Is this disclosing entity/business publicly traded?	
		7.1.2	Identify how this disclosing Entity/Business is registered with the	
			Internal Revenue Service	12
		7.1.3	Enrolling Business/Entity Questionnaire	19
		7.1.4	Attach Documentation	20
		7.1.5	Uploaded Files	21
	7.2	Indivi	idual Owners	22
		7.2.1	Add New Alias/Other Name	25
		7.2.2	Is this individual a US citizen?	27
		7.2.3	Does this owner reside outside the State of Louisiana?	27
		7.2.4	Add Related Individual	29
		7.2.5	Add Subcontractor	30
		7.2.6	Add Plan	31
		7.2.7	Enrolling Individual Questionnaire	32
		7.2.8	No Input Required	33
	7.3	Busir	ness Owners	33
		7.3.1	Add New Location	35
		7.3.2	Add New Name	36
		7.3.3	Add Subcontractor	38
		7.3.4	Add Plan	39
		7.3.5	Enrolling Business/Entity Questionnaire	40
		<u> </u>	No input Required	41
	7.4	Empl	oyee/Agent	41
		/.4.1	Is the individual named above also an owner?	45
		7.4.2	Add New Alias/Other Name	45

		7 4 2 la thia individual a US aitizan?	16
			40
		7.4.4 Does this owner reside outside the State of Louisiana?	46
		7.4.5 Add Related Individual	47
		7.4.6 Add Subcontractor	49
		7.4.7 Add Plan	50
		7.4.8 Agent/Managing Employee Questionnaire	51
	7.5	Resolution of Errors Associated with Number of Members/Owners	52
	7.6	Authorized Agents	53
		7.6.1 Next Button	54
8.0	OWN	ERSHIP ATTESTATION	55
9.0	PAR	TICIPATION AGREEMENT	56
10.0	REV	EW & SUBMIT	59
	10.1	Submission Results	60
11.0	LOU	SIANA MEDICAID PROVIDER ENROLLMENT PORTAL HELP DESK	60

## 1.0 OVERVIEW

The Provider Enrollment Portal is designed to meet Centers for Medicare and Medicaid Services (CMS) requirements for screening and enrolling Medicaid Providers and must be used by all Medicaid Providers, including those who do not participate in fee-for-service.

## 2.0 Accessing the Application

## 2.1 Louisiana Web Site Registration

Before a Provider can access the Provider Enrollment Portal, registration is required. In order to register, follow the instructions located here:

https://www.lamedicaid.com/Provweb1/Provweb Enroll/Web Registration.pdf

Please validate that the enrolling Provider's email given in the registration process is correct, as all correspondence will go to the registration email for the enrollment process.

Once registration is complete, you are enabled to login here:

https://www.lamedicaid.com/account/login.aspx

## 2.2 Log In

Detailed instructions for logging in are provided here:

https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid Provider Login PE Ins tructions User Manual.pdf

After login, look for the Provider Enrollment Portal Application, as shown below:

**Restricted Provider Applications** 

Provider Enrollment Portal Application

## 3.0 Start Page

Start	Taxonomy	Practice Address	Mailing/Pay-To Address	Ownership Disclosure	Ownership Attestation	Participation Agreement	Review & Submit
Name:		Provider Provider	ID: NPI:	Provider Type: 26 - PHARMACY Provider Specialty: 87 - All Other	Sub-Sp None Curren Provide	ecialties: t Status: r Loaded to web, not logged	l in
	We recognize the Louisiana plans, I Documentation y Using this web a Your taxonor Your main pr	at you are a fee-for Dental Benefits Pro for the Provider En op, we will ask you ny value(s) actice address	-service (FFS) facility. You gram Manager plans, and rollment web application to perform and verify the	may also be enrolled a l/or the Coordinated Sy as can be found by click ese items:	is an MCO facility (enri /stem of Care plan). king here.	olled with one of the H	ealthy
	Your Federal     Your disclosu     Then we will ask	Tax ID and mailing/pay ire of ownership inform you to review the L	-to address lation with attestation ouisiana Methicaid Provid	ler Participation Agreen	nent and confirm your	agreement.	

A link to the user manuals associated with the Provider Enrollment System is available on the Start page.

The Navigation Tabs, the **Previous** button, the **Next** button, and the **Save Progress** button are available on every page within the application.

## 3.1 What If Any of the Pre-populated Data is Wrong?

The Provider's name, Provider ID, Provider NPI, Provider Type, Provider Specialty, Sub-Specialties (if applicable), and Mailing/Pay-To Address are pre-populated. These specific pre-populated items cannot be changed within the application. You must contact the Louisiana Provider Enrollment Portal Call Center (Monday – Friday 8 a.m. – 5 p.m. CST.) at 833-641-2140 or <u>louisianaprovenroll@gainwelltechnologies.com</u> to update this information. All other fields, such as addresses, can be changed by simply typing into the specified text box in the application.

#### 3.1.1 Name Change

The Provider name is pre-populated and cannot be changed prior to completion of the application. After the portal application is completed, the Provider can contact the Provider Enrollment Portal Call Center (Monday – Friday 8 a.m. – 5 p.m. CST.) at 833-641-2140 or louisianaprovenroll@gainwelltechnologies.com to have it changed.

In the case of a name change, the call center staff will check the license website to see if the name has changed with the Provider's governing license board.

#### 3.1.2 Changing Provider Type and Specialty

Providers may change data except for the following fields: Provider Type, Specialty. For all other fields, the incorrect information can be typed over for correction.

- Primary Taxonomy
- Physical Address
- Add other sites and addresses
- Contact info for Mailing Address
- Ownership/Management/Agent information (Facilities only)

## 3.2 Navigation Tabs

Along the top of the home screen, the navigation tabs consist of links to the steps required to complete the enrollment application. The steps are listed below:

- Start
- Taxonomy
- Practice Address
- Mailing/Pay-To Address
- Ownership Disclosure
- Ownership Attestation
- Participation Agreement
- Review & Submit

As you progress through the steps of enrollment, check marks are added next to each tab for which progress has been saved, similar to that shown below:



If you click the **Save Progress** button on a page on which required data has not been entered, a red ribbon is displayed explaining the requirement, similar to that shown below:

			Enter a v	alid fax number. (###-#				
art 🗸	Taxonomy 🗸	Practice Address 🛩	Mailing/Pay-To Address 🗸	Ownership Disclosure 🗸	Owners Attestat	hip ion 🗸	Participation Agreement 🛩	Review & Submit
	Name	Provi	der ID:	Provider Type: 20 - PHYSICIAN (ND &	(GP)	Sub-Spec	ialties:	
		Provid	der NPI:	Provider Speciality 70 - Clinic or Other Gro	up Practice	Current S Provider	Status: Loaded to web, not logg	ed in
	Please verify	the following inform	nation and make change	s if necessary:				
	Main Practice	e Address Information	1					
	Street Addres	os 1-*	4200 WHIT					
	100.71.07100			CHALLOR SUITE 130				
	Street Addres	us 2:		CHALL DR SUNC 150				
	Street Addres	u 2	Ann Arbor	EMALL DR SUITE 150				
	Street Addres City: * State: *	s 2	Ann Arbor MI 🗸	ETALL DR SUITE 130				
	Street Addres City: * State: * Zip: *	ss 2:	Ann Arbor MI 🗸 481059694					
	Street Addres City: * State: * Zip: * Contact Nam	ss ≥ e: *	Ann Arbor MI 🗸 481059694 Testa Napp	Enale DR Suite 190				
	Street Addres City: * State: * Zip: * Contact Nam Contact Phon	e: * 1e: *	Ann Arbon MI 🗸 481059694 Testa Napp 225-216-6	Email DR Surre 190				

Once the required data has been entered, you can click the **Save Progress** button and a green ribbon at the top of the page will indicate that you have successfully entered all of the required data, similar to the one shown below.



## 3.3 Control Buttons

The Control Buttons near the bottom of the screen are the primary methods of navigation and saving your progress.

#### 3.3.1 Previous



The **Previous** button (when enabled) allows the user to go back one step from the current page within the application.

#### 3.3.2 Next



The **Next** button (when enabled) allows the user to move forward one step from the current page within the application.

#### 3.3.3 Save Progress



The **Save Progress** button saves the data entered so far into the application where progress was last saved. In this way, for instance, the user can log off and come back later to resume work on the enrollment application. The **Save Progress** function is also used to finalize the submission for the current section of the enrollment process. As each section is completed, be sure to click on the **Save Progress** button. When all the sections are complete and the enrollment request has been successfully submitted, a check mark is displayed to the right of each section on the Navigation Tabs, shown below:

Start 🗸	Taxonomy 🗸	Practice Address 🗸	Mailing/Pay-To Address ✔	Ownership Disclosure 🗸	Ownership Attestation 🗸	Participation Agreement	Review & Submit

## 4.0 Taxonomy

The **Taxonomy** page enables the user to provide the necessary taxonomy information. Only Primary Taxonomy is required (and is usually pre-populated). Taxonomy options are limited by Provider type and Provider specialty. If the Provider has more than one taxonomy number, up to nine taxonomies may be entered. Since this data is important, it should be entered if the Provider has more than one taxonomy. CMS requires this information for reporting purposes. All relevant taxonomies must be entered.

Taxonomy	Practice Address	Mailing/Pay-To Address	Ownership Disclosure	Ownership Attestation	Participation Agreement	Review & Submit
E	Provider I	D:	Provider Type: 26 - PHARMACY	Sub-Spe None	ialties:	
	Provider	NPI:	Provider Specialty: 87 - All Other	Current S Informati	itatus: on Gathering Started and sa	ved for later
Please supply yo	ur taxonomy infor	mation. (Primary taxonomy	is required)			
Primary Taxonom	y:	333600000X - Pharmacy			۹	
Other Taxonomy	1:	use the lookup to select			۹	
Other Taxonomy	2:	use the lookup to select			۹	
Other Taxonomy	3:	use the lookup to select			۹	
Other Taxonomy	4:	use the lookup to select			۹	
Other Taxonomy	5:	use the lookup to select			۹	
Other Taxonomy	6:	use the lookup to select			۹	
Other Taxonomy	7:	use the lookup to select			۹	
Other Taxonomy	8:	use the lookup to select			۹	
Other Taxonomy	9:	use the lookup to select			۹	
						Sava Droan

Click the lookup icon ( ) next to each Taxonomy Code field where you need to add information. A dialogue box similar to the one shown below is displayed:

Select Taxo	nomy	×
Choose a taxor	nomy from the list below	r.
Taxonomy:	no selection	~
		Close Accept

Click the down arrow in the dialogue box to display the Taxonomy dropdown list:

no selection
261QH0100X - Clinic/Center - Health Service
261QH0700X - Clinic/Center - Hearing and Speech
261QM1200X - Clinic/Center - Magnetic Resonance Imaging (MRI)
261QM2500X - Clinic/Center - Medical Specialty
261QM1300X - Clinic/Center - Multi-Specialty
261QR0200X - Clinic/Center - Radiology
261QU0200X - Clinic/Center - Urgent Care
193200000X - Multi-Specialty
193400000X - Single Specialty

When you find the one you want, select it, and then click on the **Accept** button in the dialogue box.

Select Taxo	nomy	$\backslash$
Choose a taxor	nomy from the list below:	$\backslash$
Taxonomy:	no selection	~

Click the **Close** button to close the lookup taxonomy dialogue box at any time.

Continue entering Taxonomies as needed.

Click on the Save Progress button and then the Next button.



Resolve any outstanding issues (which will be displayed as a red banner; see 3.2) and then click on the **Next** button again in order to go to the Practice Address page.

## 5.0 Practice Address

The **Practice Address** is the physical facility location of the practice that is enrolling in Louisiana Medicaid. The **Practice Address** page is also used to capture Contact Name, Contact Phone, and Contact Fax.

Main Practice Address Information		
Street Address 1: *	4200 WHITEHALL DR SUITE 150	
Street Address 2:		
City: *	Ann Arbor	
State: *	MI 🗸	
Zip: *	481059694	
Contact Name: *		
Contact Phone: *	###-###-####	
Contact Fax: *	###-###+####	
Contact Fax: *	###-###-####	

Some fields may be pre-populated, but if a field is incorrect you are enabled to correct it. Fields with an asterisk are required. Enter the information into the text boxes (except for State, for which a drop-down box similar to the one shown below is available).



Click on the Save Progress button and then the Next button.



Resolve any outstanding issues (which will be displayed as a red banner; see 3.2) and then click on the **Next** button again in order to go to the Mailing/Pay-To Address page.

## 6.0 Mailing/Pay-To Address

The **Mailing/Pay-To Address** is the mailing address of the practice that is enrolling in Louisiana Medicaid. The **Mailing/Pay-To Address** page is also used to capture Contact Name, Contact Phone, and Contact Fax, as shown below.

Mailing/Pay-To Address Information	
Your fee-for-service (FFS) mail-to address	s the same as your pay-to address on file. To change this address, submit the form at this link here
Provider Tax ID:	
Street Address 1:	114 W VERMILION ST
Street Address 2:	
City:	LAFAYETTE
State:	LA 🗸
Zip:	705010000
Contact Name: *	Testa Napp
Contact Phone: *	225-216-6081
Contact Fax: *	225-216-6083

Enter the Provider Tax ID. Each time you log out of the application without having completed the enrollment forms, you must enter the Provider Tax ID again.

The Pay-To Address may not be updated in the application. Use the form at lamedicaid.com (<u>https://www.lamedicaid.com/Provweb1/Provider\_Enrollment/20070924%20File%20Update%20</u> Form%20 3 .pdf) if this address needs to be changed.

Only the Contact Name, Contact Phone, and Contact Fax information may be updated in the application. Fields with an asterisk are required. Enter the information into the text boxes.

Click on the Save Progress button and then the Next button.

G Previous Next G	🛓 Save Progress
-------------------	-----------------

Resolve any outstanding issues (which will be displayed as a red banner; see 3.2) and then click on the **Next** button again in order to go to the Ownership Disclosure pages.

## 7.0 Ownership Disclosure

	Provider Verification and Enrollment
5	Practice Mailing/Poy-5 Ownership Ownership Praticipation Review & nt ♥ Tasonony ♥ Address ♥ Address ♥ Disclosure Attratistion Agreement Submit
	Name Proder R: Proder Type Sub-Spectrate: 21-561511/0.6.00 how Proder Spectra
	T2 - Circle or Diar Straight State and state for later
	Use the lads below to complete each form. When all information in all take has been completed, click "Viext":
	Radity Indekad Dennes Budinas Deransyseelingens Authoritaat Agents
	Is this disclosing with youriess publicly traded?
	Identify how this disclosing Entity/Reviews is registered with the Internal Revenue Service:
	Privitely Owned or Non-priotit Providers:
	Ouerroyenskipp PettershipLimited Lability Pettership
	O Limited Lability Corporation (LLC)
	Corporation
	Louisians Government Providers
	stermary ter type or compr a constraint it assumate agreementer towards. Steet composite trion among city and <i>y or Parklik</i> , Department of Children and Farney SwireskOCKSS. Other Ge Medward Hardhardtells (Other Ge Melder Melder) (Den Gel Gel Agreement and Denabelli and Service(CAA), Solid and Service(CAA), Solid and Service(CAA), Solid and Service(CAA), Children and Service(CAA), Children and Service(CAA), Children and Service(CAA), Solid and Service(CAA),
	C City and/or Parish Government
	OCFS (Department of Ohldren and Family Serviced)     OLDH OBH
	0 L0H 04A5
	C LDH VRis
	0 LDH 0CDD
	LDH Offen     enter decorption of other LDH (Acitly     Use Local Governing Srithy)
	O LB1 Excel Education Agency)
	LSU Hospital     enter LSU hospital name      Other State Owned Entity     enter description of other State-owned entity
	Has this EntityBusiness (hines is existence) – AND – Any Entity/Business efficiented with the seams Tax ID manher – AND – Any past er connel consult, specifi, mangleig engagene is person child is devicelling directed have had as convertly have any involvement as
	Errolling Business/Entity Questionnaire
	O Yes O No Ever been convicted of a orininal offense in any program under medicant, Medicaid, any Titled services in the Loukiana Medical Assistance Program?
	O Yes O No Form Margindiacylinary datas biase as against any lorense or mellitatation held is any fittere or US Territory, idealiding disciplinary lactor, board consent order; suppression, resocration; or voluting surrender of a license of centification? Use O No Form Margindiacylinary datas biase as against any constant on or voluting surrender of a license of centification? Use O No Form Margindiacylinary datas biase as against any constant on or voluting surrender of a license of centification? Use O No Form Margindiacylinary datas biase as against any constant on or voluting surrender of a license of centification?
	discipling action from Medicare, Medicale or other healthcare program(s) in any State or CHamistra and any State or CHamistra and State (State State) O Yes O No Currently have a negative balance or currently ones money to any State or Federal funded program including Medicael
	and Medicare? Oties Onio Betweeter the subject of any investigation under MAPE (Louisand's Medical Assistance Program Integrity Lan) or by any be informed and the constantion or State assess?
	Yes O No Correctly have any open or pending healthcare court cases?
	Vits No Eersteen derlied mäljandisk insunnas? Vits No Currently has or eerst had any type of felony conviction/pill
	A summary of details MSI be provided in the box below for questions answerd "HS" and supporting documentation MSII be attached. (Failure to provide details and an attachment will recall in a supported application)
	A vetic license, if applicable, <u>MSS</u> be uploaded here.
	A Mach Topuretation
	© recotos neor ♥ O 2022 Galewell Technologies   All Rights Exerved   Version 1.0
	Fer Gainvell Technologies Technical Support, cell fool-free 1-877-588-8753 Mailing Lucasae Department of Health 1/0. Bac 68 (3 Jatan Ruoge, L. 7021-0827 Physical Köll N. Mai Herne (Tatos Tong, L. 7020) [Phane: 252: 550 (1 Fac: 252: 550 (1
	Medicaid Castomer Service: 1888 342:6207   Healthy Louisiana: 1855 223 6948

The Disclosure of Ownership for Facilities form is separated into five sections, or tabs, as shown at the top of the form:

Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents
				-

The default tab, Facility, is selected for you when you first access the Disclosure of Ownership for Facilities form.

## 7.1 Facility

#### 7.1.1 Is this disclosing entity/business publicly traded?



Select the Yes radio button or the No radio button.

# 7.1.2 Identify how this disclosing Entity/Business is registered with the Internal Revenue Service

ivately Owned or Non-profit Providers:	
O Sole Proprietorship	
O Partnership/Limited Liability Partnership	
O Limited Liability Corporation (LLC)	
○ Nonprofit	
O Corporation	
iisiana Government Providers: entify the type of Entity / Business if Louisia ildren and Family Services(DCFS), Office of	ana government owned. Select only one from among City and / or Parish, Departmen Behavioral Health(OBH), Office of Public Health(OPH), Office of Aging and Adult
rvices(OAAS), Office for Citizens with Devel uisiana State University(LSU), or Other State	opmental Disabilities(OCDD), Villa, Other LDH agency, Local Education Agency(LEA), e - owned entity.Check the appropriate box and complete the applicable fields.
O City and/or Parish Government	
O DCFS (Department of Children and Fami	ly Services)
O LDH OBH	
O LDH OAAS	
O LDH Villa	
O LDH OPH	
O LDH OCDD	
O LDH Other:	enter description of other LDH facility
O LGE (Local Governing Entity)	
O LEA (Local Education Agency)	
O LSU Hospital:	enter LSU hospital name
O Other State Owned Entity:	enter description of other State-owned entity

#### 7.1.2.1 Privately Owned or Non-Profit Providers

Click on the radio button of the appropriate selection.

Priv	vately Owned or Non-profit Providers:
	O Sole Proprietorship
	O Partnership/Limited Liability Partnership
	O Limited Liability Corporation (LLC)
	O Nonprofit
	<ul> <li>Corporation</li> </ul>

#### **Sole Proprietorship**

No additional questions.

#### Partnership/Limited Liability Partnership

If Partnership/Limited Liability Partnership is selected, an additional question is displayed:

Partnership/Limited Liability Partnership
Number of members identified for this partnership: \* (minimum 2)

In the text box, enter the number of members in the partnership. The asterisk indicates that this is required information. The minimum number of members is 2.

The number of members specified under the Facility tab must match the number of records for members created in the Individual Owners and/or Business Owners tab. For instance, if you entered 2 members under the Facility tab, but created a record for only one member, the system responds with the following messages after you select **Next** or **Save Progress**:

The number of ownership disclosures does not match the number of members entered on the Facility tab. The number of Individual Owners and/or Business Owners disclosed must match.

Please enter at least one record for agents/managing employees (this is required for a response of 'Yes' on the Employee Agent tab).

#### Limited Liability Corporation (LLC)

If Limited Liability Corporation (LLC) is selected, two additional questions are displayed:

Limited Liability Corporation (LLC)
 Number of members identified for this LLC: \*
 Number of managing employees identified for this LLC: \*

	7
	5

In the first text box, enter the number of members in the LLC. The asterisk indicates that this is required information. Enter any number greater than 0 for members.

In the second text box, enter the number of managing employees in the LLC. The asterisk indicates that this is required information. You must enter any number including 0, for managing employees.

Go to 7.2 (Individual Owners), and/or 7.3 (Business Owners and/or 7.4 (Employee/Agent). If you enter data into the text boxes and attempt to proceed or save your progress before going to the other tabs, the system responds with the following message.

Please indicate whether this facility has individual owners by selecting Yes or No on the Individual tab.

The number of members/managing employees specified under the Facility tab must match the number of records for members created in the Individual Owners and/or Business Owners and/or Employee/Agent tabs. For instance, if you entered 2 members and 1 managing employee under the Facility tab, but created a record for only one member, the system responds with the following message after you select **Next** or **Save Progress**:

The number of ownership disclosures does not match the number of members entered on the Facility tab. The number of Individual Owners and/or Business Owners disclosed must match.

Please enter at least one record for agents/managing employees (this is required for a response of 'Yes' on the Employee Agent tab).

#### Nonprofit

If Nonprofit is selected, an additional question is displayed:



In the text box, enter the number of members on the governing board. The asterisk indicates that this is required information.

Go to 7.2 Individual Owners and/or 7.4 Employee/Agent. If you attempt to proceed or save progress before entering data into the number of board members, the following message is displayed:

A Nonprofit requires a number of members appointed to the governing board.

The number of members specified under the Facility tab must match the number of records for members created in the Individual Owners and/or Employee/Agent tab. For instance, if you entered 2 members under the Facility tab, but created a record for only one member, the system responds with the following message after you select **Next** or **Save Progress**:

The number of disclosures marked as board members does not match the number of board members entered on the Facility tab. The number of disclosures marked as board members (Individual Owner and/or Employee Agent tabs) must match.

#### Corporation

If Corporation is selected, three additional questions and an additional radio button are displayed:

Corporation	
Number of stakeholders/individual owners identified for this corporation with 5% or greater ownership: *	
Number of Board of Director members identified for this corporation: *	
Number of officers identified for this corporation: *	
$\hfill \square$ This corporation's annual revenue is greater than or equal to \$5 Million	

In the first text box, enter the number of stakeholders/individual owners  $\frac{1}{2}$  with 5% or greater ownership in the corporation. The asterisk indicates that this is required information. Enter a number 0 or greater.

In the second text box, enter the number of Board of Directors for the corporation. The asterisk indicates that this is required information. Enter a number 0 or greater.

In the third text box, enter the number of officers in the corporation. The asterisk indicates that this is required information. Enter a number 1 or greater.

Click on the additional radio button if the corporation's annual revenue is greater than or equal to \$5 Million. Do not click on the radio button if the corporation's annual revenue is less than \$5 Million.

Go to 7.2 Individual Owners and/or 7.3 Business Owners and/or 7.4 Employee/Agent. If you enter data into the text boxes and attempt to proceed or save your progress before going to the other tabs, the system responds with the following message.

Please indicate whether this facility has individual owners by selecting Yes or No on the Individual tab.

A Corporation requires a number of stakeholders/individual owners. A Corporation requires a number of Board of Director members. A Corporation requires a number of officers.

The number of Stakeholder/Individual owners, Board of Directors and officer specified under the Facility tab must match the number of records for members and officers created in the Individual Owners and/or Business Owners and/or Employee/Agent tabs. For instance, if you entered 2 Board of Director members and 2 officers under the Facility tab, but created a record for only one member, the system responds with the following messages after you select **Next** or **Save Progress**:

The number of ownership disclosures does not match the number of members entered on the Facility tab. The number of Individual Owners and/or Business Owners disclosed must match. The number of disclosures marked as corporate officers does not match the number of officers entered on the Facility tab. The number of disclosures marked as officer (Individual Owner and/or Employee Agent tabs) must match.

#### 7.1.2.2 Louisiana Government Providers

Select only one option from the displayed government entities.

Louisiana Government Providers: Identify the type of Entity / Business if Louisiana government owned. Select only one from among City and / or Parish, Department of Children and Family Services(DCFS), Office of Behavioral Health(OBH), Office of Public Health(OPH), Office of Aging and Adult Services(OAAS), Office for Citizens with Developmental Disabilities(OCDD), Villa, Other LDH agency, Local Education Agency(LEA), Louisiana State University(LSU), or Other State - owned entity.Check the appropriate box and complete the applicable fields.

O City and/or Parish Government		
O DCFS (Department of Children and Family	y Services)	
O LDH OBH		
O LDH OAAS		
O LDH Villa		
O LDH OPH		
O LDH Other:	enter description of other LDH facility	
O LGE (Local Governing Entity)		
O LEA (Local Education Agency)		
O LSU Hospital:	enter LSU hospital name	
O Other State Owned Entity:	enter description of other State-owned entity	

If LDH Other is selected, the corresponding text box is activated. Enter the description of the facility into the text box.

LDH Other:	enter description of other LDH facility

If you attempt to proceed or save your progress before entering a description, the system responds with the following message.

Enter a description for the LDH - Other entity.

Go to 7.2 Individual Owners and 7.3 Business Owners. If you attempt to proceed or save your progress before doing so, the system responds with the following message.

At least one record must be designated as authorized agent. Use the Employee/Agent tab to enter an agent record and mark the Authorized Agent checkbox.

If LSU Hospital is selected, the corresponding text box is activated. Enter the name of the LSU hospital into the text box.

LSU Hospital:
 enter LSU hospital name

If you attempt to proceed or save your progress without entering the LSU hospital name, the system responds with the following message.

Enter the LSU hospital name/description.

Go to 7.2 (Individual Owners) and 7.3 (Business Owners). If you attempt to proceed or save your progress before doing so, the system responds with the following message.

At least one record must be designated as authorized agent. Use the Employee/Agent tab to enter an agent record and mark the Authorized Agent checkbox.

If Other State-Owned Entity is selected, the corresponding text box is activated. Enter a description of the entity into the text box.

If you attempt to proceed or save your progress without entering a description, the system responds with the following message.

	Enter the descrip	tion for Other State-owned Entity.	
• Other State Owne	d Entity:	enter description of other State-owned entity	

Go to 7.2 Individual Owners and 7.3 Business Owners. If you attempt to proceed or save your progress before doing so, the system responds with the following message.

At least one record must be designated as authorized agent. Use the Employee/Agent tab to enter an agent record and mark the Authorized Agent checkbox.

#### 7.1.2.3 Selection Change

Changing your response to IRS entity type will cause the software to display the following information:



#### 7.1.3 Enrolling Business/Entity Questionnaire

Has this Entity/Business (since its existence) – AND – Any Entity/Business affiliated with the same Tax ID number – AND – Any past or current owners, agents, managing employees or persons with a controlling interest have had or currently have any involvement or participation with (since the inception of those programs), as follows:

Read each question carefully and click on the appropriate Yes or No radio button.

O Yes	O No	Ever been convicted of a criminal offense in any program under medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program?
O Yes	O No	Ever had any disciplinary action taken against any license or certification held in any State or US Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license of certification?
O Yes	○ No	Ever been denied enrollment, suspended, or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid, or other healthcare program(s) in any State or US Territory?
O Yes	O No	Currently have a negative balance or currently owes money to any State or Federal Funded program including Medicaid and Medicare?
O Yes	O No	Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by an law enforcement, regulatory, or State agency?
O Yes	O No	Currently have any open or pending healthcare court cases?
○ Yes	O No	Ever been denied malpractice insurance?
O Yes	O No	Currently has or ever had any type of felony conviction(s)?
i summ Failure i	ary of det to provide	ails <u>MUST</u> be provided in the box below for questions answered "YES" and supporting documentation <u>MUST</u> be attached. details and an attachment will result in a suspended application)
valid l	icense, if a	pplicable, <u>MUST</u> be uploaded here.
1 Att	ach Docum	entation
I Att	ach Docum	entation

All questions are required. Use the text box to submit

regarding each "**Yes**" answer. If necessary, use the box resize function to expand or reduce the size of the text box to fit your requirement.

details

#### 7.1.4 Attach Documentation

Allowed file extensions for uploads are pdf, jpg, gif, png, doc, docx, tif and tiff.

- No limit to the number of uploads
- 10mb max per file



Click on the **Attach Documentation** button to open the **Upload Documentation** window. Attach all official legal documents regarding the occurrence of a Yes answer, including any reinstatements.

Upload Documentation	×
Choose File No file chosen Description	
Close	Jpload

Click on the **Choose File** button to begin the upload. Your computer's file exploration tool will open.

💿 Open					×
$\leftarrow \rightarrow$ $\checkmark$ $\uparrow$ $\blacksquare$ > This	s PC > Desktop > PES	~	5	, P Search PES	
Organize • New folde	r			III	- 🔳 🔞
S This PC	Name			Status	Date mo '
3D Objects	Enrollment_Entities			$\odot$	5/5/202
Desktop	Enrollment_Entities			$\odot$	5/5/2021
Cocuments	PES_Fac_FFS			$\odot$	4/21/202
Downloads	PES_Fac_FFS			$\odot$	4/21/202
h Music	PES_Fac_MCO			$\odot$	4/21/202
<ul> <li>Rictures</li> </ul>	PES_Fac_MCO			$\odot$	4/21/202
Pictures	PES_Ind_FFS			$\odot$	4/21/202
Videos	PES_Ind_FFS			$\odot$	4/21/202
😂 OSDisk (C:)	PES_Ind_MCO			2	5/10/202
SheehanR (\\labr	PES_Ind_MCO			$\odot$	5/3/2021
🦡 Genpublic\$ (\\lat	PES_Ind_MCO-tb edits			$\odot$	5/10/202
🛶 Shared A\labrfsr 🗡	<				>
File nar	ne: PES_Ind_MCO		~	Custom Files	~
				Open	Cancel
				1	

Find the file you want and select it, then click on the **Open** button. The file name you selected is now displayed in the Upload Documentation window.

Upload Documentation	×
Choose File PES_Fac_MCO.pdf Description	Type a description of the document into the text box.
	Use box re-size function to expand or reduce the size of the text box to fit your requirement.
Close	Then click on the <b>Upload</b> button.

#### 7.1.5 Uploaded Files

After you have uploaded files, they are displayed in a manner similar to that shown below:

File Name	Description	Added		
	1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.			
test 2.docx	N/A	07/07/2021	Telete	

If you misplace the file, you are enabled to click on the file name to download it to your computer. You are also enabled to delete any file you may have uploaded.

Delete File?	×
Are you sure you want to delete this file? (this action cannot be undone)	:
Cancel Confirm	n

Click on the **Confirm** button to delete the file. The file will be immediately removed, and the following message displayed:





Next, you must click on the Individual Owners tab, then the Business Owners tab, then the Employee/Agent tab, and then possibly the Authorized Agents tab to answer the following questions:

## 7.2 Individual Owners

#### **Usage Notes:**

- If a Louisiana Government Provider IRS reporting type is selected, the Individual Owners tab will be inactive but viewable.
- If you have started completing information in any of the tabs and realize it should have been entered in another tab, you will need to click the "Cancel" button in the bottom right corner to remove the record that was started and select the "No" radio button for the individual owner with 5% or more question at the top of the screen.

Disclosure o	f Ownership for Facil	ities				
Use the tabs	below to complete ea	ch form. When all in	formation in all tabs	has been completed, cl	lick "Next":	
Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents		
Under Federal interest (either	REGULATIONS, AN ENTITY/BU R SEPARATELY OR IN COMBINA	isiness must fully disclo tion) of 5% or more of 1	se ALL persons and entitie this disclosing Entity/Bus	INESS.		
See Federal Reg	SULATIONS 42 CFR § 455.104	4(в)(1)				
Doos this fac	ility have any individ	ual owners with own	archip of 5% or graat	ar <sup>2</sup>		
Does this fue	any nave any married	uu owners wun own	ership of 5% of great			
○ Yes ○ No A valid licens	o e. if applicable. MUST l	be unloaded here.				
	-, -, -, -, -,				<u> </u>	
					1	
🏦 Attach D	ocumentation					
Uploaded	files:					

#### If No, proceed to the **Business Owners** tab (7.3).

If Yes:

Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents
For each india buttons to mo	vidual with direct own ake changes:	ership of 5% or or g	reater in this entity, cl	ick "Add New" and complete the form. Use the "Edit" and "Delete"
Name	Add	ress	Percent O	wnership
+ Add New	Individual Owner			

For each individual with direct ownership of 5% or greater, click on the **+Add New Individual Owner** button.

First Name *		
Middle Name *		
Maiden Name		
Last Name *		
Hyphenated Last Name		
Title/Position *		
Percent Ownership In Disclosing Business *	100	
SSN *		
Date of Birth *		
NPI		
Phone Number *	###_6##_#6##	

Fill out the form carefully. Red asterisks denote required fields. If Sole Proprietor is selected, the percent of ownership will be populated with 100% and the field cannot be changed.

As shown in the table below, at least one check box is displayed next, dependent on the privately-owned or non-profit IRS registration type (see 7.1.2).

	This individual is a board member of this organization	This individual is an officer of this organization	This individual is an authorized agent of this organization
Sole Proprietorship			Ø
Partnership/Limited			
Liability			
Partnership			
Limited Liability			
Corporation			
Nonprofit	V		$\overline{\mathbf{A}}$
Corporation	${\bf \triangleleft}$	${\bf \triangleleft}$	$\checkmark$



Click on the check box if the specified individual is a board member. Ensure that for each individual that is a board member this box is checked. This check box only shows when the Non-profit and Corporation radio buttons are selected.



Click on the check box if the specified individual is an officer. Ensure that for each individual that is an officer this box is checked. This check box only shows when the Corporation radio button is selected.

This individual is an authorized agent of this facility \* \* authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms

Click on the check box if the specified individual is an authorized agent of the facility. Otherwise leave it unchecked. If checked, the Authorized Agent tab will be populated with data (see 7.6). At least one Individual Owner or Employee/Agent must be designated as an Authorized Agent. Ensure that for each individual that is an authorized agent this box is checked.

Address Line *	
City *	
State *	<b>v</b>
Zip *	
ng Address/PO Box:	
ing Address/PO Box:	
ng Address/PO Box: Address Line *	
ing Address/PO Box: Address Line * City *	
Address /PO Box: Address Line * City * State *	

Fill out the form carefully. Red asterisks denote required fields.

Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?
○ Yes ○ No
Is this individual a US citizen? If no, provide alien verification number:
○Yes ○No
Alien Verification
Does this owner reside outside the State of Louisiana?
○ Yes ○ No
Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?
○Yes ○No
Does the individual owner have a business transaction with any subcontractor(s) for services amounting to \$25,000 or more?
⊖Yes ⊖No
Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participate in a Federal/State Funded healthcare program?
⊖Yes ⊖No

#### 7.2.1 Add New Alias/Other Name

Has the owner named above ever used or been known by any other name including married, maiden, hyphenated or alias?

If yes, the page expands to include the +Add New Alias/Other Name button.

If no, proceed to next question.

Has	the owner named abov	re ever used or been known	ו by any other name includi	ng married, maiden, hyphenated, or alias?		
• Y	$\odot$ Yes $\bigcirc$ No					
FOF	For each alias or other name, click "Add New" and complete the form. Use the "Edit" and "Delete" buttons to make changes:					
	First Name Middle Name Last Name Hyphenated Last Name					
	+ Add New Alias/Other Na	ame				

For each other name, click on the **+Add New Alias/Other Name** button. The system responds by opening the Alias/Other Name window, as shown below:

Alias/Other Name	×
First Name: *	
Middle Name: *	
Maiden Name:	
Last Name: *	
Hyphenated Last Name:	
	Cancel

The red asterisks indicate required fields. Click on the **Save** button once you have entered the data.

Once you have created a record, a summary is displayed along with the Edit and Delete icons.

First Name	Middle Name	Last Name	Hyphenated Last Name	
Rocky	R	Smith		🖉 Edit 📋 Delete
+ Add New Alias/	Other Name			

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

 $\mathbf{N}$ 

 $\backslash$ 

#### 7.2.2 Is this individual a US citizen?

If yes, proceed to next question.

If no, the Alien Verification text box is activated.

Is this individual a US citizen? If no, provide alie	en verification number:
○ Yes ● No	
Alien Verification	

Enter the alien verification number.

#### 7.2.3 Does this owner reside outside the State of Louisiana?

Does this owner reside outside the State of Louisiana?	
○Yes ○No	

If no, proceed to next question.

If yes, the form expands to include the following additional question:

Has this owner been issued any Medicare or Medicaid provider numbers by the domicile state?

If no, proceed to next question.

If yes, the form expands again to include the +Add Additional State Provider Number button.

State	Medicaid Number	Medicare Number
-------	-----------------	-----------------

For each additional Provider number, click on the **+Add Additional State Provider Number** button. The system responds by opening the Non Resident Provider window, as shown below:

Non Resident Provider		×	Use the drop down box to
State: *			select a state, and then enter the Medicaid Number
Medicaid Number: *			and the Medicare
Medicare Number: *			asterisks indicate required fields.
	Cancel	ve	Then click on the <b>Save</b> button.

Once you have created a record, a summary is displayed along with the **Edit** and **Delete** icons.

State	Medicaid Number	Medicare Number	
AL	1111111	222222222	🖋 Edit 🛛 📋 Delete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.2.4 Add Related Individual

Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?

If no, proceed to next question.

If yes, the form expands to include the **+Add Related Individual** button.

Is this owner related to any other individual own disclosing Entity/Business?	Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?				
Yes O No For each relative, click "Add New" and complete	the form. Use the "Edit" and	"Delete" buttons to make changes:			
First Name	Last Name	Title			
+ Add Related Individual					

For each related individual, click on the **+Add Related Individual** button. The system responds by opening the Individual Owner Relative window, as shown below:

Individual Owner Relative	×	Enter the required data into the text
First Name: *		required fields. Then click on the
Middle Name: *		Save button.
MaidenName		
Last Name: *		
HyphenatedLastName		
Relationship: *		
Title: *		
Relationship Type: *	Owner O Agent O Managing Employee O Subcontractor	
	Cancel Save	

Once you have created a record, a summary is displayed along with the **Edit** and **Delete** icons.

First Name	Last Name	Title		
Manfred	Rococo	None	🖉 Edit	Telete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

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#### 7.2.5 Add Subcontractor

Does the individual owner have a business transaction with any subcontractor(s) for services amount to \$25,000 or more?

If no, proceed to next question.

If yes, the form expands to include the +Add Subcontractor button.



For each subcontractor, click on the **+Add Subcontractor** button. The system responds by opening the Subcontractor window, as shown below:

Subcontractor		×	Enter the required data into the boxes.
Subcontractor Business Name: *			The red asterisks indicate required
Subcontractor Owner Name: *			fields. Then click on the <b>Save</b> button.
Address: *			/
City: *			
State: *	💙		
Zip: *	##### or #########		
Phone Number: *	###-###-####		
Contact Email: *			
		Cancel Save	

Once you have created a record, a summary is displayed along with the **Edit** and **Delete** icons.

Subcontractor Business Name	Subcontractor Owner Name	State		
Satellite	Testa Napp	LA	🖉 Edit	Telete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.2.6 Add Plan

Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?

If no, proceed to next question.

If yes, the form expands to include the +Add Plan button.

Does the individual owner have in a Federal/State Funded heal	e direct or indirect ownership or controlling interest o thcare program?	f 5% or greater in any other Entity/Business that participates
● Yes ○ No For each participating plan, cli	ck "Add New" and complete the form. Use the "Edit" o	and "Delete" buttons to make changes:
Plan Name	DBA Name	State
+ Add Plan		

For each plan, click on the **+Add Plan** button. The system responds by opening the Other Plan window, as shown below:

Other Plan	×	Enter the data into the
Plan Name: •	1	boxes. Then click on the Save button
DBA Name: •		
Tax ID: •		The red asterisks
State: •		required
Plan ID Number: •		lielus.
	Cancel Save	

Once you have created a record, a summary is displayed along with the Edit and Delete icons.

Plan Name	DBA Name	State	
Medicare	Satellite	LA	🖋 Edit 👕 Delete
+ Add Plan			

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.2.7 Enrolling Individual Questionnaire

Read each question carefully and click on the appropriate **Yes** or **No** radio button.

○ Yes	O No	Ever been convicted of a criminal offense in any program under medicare, Medicaid, any Titled services in the Louisian Medical Assistance Program?
O Ves	○ No	Ever had any disciplinary action taken against any license or certification held in any State or US Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license of certification?
⊖ Yes	O No	Ever been denied enrollment, suspended, or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid, or other healthcare program(s) in any State or US Territory?
⊖ Yes	O No	Currently have a negative balance or currently owes money to any State or Federal Funded program including Medica and Medicare?
⊖ Yes	O No	Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by a law enforcement, regulatory, or State agency?
O Yes	○ No	Currently have any open or pending healthcare court cases?
O Yes	O No	Ever been denied malpractice insurance?
O Yes	O No	Currently has or ever had any type of felony conviction(s)?
summ ailure	ary of det to provide	alls <u>MUST</u> be provided in the box below for questions answered "YES" and supporting documentation <u>MUST</u> be attached details and an attachment will result in a supported application)

All questions are required. Use the text box to submit details regarding each "**Yes**" answer. If necessary, use the box re-size function to expand or reduce the size of the text box to fit your requirement. Click on the **Save Individual Owner** button when you are finished.

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#### 7.2.8 No Input Required

If all required data has been submitted or the IRS registration type is a government entity and the user clicks on the Individual Owners tab, the screen below is displayed:

e the tabs	below to complete ea	ch form. When all inf	ormation in all tabs h	nas been completed, click "Next"
Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents

## 7.3 Business Owners

If you have started completing information in any tabs and realize it should have been entered in another tab, you will need to click the "Cancel" button in the bottom right corner to remove the record that was started and select the "No" radio button for the individual owner with 5% or more question at the top of the screen.

Disclosure o	Disclosure of Ownership for Facilities					
Use the tabs	ise the tabs below to complete each form. When all information in all tabs has been completed, click "Next":					
Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents		
Under Federai interest (eithe See Federal Re	Jnder Federal Regulations, an Entity/Business must fully disclose ALL persons and entities that have an ownership nterest (either separately or in combination) of 5% or more of this disclosing Entity/Business. See Federal Regulations 42 CFR § 455.104(b)(1)					
Does this fa	cility have any business	owners with owners	nip of 5% or greater?			
○ Yes ○ N A valid licen:	o se, if applicable, <u>MUST</u> b	e uploaded here.				
1 Attach I	▲ Attach Documentation					
Uploaded	files:					

If No, proceed to the Employee/Agent tab (7.4).

If yes:

Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents
For each bus buttons to m	iness with direct owner ake changes:	ship of 5% or greater	in this entity, click ".	Add New" and complete the form. Use the "Edit" and "Delete"
Name			Address	
+ Add New	Business Owner			

For each business with direct ownership of 5% or greater, click on the **+Add New Business Owner** button.

DBA Name: *	
Legal Name: *	
Tax ID Number *	
Phone: *	###-###
Fax: *	###+-####-#####
Email: *	
Website *	
Street Address:	
Address Line: *	
City: *	
State: *	<b>v</b>
Zip *	

The red asterisks indicate required fields.

Mai	ling Address/PO Box:	
	Address Line: *	
	City: *	
	State: *	
	Zip *	
Doe O Y Has O Y Doe	es this business have any additional locations es O No the Entity/Business owner used or previously es O No es the entity/business owner have a business t es O No	been known by any name other than the legal name or the Doing Business As (DBA) name? ransaction with any subcontractor(s) for services amounting to \$25,000 or more?
ls th	nis Entity/Business currently enrolled in a Fed	eral/State Funded healthcare program?
ΟY	es O No	

#### 7.3.1 Add New Location

Does this business have any additional locations?

If no, proceed to 7.3.2.

If yes, the form expands to include the **+Add New Location** button.

Does this business have any additional locations?			
● Yes O No			
For each additional location, click "Add New" and	l complete the form. Use the "Edit" o	and "Delete" buttons t	o make changes:
Location DBA Name	Address	City	State
+ Add New Location			

For each location, click on the **+Add New Location** button. The system responds by opening the Business Location window, as shown below:

DBA Name: Ine Doxes. The red asterisks indicate required fields. Then click on the Save button.   Iax ID Number ###.###.####   Fax: ###.###.####   Fax: ###.###.####   Email: Street Address:   \[ \[ \[ \] City: \[ \] \[ \] City:   State: \[ \] \[ \] \[ \] \[ \] City:	Business Location		×	Enter the required data into
Legal Name:  Tax ID Number Phone:  ###.#################################	DBA Name: *			red asterisks
Tax ID Number*	Legal Name: *			fields. Then click
Phone: * ###################################	Tax ID Number *			button.
Fax:*       ###.###         Email:*	Phone: *	###.###.####		
Email: * Street Address: Address Line: * City: * State: * Zip * Cancel Save	Fax: *	###.###.####		
Street Address:	Email: *			
Address Line: * City: * State: * Zip * Cancel Save	Street Address:		p	
City: * State: * Zip * Cancel Save	Address Line: *			
State:* V Zip* Cancel Save	City: *			
Zip *	State: *	🗸		
Cancel Save	Zip *			
Cancel			A	
			Cancel Save	

Once you have created a record, a summary is displayed along with the Edit and Delete icons.

Location DBA Name	Address	City	State
Satellite	2220 Blues Drive	Baton Rouge	LA 🕜 Edit 👕 Delete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.3.2 Add New Name

Has the Entity/Business owner used or previously been known by any name other than the legal name or the Doing Business As (DBA) name?

If no, proceed to 7.3.3.

If yes, the page expands to include the **+Add New Name** button.

Has the Entity/Business owner used or previo	usly been known by any name other than the legal name or the Doing Business As (DBA) name	?
● Yes O No		
For each additional name, click "Add New" o	nd complete the form. Use the "Edit" and "Delete" buttons to make changes:	
Name	Tax ID	
+ Add New Name		

For each other name, click on the **+Add New Name** button. The system responds by opening the Business Other Name window, as shown below:

Business Other Name	×
Name: *	
Tax ID: *	
	Cancel

Click on the **Save** button once you have entered the data.

Once you have created a record, a summary is displayed along with the **Edit** and **Delete** icons.

Name	Tax ID		
Rocky Rococo	22222222	🖋 Edit	Telete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.3.3 Add Subcontractor

Does the entity/business owner have a business transaction with any subcontractor(s) for services amounting to \$25,000 or more?

If no, proceed to 7.3.4.

If yes, the form expands to include the +Add Subcontractor button.



For each subcontractor, click on the **+Add Subcontractor** button. The system responds by opening the Subcontractor window, as shown below:

Subcontractor		×	Enter the required data into the boxes. The red asterisks
Subcontractor Business Name: *			indicate required fields. Then
Subcontractor Owner Name: *			
Address: *			
City: *			
State: *	🗸		
Zip: *	###### or ##########		
Phone Number: *	###-###-####		/
Contact Email: *			
		Cancel Save	

Once you have created a record, a summary is displayed along with the Edit and Delete icons.

Subcontractor Business Name	Subcontractor Owner Name	State	
Satellite	Testa Napp	LA	🖋 Edit 🔋 Delete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

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#### 7.3.4 Add Plan

Is this Entity/Business currently enrolled in a Federal/State Funded healthcare program?

If no, proceed to 7.3.5.

If yes, the form expands to include the +Add Plan button.

Is this Entity/Business currently e	enrolled in a Federal/State Funded healthcare progra	am?
● Yes ○ No		
For each participating plan, click	"Add New" and complete the form. Use the "Edit" o	and "Delete" buttons to make changes:
Plan Name	DBA Name	State
+ Add Plan		

Click on the **+Add Plan** button and enter the data into the text boxes:

Other Plan		×
Plan Name: *		
DBA Name: *		
Tax ID: *		
State: *	•	
Plan ID Number: *		
	Cancel Save	

Once you have created a record, a summary is displayed along with the **Edit** and **Delete** icons.

Plan Name	DBA Name	State	
Medicare	Satellite	LA	🖋 Edit 👕 Delete
+ Add Plan			

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

## 7.3.5 Enrolling Business/Entity Questionnaire

Read each question carefully and click on the appropriate **Yes** or **No** radio button.

Ever been convicted of a criminal offense in any program under medicare, Medicaid, any Titled services in the Louisiana	ale leguileu.
Medical Assistance Program:	Use the text
Ever had any disciplinary action taken against any license or certification held in any State or US Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license of certification?	details
Ever been denied enrollment, suspended, or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid, or other healthcare program(s) in any State or US Territory?	each " <b>Yes</b> " answer, If
Currently have a negative balance or currently owes money to any State or Federal Funded program including Medicaid and Medicare?	necessary, use the box
Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency?	re-size function to
Currently have any open or pending healthcare court cases?	expand or
Ever been denied malpractice insurance?	reduce the size of the text
Currently has or ever had any type of felony conviction(s)?	box to fit your
MUST be provided in the box below for questions answered "YES" and supporting documentation <u>MUST</u> be attached. tails and an attachment will result in a suspended application) Save Business Owner Cancel	requirement. Click on the <b>Save</b> <b>Business</b> <b>Owner</b> button when you are finished.
	Ever had any disciplinary action taken against any license or certification held in any State or US Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license of certification? Ever been denied enrollment, suspended, or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid, or other healthcare program(s) in any State or US Territory? Currently have a negative balance or currently owes money to any State or Federal Funded program including Medicaid and Medicare? Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency? Currently have any open or pending healthcare court cases? Ever been denied malpractice insurance? Currently has or ever had any type of felony conviction(s)? MUSET be provided in the box below for questions answered "YES" and supporting documentation MOST be attached alls and an attachment will result in a suspended application) Save Business Owner Cancel

#### 7.3.6 No Input Required

If all required data has been submitted or the IRS registration type is a government entity and the user clicks Business Owners tab, the screen below is displayed:

Disclosure o	Disclosure of Ownership for Facilities				
Use the tabs	below to complete eac	h form. When all info	ormation in all tabs h	as been completed, click "Next":	
Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents	
No input is r	required on this tab at t	his time. Please cont	inue by clicking on th	e Employee/Agent tab.	

## 7.4 Employee/Agent

Facility       Individual Owners       Business Owners       Employee/Agent       Authorized Agents         UNDER FEDERAL REGULATIONS, A PROVIDER MUST DISCLOSE TO THE MEDICAID AGENCY, PRIOR TO ENROLLING, THE NAME AND ADDRESS OF EACH PERSON WHO IS AN AGENT OR MANAGING EMPLOYEE OF THE PROVIDER (GENERAL MANAGER, BUSINESS       MANAGER, ADMINISTRATOR, OR OTHER INDIVIDUAL WHO EXERCISES OPERATIONAL OR MANAGERIAL CONTROL OR CONDUCTS DAY TO DAY OPERATIONS OF THE AGENCY) AND ANY PERSON WITH AUTHORITY TO OBLIGATE OR ACT ON BEHALF OF THE DISCLOSING ENTITY.         See FeDERAL REGULATIONS 42 CFR § 455.106(A)(1)(2)       Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or officer?         O Yes       NO         A valid license, if applicable, MUST be uploaded here.         A ttach Documentation         Inloaded files:	Use the tabs below to complete each form. When all information in all tabs has been completed, click "Next":					
Facility       Individual Owners       Business Owners       Employee/Agent       Authorized Agents         JUNDER FEDERAL REGULATIONS, A PROVIDER MUST DISCLOSE TO THE MEDICAID AGENCY, PRIOR TO ENROLLING, THE NAME AND LODRESS OF EACH PERSON WHO IS AN AGENT OR MANAGINE EMPLOYEE OF THE PROVIDER (GENERAL MANAGER, BUSINESS MANAGER, ADMINISTRATOR, OR OTHER INDIVIDUAL WHO EXERCISES OPERATIONAL OR MANAGERIAL CONTROL OR CONDUCTS DAY TO DAY OPERATIONS OF THE AGENCY) AND ANY PERSON WITH AUTHORITY TO OBLIGATE OR ACT ON BEHALF OF THE DISCLOSING ENTITY.         Isee FEDERAL REGULATIONS 42 CFR § 455.106(A)(1)(2)       Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or fficer?         O Yes       O No         Valid license, if applicable, MUST be uploaded here.         Attach Documentation         Halanded files:		-			-	
JNDER FEDERAL REGULATIONS, A PROVIDER MUST DISCLOSE TO THE MEDICAID AGENCY, PRIOR TO ENROLLING, THE NAME AND ADDRESS OF EACH PERSON WHO IS AN AGENT OR MANAGING EMPLOYEE OF THE PROVIDER (GENERAL MANAGER, BUSINESS MANAGER, ADMINISTRATOR, OR OTHER INDIVIDUAL WHO EXERCISES OPERATIONAL OR MANAGERIAL CONTROL OR CONDUCTS DAY TO DAY OPERATIONS OF THE AGENCY) AND ANY PERSON WITH AUTHORITY TO OBLIGATE OR ACT ON BEHALF OF THE DISCLOSING ENTITY. SEE FEDERAL REGULATIONS 42 CFR § 455.106(A)(1)(2) Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or officer? O Yes O NO A valid license, if applicable, MUST be uploaded here. Attach Documentation Inlocaded files:	Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents	
JNDER FEDERAL REGULATIONS, A PROVIDER MUST DISCLOSE TO THE MEDICAID AGENCY, PRIOR TO ENROLLING, THE NAME AND ADDRESS OF EACH PERSON WHO IS AN AGENT OR MANAGING EMPLOYED OF THE PROVIDER (GENERAL MANAGER, BUSINESS MANAGER, ADMINISTRATOR, OR OTHER INDIVIDUAL WHO EXERCISES OPERATIONAL OR MANAGERIAL CONTROL OR CONDUCTS DAY TO DAY OPERATIONS OF THE AGENCY) AND ANY PERSON WITH AUTHORITY TO OBLIGATE OR ACT ON BEHALF OF THE DISCLOSING ENTITY. SEE FEDERAL REGULATIONS 42 CFR § 455.106(A)(1)(2) Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or fficer? ) Yes O No valid license, if applicable, <u>MUST</u> be uploaded here. Attach Documentation Indocded files:						
MANAGER, ADMINISTRATOR, OR OTHER INDIVIDUAL WHO EXERCISES OPERATIONAL OR MANAGERIAL CONTROL OR CONDUCTS DAY TO DAY OPERATIONS OF THE AGENCY) AND ANY PERSON WITH AUTHORITY TO OBLIGATE OR ACT ON BEHALF OF THE DISCLOSING ENTITY. SEE FEDERAL REGULATIONS 42 CFR § 455.106(a)(1)(2) Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or fficer? D Yes O No Valid license, if applicable, <u>MUST</u> be uploaded here.	JNDER FEDERAL	Regulations, a provider m	iust disclose to the Medica	AID AGENCY, PRIOR TO ENRO	LLING, THE NAME AND	
Day operations of the Agency) AND ANY PERSON WITH AUTHORITY TO OBLIGATE OR ACT ON BEHALF OF THE DISCLOSING ENTITY. See Federal Regulations 42 CFR § 455.106(A)(1)(2) Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or officer? ) Yes O No A valid license, if applicable, <u>MUST</u> be uploaded here. Attach Documentation	ADDRESS OF EAC	TH PERSON WHO IS AN AGENT	OR MANAGING EMPLOYEE OF T	THE PROVIDER (GENERAL MA	ANAGER, BUSINESS	
SEE FEDERAL REGULATIONS 42 CFR § 455.106(A)(1)(2) Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or officer? O Yes O No A valid license, if applicable, <u>MUST</u> be uploaded here.  A Attach Documentation Inlocaded files:	DAY OPERATION	S OF THE AGENCY) AND ANY P	ERSON WITH AUTHORITY TO OF	BLIGATE OR ACT ON BEHALF	OF THE DISCLOSING ENTITY.	
Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or officer? Yes O No Valid license, if applicable, <u>MUST</u> be uploaded here.						
Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or officer? O Yes O No A valid license, if applicable, <u>MUST</u> be uploaded here.	SEE FEDERAL REGULATIONS 42 CFR § 455.106(a)(1)(2)					
Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or fficer?	See Federal Re	gulations 42 CFR § 455.106	6(A)(1)(2)			
Does this facility have any agents or individuals who are a partner, manager, managing employee, board member, stakeholder, director, or officer?	See Federal Re	gulations 42 CFR § 455.106	6(A)(1)(2)			
officer?	See Federal Re	gulations 42 CFR § 455.106	5(A)(1)(2)			
O Yes ○ No A valid license, if applicable, <u>MUST</u> be uploaded here.	See Federal Re Does this fac	GULATIONS 42 CFR § 455.104	<sup>5(Α)(1)(2)</sup> or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or
O Yes ○ No A valid license, if applicable, <u>MUST</u> be uploaded here.	See Federal Re Does this fac	GULATIONS 42 CFR § 455.104	6(A)(1)(2) or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or
A valid license, if applicable, <u>MUST</u> be uploaded here.	See Federal Re Does this fac officer?	GULATIONS 42 CFR § 455.104	6(A)(1)(2) or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or
Attach Documentation	See Federal Re Does this fac officer?	GULATIONS 42 CFR § 455.104 cility have any agents	6(A)(1)(2) or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or
Attach Documentation Inloaded files:	Does this fac Does this fac Dfficer? D Yes O N A valid licens	GULATIONS 42 CFR § 455.106 cility have any agents 0 se, if applicable, <u>MUST</u> [	or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or
Attach Documentation	Does this fac Does this fac officer? O Yes O N A valid licens	GULATIONS 42 CFR § 455.106 cility have any agents 0 se, if applicable, <u>MUST</u> [	or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or
Inleaded files:	Does this fac officer? O Yes O N A valid licens	GULATIONS 42 CFR § 455.106 cility have any agents 0 se, if applicable, <u>MUST</u> l	or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or
Inleaded filer:	Does this fac officer? Dyes O N: A valid licens	GULATIONS 42 CFR § 455.104 cility have any agents o se, if applicable, <u>MUST</u> l	or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or
	Does this fac officer? D Yes O N A valid licens	GULATIONS 42 CFR § 455.100 cility have any agents o se, if applicable, <u>MUST</u> l	or individuals who are	e a partner, manager,	managing employee, boo	ard member, stakeholder, director, or

If the answer to the opening question is No, proceed to the Authorized Agents tab (7.6)

#### If yes:

For each agent or ir make changes:	ndividual who is also a part of m	anagement, click "Add New" and complete the form. Use the "Edit" and "Delete" buttons t	o
Name	Address	Percent Ownership	
+ Add New Agent/B	Employee		

For each agent or individual who is part of management, click on the **+Add New Agent/Employee** button.

+ Add New Agent/Employee	
First Name *	
Middle Name *	
Maiden Name	
Last Name *	
Hyphenated Last Name	
Title/Position *	
Percent Ownership In Disclosing Business *	0
SSN *	
Date of Birth *	
NPI	
Phone Number *	###_###_####

Fill out the form carefully. Red asterisks denote required fields.

As shown in the table below, at least one check box is displayed next, dependent on the privately-owned or non-profit IRS registration type (see 7.1.2).

	This individual is a board member of this organization	This individual is an officer of this organization	This individual is an authorized agent of this organization
Sole Proprietorship			
Partnership/Limited			
Liability			
Partnership			
Limited Liability			
Corporation			
Nonprofit	$\overline{\mathbf{A}}$		$\checkmark$
Corporation	$\overline{\mathbf{A}}$	$\overline{\mathbf{A}}$	



Click on the check box if the specified individual is a board member. Ensure that for each individual that is a board member this box is checked.

This individual is an officer of this organization

Click on the check box if the specified individual is a board member. Ensure that for each individual that is a board member this box is checked.



Click on the check box if the specified individual is an authorized agent of the facility. Otherwise leave it unchecked. If checked, the Authorized Agent tab will be populated with data (see 7.6). At least one Individual Owner or Employee/Agent must be designated as an Authorized Agent.

a Address.	
Address Line *	
City *	
State *	
Zip *	
ng Address/PO Box:	
ng Address/PO Box: Address Line *	
ng Address/PO Box: Address Line * City *	
ing Address/PO Box: Address Line * City * State *	
ng Address/PO Box: Address Line * City * State * Zip *	

Is the individual named above also an owner?
○ Yes ○ No
Has the individual named above ever used or been known by any other name including married, maiden, hyphenated, or alias?
○ Yes ○ No
Is this individual a US citizen? If no, provide alien verification number:
○ Yes ○ No
Alien Verification
Does this owner reside outside the State of Louisiana?
○ Yes ○ No
Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?
○ Yes ○ No
Does the individual owner have a business transaction with any subcontractor(s) for services amounting to \$25,000 or more?
○ Yes ○ No
Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?
○ Yes ○ No

#### 7.4.1 Is the individual named above also an owner?



Click the Yes radio button or the No radio button.

#### 7.4.2 Add New Alias/Other Name

Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?

If no, proceed to 7.4.3.

If yes, the page expands to include the +Add New Alias/Other Name button.

Ha	Has the owner named above ever used or been known by any other name including married, maiden, hyphenated, or alias?				
⊙ Fo	Yes O No r each alias or other name	e, click "Add New" and co	mplete the form. Use the "Edit	" and "Delete" buttons to make changes:	
	First Name	Middle Name	Last Name	Hyphenated Last Name	
	+ Add New Alias/Other Name				

For each other name, click on the **+Add New Alias/Other Name** button. The system responds by opening the Alias/Other Name window, as shown below:

Alias/Other Name	×
First Name: *	
Middle Name: *	
Maiden Name:	
Last Name: *	
Hyphenated Last Name:	
	Cancel Save

The red asterisks indicate required fields. Click on the **Save** button once you have entered the data.

Once you have created a record, a summary is displayed along with the Edit and Delete icons.

First Name	Middle Name	Last Name	Hyphenated Last Name	
Rocky	R	Smith		🖉 Edit 🗐 Dele

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.4.3 Is this individual a US citizen?

If yes, proceed to 7.4.4.

If no, the Alien Verification text box is activated.

Is this individual a US citizen? If no, provide alie	n verification number:
○ Yes ● No	
Aler vehication	

Enter the alien verification number.

#### 7.4.4 Does this owner reside outside the State of Louisiana?



If no, proceed to 7.4.5.

If yes, the form expands to include the following additional question:

● Yes O`No

If yes, the form expands again to include the +Add Additional State Provider Number button.

or each state a	nd provider number, click "Add New" and co	omplete the form. Use the "Edit" and "Delete" buttons to make changes:
State	Medicaid Number	Medicare Number
+ Add Additi	ional State Provider Number	

For each additional Provider number, click on the **+Add Additional State Provider Number** button. The system responds by opening the Non Resident Provider window, as shown below:

Non Resident Provider	×	Use the drop down box to
State: *	🗸	select a state, and then enter the
Medicaid Number: *		Medicaid Number and the Medicare
Medicare Number: *		Number. The red asterisks indicate
	Cancel	required fields.
	Cancel Save	<b>Save</b> button.

Once you have created a record, a summary is displayed along with the Edit and Delete icons.

State	Medicaid Number	Medicare Number	
ID	1111111	222222222	🖋 Edit 🛛 👕 Delete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.4.5 Add Related Individual

Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?

If no, proceed to 7.4.6.

If yes, the form expands to include the **+Add Related Individual** button.

Is this owner related to any other individual owners, agents, managing employees, or subcontractor business owners associated with the disclosing Entity/Business?		
● Yes ○ No For each relative, click "Add New" ar	d complete the form. Use the "Edit" and "Delete	e" buttons to make changes:
First Name	Last Name	Title
+ Add Related Individual		

For each related individual, click on the **+Add Related Individual** button. The system responds by opening the Individual Owner Relative window, as shown below:

Individual Owner Relative	×	Enter the required data into
First Name: *		asterisks indicate required
Middle Name: *		button.
MaidenName		
Last Name: *		
HyphenatedLastName		
Relationship: *		
Title: *		
Relationship Type: *	○ Owner ○ Agent ○ Managing Employee ○ Subcontractor	
	Cancel Save	

Once you have created a record, a summary is displayed along with the **Edit** and **Delete** icons.

First Name	Last Name	Title		
Manfred	Rococo	None	🖋 Edit	Telete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

\

#### 7.4.6 Add Subcontractor

Does this individual owner have a business transaction with any subcontractor(s) for services amounting to \$25,000 or more?

If no, proceed to 7.4.7.

If yes, the form expands to include the **+Add Subcontractor** button.

Does the individual owner have a business trans	action with any subcontractor(s) for services amounting to \$	\$25,000 or more?
Yes O No For each subcontractor, click "Add New" and cor	nplete the form. Use the "Edit" and "Delete" buttons to mak	e changes:
Subcontractor Business Name	Subcontractor Owner Name	State
+ Add Subcontractor		

For each subcontractor, click on the **+Add Subcontractor** button. The system responds by opening the Subcontractor window, as shown below:

Subcontractor		×	Enter the required data into the boxes.
Subcontractor Business Name: *			The red asterisks indicate required
Subcontractor Owner Name: *			fields. Then click on the <b>Save</b> button.
Address: *			/
City: *			
State: *	🗸		
Zip: *	##### or #########		
Phone Number: *	###-###-####		
Contact Email: *			
		Cancel Save	

Once you have created a record, a summary is displayed along with the Edit and Delete icons.

Subcontractor Business Name	Subcontractor Owner Name	State		
Satellite	Testa Napp	LA	🥓 Edit	Telete

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.4.7 Add Plan

Does the individual owner have direct or indirect ownership or controlling interest of 5% or greater in any other Entity/Business that participates in a Federal/State Funded healthcare program?

If no, proceed to 7.4.8.

If yes, the form expands to include the +Add Plan button.

Does the individual owner have in a Federal/State Funded healt	direct or indirect ownership or controlling interest hcare program?	of 5% or greater in any other Entity/Business that participates
Yes O No For each participating plan, click	k "Add New" and complete the form. Use the "Edit"	and "Delete" buttons to make changes:
Plan Name	DBA Name	State
+ Add Plan		

For each plan, click on the **+Add Plan** button. The system responds by opening the Other Plan window, as shown below:

Other Plan			Enter the data into the boxes. Then click on the
Plan Name: *			<b>Save</b> button.
DBA Name: *			
Tax ID: *			
State: *	*		
Plan ID Number: *			
		Cance	

Once you have created a record, a summary is displayed along with the Edit and Delete icons.

Plan Name	DBA Name	State	
Medicare	Satellite	LA	🖋 Edit 🛛 盲 Delete
+ Add Plan			

Click on the **Edit** icon to re-open the window and make changes. Click on the **Delete** icon to remove the record.

#### 7.4.8 Agent/Managing Employee Questionnaire

Read each question carefully and click on the appropriate **Yes** or **No** radio button.

Agent/Managing	Employee Questionnaire
○ Yes ○ No	Ever been convicted of a criminal offense in any program under medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program?
○ Yes ○ No	Ever had any disciplinary action taken against any license or certification held in any State or US Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license of certification?
○ Yes ○ No	Ever been denied enrollment, suspended, or terminated from participation, excluded or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid, or other healthcare program(s) in any State or US Territory?
○ Yes ○ No	Currently have a negative balance or currently owes money to any State or Federal Funded program including Medicaid and Medicare?
○ Yes ○ No	Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency?
○ Yes ○ No	Currently have any open or pending healthcare court cases?
○ Yes ○ No	Ever been denied malpractice insurance?
○ Yes ○ No	Currently has or ever had any type of felony conviction(s)?
A summary of deta (Failure to provide (	ils <u>MUST</u> be provided in the box below for questions answered "YES" and supporting documentation <u>MUST</u> be attached. Ietails and an attachment will result in a suspended application)
A valid license, if ap	plicable, <u>MUST</u> be uploaded here. Save Agent/Employee Cancel
🏦 Attach Docume	ntation

All questions are equired. Use the ext box to submit etails regarding ach "Yes" nswer. If ecessary, use ne box re-size inction to expand r reduce the size f the text box to your equirement. lick on the Save gent/Employee utton when you re finished.

## 7.5 Resolution of Errors Associated with Number of Members/Owners

The number of members specified under the Facility tab must match the number of records for members created. For instance, if you entered 2 members under the Facility tab, but created a record for only one member, the system responds with the following message after you select **Next** or **Save Progress**:

The number of ownership disclosures does not match the number of members entered on the Facility tab. The number of Individual Owners and/or Business Owners disclosed must match.

Please enter at least one record for agents/managing employees (this is required for a response of 'Yes' on the Employee Agent tab).

**Resolution:** 

- Go back to the Facility tab and re-enter the number of members/owners/agents/managing employees/officers/Board of Directors to match the number of records; or
- 2. Continue to enter records for members/owners/agents to match the number specified in the Facility tab.

If under the Facility tab no members/owners have yet been specified and you select **Next** or **Save Progress**, one of the following messages is displayed:

#### Sole Proprietorship:

At least one record must be designated as authorized agent. (Individual Owner and/or Employee Agent tab).

#### Partnership/Limited Liability Partnership:

A Partnership / Limited Liability Partnership requires a number of members to be entered.

#### Limited Liability Corporation (LLC):

A Limited Liability Corporation requires a number of members to be entered.

A Limited Liability Corporation requires a number of managing employees to be entered.

#### Nonprofit:

A Nonprofit requires a number of members appointed to the governing board.

#### Corporation:

A Corporation requires a number of stakeholders/individual owners. A Corporation requires a number of Board of Director members. A Corporation requires a number of officers.

**Resolution:** 

Go back to the Facility tab and enter the number of owners. In the case of the Corporation, it is acceptable to enter 0 for stakeholders/individual owners and/or 0 for Board of Director members. But at least 1 officer must be specified.

## 7.6 Authorized Agents

If no Authorized Agent or Agents have been defined in the Individual Owners tab (see 7.2) or the Employee/Agent tab (see 7.4), then selecting the Authorized Agents tab will result in a screen like the one shown below.

e the tabs	below to complete eac	ch form. When all inf	ormation in all tabs ho	ns been completed, clic	k "Next":
Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents	
No individ Employee/	uals were designated ( Agent (whichever is ap	as authorized agents oplicable) be designat	in the previous section ted as an authorized a	s. It is a requirement ti gent. Please return to t	nat at least one Individual Owner or he previous tabs and add or edit
No individ Employee/ records (us valid licens	uals were designated o Agent (whichever is a e the Authorized Ager e, if applicable, <u>MUST</u> b	as authorized agents oplicable) be designa nt checkbox to design ne uploaded here.	in the previous section ted as an authorized a ate at least one author	s. It is a requirement ti gent. Please return to t ized agent).	nat at least one Individual Owner or he previous tabs and add or edit

Once the Authorized Agent or Agents have been defined in the Individual Owners tab (see 7.2) and/or the Employee/Agents tab (see 7.4), selecting the Authorized Agents tab results in the display of a screen similar to the one shown below:

Disclosure of	Ownership for Faci	lities			
Use the tabs l	elow to complete ea	ch form. When all info	ormation in all tabs he	as been completed, clici	k "Next":
Facility	Individual Owners	Business Owners	Employee/Agent	Authorized Agents	
The listing I direct depos Each indivio authorized make chang	below summarizes e iit forms and/or cha lual listed below wa agent listed below, y ges.	ach individual who is c ages to the disclosure o s designated and disclo ou must go back to the	nuthorized to sign into of ownership forms. osed in the previous se e screen this informate	e legal, binding docume ections. If you need to e ion was entered on (Inc	ents on behalf of this provider, such as dit the Name or Position/Title of an dividual or Employee/Agent tab) to
Name			Position/Ti	tle	
John Smit	h		test		
If the inform A valid license	nation is correct, clic , if applicable, <u>MUST</u>	k Next to validate the be uploaded here.	disclosure and procee	d with the application.	
Attach Do	icumentation				

#### 7.6.1 Next Button

Click on the Next button.

Save Progress

Resolve any outstanding issues (which will be displayed as a red banner; see 3.2) and then click on the **Next** button again if necessary in order to go to the Ownership Attestation page.

## 8.0 Ownership Attestation

The Attestation of Ownership page certifies that the information that has been entered is true, correct, and complete.

TH MY SIGNATURE BELOW, I AT	TEST.			
			_	
That I have disclosed all	NECESSARY INFORMATION;			
That I am the individual	dentified in Section I and, as	SUCH, HAVE THE AUTHORITY TO EN	TER INTO A PROVIDER	
REEMENT WITH THE LOUISIANA	Medicaid Program;		_	
That I have reviewed the	INFORMATION ON THIS INDIVIDU	JAL DISCLOSURE FORM AND ATTEST	THAT IT IS TRUE, ACCURATE	
ID COMPLETE;				
That I understand that k	NOWINGLY AND WILLFULLY FAIL	ING TO FULLY AND ACCURATELY DISC	CLOSE THE INFORMATION	
QUESTED MAY RESULT IN THE D	ENIAL OF ANY REQUEST TO PARTI	cipate in Louisiana's Medicaid B	ROGRAM, OR WHERE THE	_
DIVIDUAL ALREADY PARTICIPATE	5, A TERMINATION OF THE PROVI	DER AGREEMENT OR CONTRACT WITH	h LDH or the Secretary,	
IVIDUAL ALREADY PARTICIPATE	S, A TERMINATION OF THE PROVI	DER AGREEMENT OR CONTRACT WITH	H LDH OR THE SECRETARY,	

Use the scroll tool to read the entire attestation statement.

Once you have read and understood the attestation statement, click on the **I Agree** check box so that a check mark is inserted:



Then click on the Sign Attestation button.

Click on the Save Progress button at the bottom of the screen.



Click on the **Next** button to go to the Participation Agreement page.

## 9.0 Participation Agreement

The Participation Agreement is a legally binding certification of agreement to participate in Louisiana Medicaid and to adhere to requirements specified in the agreement.

Use the scroll bar to view and read the entire agreement.

THE UNDERSIGNED, CERTIFY AND AGREE TO THE FOLLOWING:	
NROLLMENT IN LOUISIANA MEDICAID	
I have read the contents of this Louisiana Medical Assistance Program Portal Application and the	
NFORMATION SUPPLIED HEREIN IS TRUE, CORRECT AND COMPLETE;	
UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ENSURE THAT ALL INFORMATION IS KEPT UP TO DATE ON THE LOUISIANA	
Aedicaid Provider File;	
• I MUST SEND A NOTICE TO THE LDH PROVIDER ENROLLMENT SECTION FOR ANY CHANGES SUCH AS ADDRESS, ETC. FAILURE	-
D DO SO MAY NEGATIVELY AFFECT ATTEMPTS TO REVALIDATE THE INFORMATION AND RESULT IN ACCOUNT CLOSURE.	
DO SO MAY NEGATIVELY AFFECT ATTEMPTS TO REVALIDATE THE INFORMATION AND RESULT IN ACCOUNT CLOSURE.	

Click on the **Sign Participation Agreement** button. The screen expands to display the Electronic Signature statement and the **I Agree** check box, as shown below:

ELECTRONIC SIGNATURE BY INDICATING "I AGREE" BELOW, I AM SIGNING THIS AGREEMENT ELECTRONICALLY AND UNDERSTAND THAT THIS ELECTRONIC SIGNATURE IS THE LEGAL EQUIVALENT OF MY MANUAL SIGNATURE ON THIS AGREEMENT. I CONSENT TO BE LEGALLY BOUND BY THIS AGREEMENT'S TERMS AND CONDITIONS. I AGREE THAT NO CERTIFICATION AUTHORITY, OR OTHER THIRD-PARTY VERIFICATION, IS NECESSARY TO VALIDATE THIS ELECTRONIC SIGNATURE AND THAT THE LACK OF SUCH CERTIFICATION OR THIRD-PARTY VERIFICATION WILL NOT IN ANY WAY AFFECT THE ENFORCEABILITY OF THIS ELECTRONIC SIGNATURE, OR ANY RESULTING CONTRACT BETWEEN MYSELF AND THE LOUISIANA DEPARTMENT OF HEALTH. I REPRESENT THAT I AM THE PROVIDER APPLICANT OR THAT I AM	Use t bar to and r entire signa state
MYSELF AND THE LOUISIANA DEPARTMENT OF HEALTH. I REPRESENT THAT I AM THE PROVIDER APPLICANT, OR THAT I AM AUTHORIZED TO ENTER INTO THIS AGREEMENT ON BEHALF OF THE PROVIDER APPLICANT. I AGREE THAT THE TERMS OF THE AGREEMENT ARE EQUALLY BINDING WHETHER THE PROVIDER SIGNS THE AGREEMENT OR AN AUTHORIZED SIGNER ENTERS INTO THE	then the I checl

Use the scroll bar to view and read the entire signature statement, then click on the **I Agree** check box.

An email with text similar to that shown below will be sent to the email address on file:

We have accepted your electronic signature for the Provider Participation Agreement with the Louisiana Medicaid Program for provider nnnnnn.

Please retain this email message for your records. Please continue the enrollment process and submit your application.

Please contact the Louisiana Medicaid Provider Enrollment Call Center at 1-833-641-2140 should you have questions or need assistance.

Please do not reply to this message as it was sent from an unattended mailbox.

Louisiana Medicaid

Click the "Request Verification Code" button below to have a verification code sent to the email address we have on file for you. If this email address is not correct, the Email address can only be changed by the Admin user at LAMedicaid.com.
Email:
tom@cat.com
Request Verification Code
Submit Code
Tode:
Tyou did not receive the verification code, eneck your email spam folder or if verification code has expired, please request new code by clicking the Request New Code button :
Request New Code
Code:
Request New Code

The screen expands to reveal the Verification Code function, as shown below:

Click on the **Request Verification Code** button. The "Verification code sent" window opens, as shown below.

Verification code sent	×
The verification code has been sent to the email address sh	iown.
	Close

Click on the **Close** button and check your email for the code (sample email shown below). The code will expire after 15 minutes.

Test Email 228117 : Louisiana Medicaid Provider Enrollment Verification Code	To Berly	We Burke All	- Freend	
DNNotReply@gainweiltechnologies.com 1a Fores Robert (582: 10-5): Chapman, Karen (581: 1015)	C. S. Martin	.7 mpg ve	File 7/30/2021	3.50 PM
Louisiana Medicaid Provider Enrollment Verification Code				
You requested a verification code for provider, Please enter the below code in the Verification Code box on the Electronic	ic Signature panel to complete the self-	service action.		
VERIFICATION CODE: 475424				
This code will not longer be valid if it has expired, your browser has closed, or you exited the self-service process. You can return to	o the self-service process to request a n	ew code.		
Please contact the Louisiana Medicaid Provider Enrollment Call Center at 1-833-641-2140 should you have questions or need assist	tance.			
Please do not reply to this message as it was sent from an unattended mailbox.				
Louisiana Medicaid				
Code:	Subr	nit Code	•1	
	Subi	int obuc		

Type the code the text box and click on the **Submit Code** button.

If you do not receive your code within five minutes, carefully check the various folders of your email account to see if the code is in one of them. If you can't find the code, verify that your email address is correct and then click on the **Request New Code** button. If the email address is incorrect, use the account management tool to correct it (see **Section 6.0**).

If you did not receive the verification code, check your email spen folder or verify the email address shown above. If you need to request a new verification code, click the Request New Code button:           Request New Code	
	If you did not receive the verification code, check your email span folder or verify the email address shown above. If you need to request a new verification code, click the Request New Code button:
	Request New Code 💿

After you enter the code sent to you, click on the **Save Progress** button at the bottom of the screen.



Click on the **Next** button to go to the Review and Submit page.

## 10.0 Review & Submit

Revi page	ew the checklist below to ensure you have completed all sections of this application. If corrections are needed please visit the application es to revise. Once all items are complete, click the Submit button.
•	Taxonomy/Taxonomies
•	Practice address
•	Federal Tax ID and mailing/pay-to
•	Disclosure of ownership information with attestation
•	Participation Agreement
Note	e: Once the submit button is clicked, your application will be submitted and no further changes can be made!
	Submit Application 🔸

Click on the **Submit Application** button. Once you click the Submit Application button, the information is locked for review and can only be viewed.

After selecting the **Submit Application** button, the system responds with the Confirm Submission window:

Confirm Submission	×
Are you sure you want to submit this application? Before you confirm, make certain you have completed a disclosure as an authorized agent. If you confirm without a disclosure, the application will suspend, delaying the enrollment process. Once submitted, the application cannot be modified.	STOP
Cancel	Confirm

## **10.1 Submission Results**

Your submission may result in any of the following:

Your submission has been received
Screening is in process
Your enrollment with the State is complete
9 Your enrollment with the State is denied and a letter is being mailed

You will receive an email (with text similar to that shown below) that contains a link to check the status of your submission. Using the link, check back after 24-48 hours to review your submission status.

Thank you for completing and submitting your application for provider You can check your application status by logging into the portal at <u>www.lamedicaid.com/account/login.aspx</u> . If you have questions, you can call our Provider Enrollment Portal Help Line at 833-641-2140.
No further action from you or your staff is required at this time.
1-833-641-2140 should you have questions or need assistance.
Please do not reply to this message as it was sent from an unattended mailbox.

Louisiana Medicaid

## 11.0 Louisiana Medicaid Provider Enrollment Portal Help Desk

The Louisiana Medicaid Provider Enrollment Portal Help Desk is available to assist you from Monday – Friday 8 a.m. to 5 p.m. CST.) The toll-free number is 833-641-2140; email louisianaprovenroll@gainwelltechnologies.com.