



# Louisiana Medicaid Management Information System (LMMIS)

## Provider Enrollment Portal Application User Manual For MCO Individual

Date Created: 06/28/2021  
Date Revised: 09/22/2022

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**PROJECT INFORMATION**

<b>Document Title</b>	Louisiana Medicaid Management Information System (LMMIS) – Provider Enrollment Portal User Manual for MCO Individual		
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	<b>Revision History</b>		
<b>Date</b>	<b>Description of Change</b>	<b>LIFT</b>	<b>By</b>
June 28, 2021	Initial version	12133	LDH and GW development group
July 13, 2021	Added hours of operation for help desk, 3.1.1.	12133	Randy Sheehan
July 16, 2021	Modified title page, 3.0, 3.2, 5.0, 6.0, 6.1, and 7.0	12133	Randy Sheehan
July 19, 2021	Refined screen captures in 6.0 and 7.0.	12133	Randy Sheehan
July 30, 2021	Updated 3.0, 3.1.2, 4.0, 6.0, 8.0, 9.0, 12.0, and 13.0.	12133	Randy Sheehan
August 20, 2021	Updated 3.1, 3.2, 8.1, 8.3.2, 12.0, and 14.0. Added 13.1.	12133	Randy Sheehan
August 26, 2021	Updated 7.0, 8.0, and 8.1.1.	12133	Taunya Williams, Randy Sheehan
September 17, 2021	Updated 8.1, 10.0, 11.1, 12.0, and 13.1.	12133	Aliona Orjuhovschi, Randy Sheehan
September 24, 2021	Updated screenshots to remove Provider Number from Verification Email.	12133	Jody Lavigne
March 15, 2022	Updated 2.2 and 3.1.	12133	Randy Sheehan
August 12, 2022	Updated 4.0 to incorporate Provider Type, Provider Specialty, Provider Sub-specialty or taxonomy change requests.	12431	Randy Sheehan and GW QA
September 22, 2022	Updated screenshots in 8.3, 8.3.1, 11.0, 12.0, and 13.0. Added list of types of files that can be attached to 8.3.1. Ensured that all instances of the word “provider” were capitalized. Added text to 11.0.	12431	Randy Sheehan, GW QA, and LDH

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## 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](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:

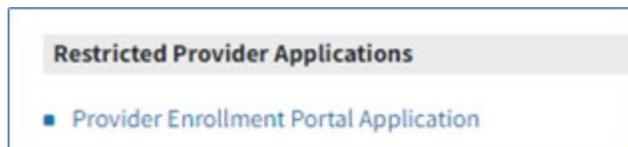
<https://www.lamedicaid.com/account/login.aspx>

### 2.2 Log In

Detailed instructions for logging in are provided here:

[https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid\\_Provider\\_Login\\_PE\\_Instructions\\_User\\_Manual.pdf](https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid_Provider_Login_PE_Instructions_User_Manual.pdf)

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



### 3.0 Start Page

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, and Provider NPI 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 [louisianaprovenroll@gainwelltechnologies.com](mailto:louisianaprovenroll@gainwelltechnologies.com) 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 Louisiana Medicaid Provider Enrollment Portal Help Desk (Monday – Friday 8 a.m. to 5 p.m. CST) at 833-641-2140 or [louisianaprovenroll@gainwelltechnologies.com](mailto: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.

### 3.2 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
- Other Addresses
- Mailing Address
- Ownership Disclosure
- Ownership Attestation
- Other Programs
- 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:

Zip is required.  
Contact name is required.  
Phone number is required.  
Fax number is required.

Start ✓ Taxonomy ✓ Practice Address ⚠ Other Addresses Mailing Address Ownership Disclosure Ownership Attestation Other Programs Participation Agreement Review & Submit

Name: [Redacted] Provider ID: [Redacted] Provider NPI: [Redacted] Provider Type: 20 - PHYSICIAN (IND & GP) Sub-Specialties: None  
Provider Specialty: 16 - OB/GYN Current Status: Information Gathering Started and saved for later

Please verify the following information and make changes if necessary:

Main Practice Address Information

Street Address 1: \* 7600 Beechnut  
Street Address 2:   
City: \* Houston  
State: \* FL  
Zip: \* \*\*\*\* or \*\*\*\*\*  
Contact Name: \*   
Contact Phone: \* ###-###-####  
Contact Fax: \* ###-###-####

Previous Next Save Progress

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 only 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, as shown below:

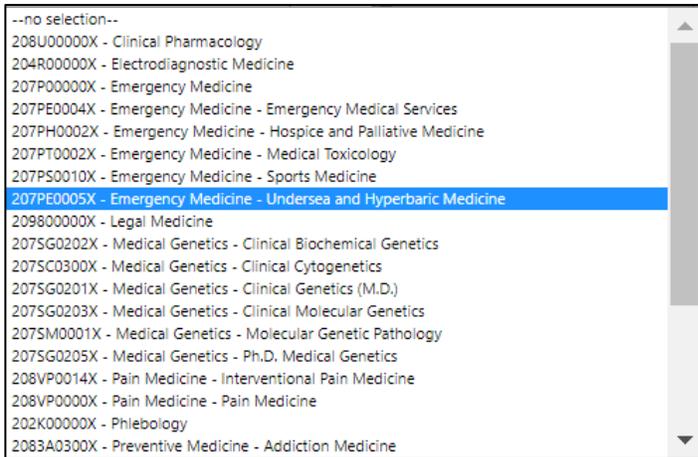


## 4.0 Taxonomy

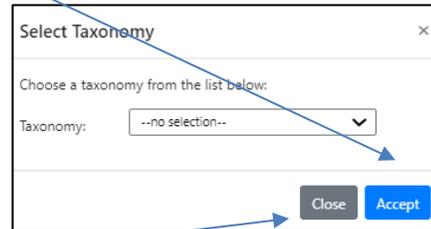
The **Taxonomy** page enables the user to provide the necessary taxonomy information. Only Primary Taxonomy is required (and is usually pre-populated). Taxonomy options are limited by Provider Type and Provider Specialty. If the Provider has more than one taxonomy number, up to nine taxonomies may be 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.

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:

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



Use the navigation tool to scroll through the Taxonomy options. When you find the one you want, select it, and then click on the **Accept** button in the dialogue box.



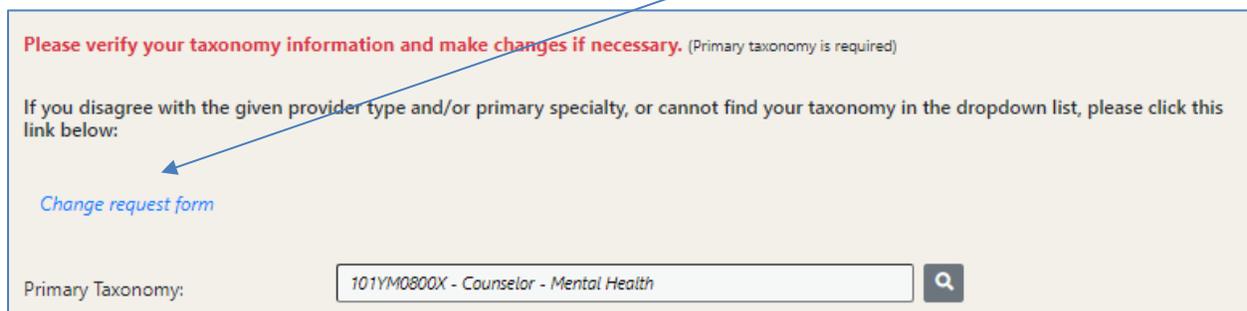
Click the **Close** button to close the lookup taxonomy dialogue box at any time.

Continue entering Taxonomies as needed. Then click on the **Save Progress** button at the bottom of the screen.

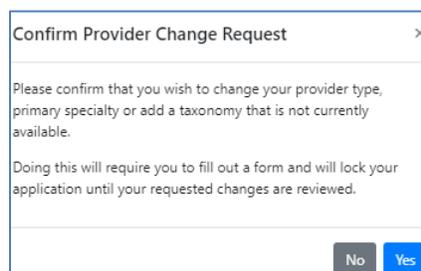


## 4.1 Change Request Form

If you disagree with the given Provider Type and/or primary specialty, or cannot find your taxonomy in the dropdown list, click on the **Change request form** link:



The system responds with the following prompt:



Click the **No** button to return to the Taxonomy page. Click the **Yes** button to open the Specialty – Sub-Specialty – Provider Type – Taxonomy Change Form, as shown below:

Specialty - Sub-Specialty - Provider Type - Taxonomy Change Form

This form will gather the necessary information for you to request changes be made to your Provider Type, Primary Specialty, Sub-Specialties, or Taxonomies. Fill out the form and click the Submit button to make a request. Click the Cancel button to not make any changes and return to the Taxonomy screen.

Provider Name: [Redacted]

Provider ID: [Redacted]

Provider NPI: [Redacted]

Provider Type: LICENSED PROFESSION COUNSELOR

Entity Type: MCO Individual

[Click this link to see information about relationships and choices regarding existing options](#)

Change Provider Specialty To: \* --Select--

Change Provider Type To: \* --Select--

Change Provider Sub-Specialty To: \*

Desired Taxonomy: \* --Select--

If the desired taxonomy is not listed, check this box and enter your taxonomy in the field provided.

Requestor's Signature: Test Test

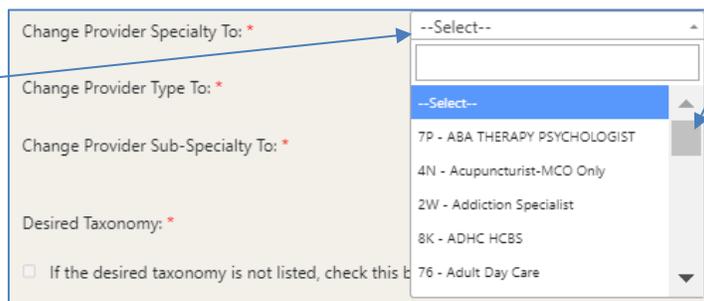
Cancel Submit

#### 4.1.1 Information About Relationships and Choices Regarding Existing Options

Optionally, you are enabled to view the Provider Change Form Instruction page ([www.lamedicaid.com/provweb1/forms/ProviderChangeFormInstructions.pdf](http://www.lamedicaid.com/provweb1/forms/ProviderChangeFormInstructions.pdf)), which provides details regarding Provider Types and Specialties/Sub-specialties.

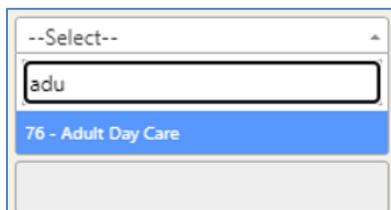
### 4.1.2 Change Provider Specialty To

Click within the Change Provider Specialty To: selection box to display the drop down box of available options.



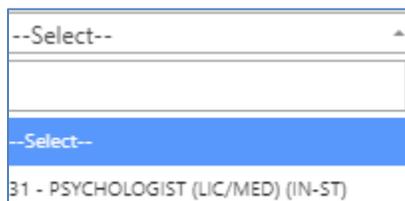
Use the scroll tool to browse the available options and click on the specialty.

You can also enter the first few letters of the specialty into the box to quickly locate the one required. For instance, you can enter “adu” in the box, and any specialty that begins with the letters “adu” is displayed:



### 4.1.3 Change Provider Type To

Once the specialty has been selected the Change Provider Type To: selection box is enabled. Click within the selection box to display the Provider Type associated with the previously selected specialty:

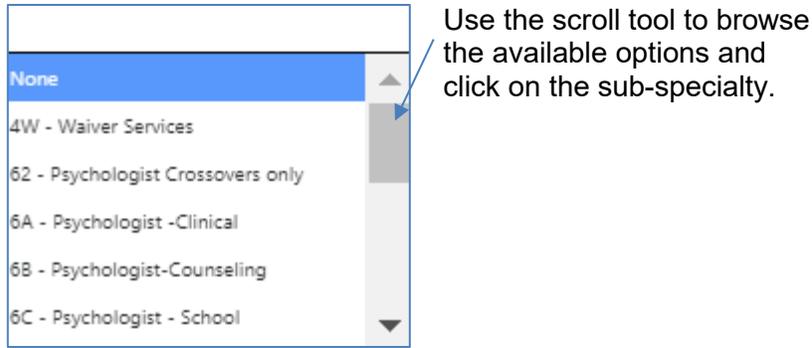


Click on the Provider Type to continue.

You can also enter the first few letters of the Provider Type into the box to quickly locate the one required.

### 4.1.4 Change Provider Sub-Specialty To

Once the Provider Type has been selected, the Change Provider Sub-Specialty To: selection box is enabled. Click within the box to see the drop down list of available options:



Use the scroll tool to browse the available options and click on the sub-specialty.

You can also enter the first few letters of the sub-specialty into the box to quickly locate the one required.

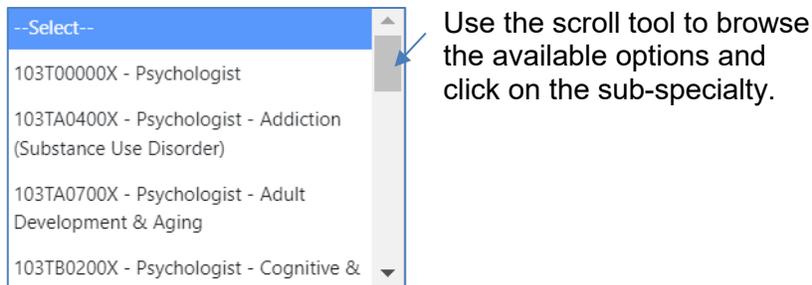
You are enabled to enter up to nine sub-specialties; in the instance below, four have been chosen.



Note: You can also elect to change the sub-specialty none.

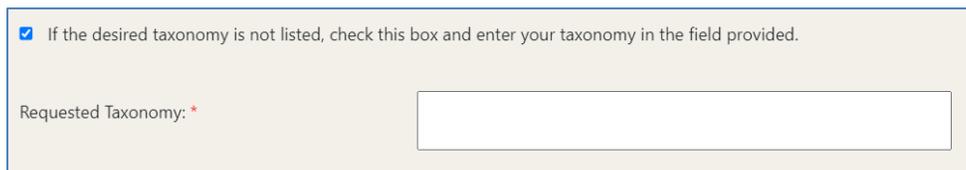
### 4.1.5 Desired Taxonomy

Once a sub-specialty has been selected, the Desired Taxonomy drop down box is enabled. Click within the box to see the drop down list of available options:



Use the scroll tool to browse the available options and click on the sub-specialty.

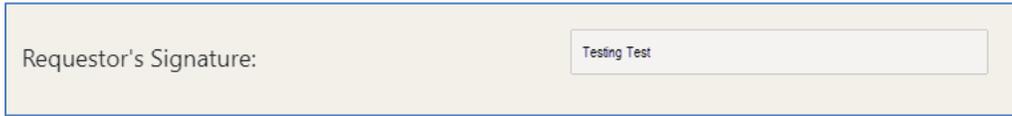
If the desired taxonomy is not listed, click on the check box below the Desired Taxonomy drop down box to enable a text box into which you can type the desired taxonomy:



You are enabled to select up to nine taxonomies.

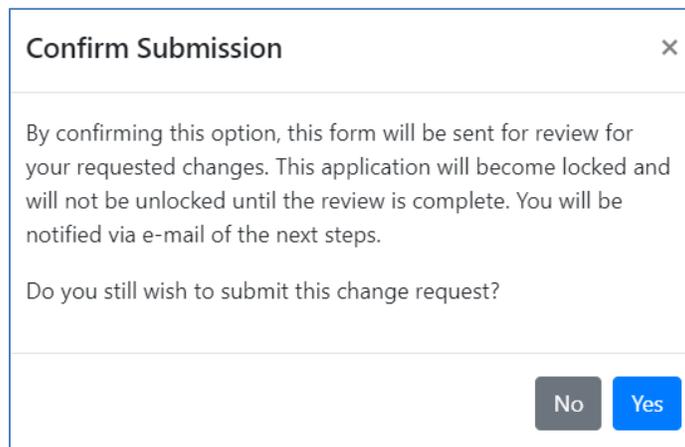
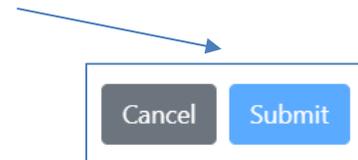
### 4.1.6 Requestor's Signature

The user's name is pre-populated in the Requestor's Signature text box:



A screenshot of a form field labeled "Requestor's Signature:". To the right of the label is a text input box containing the text "Testing Test".

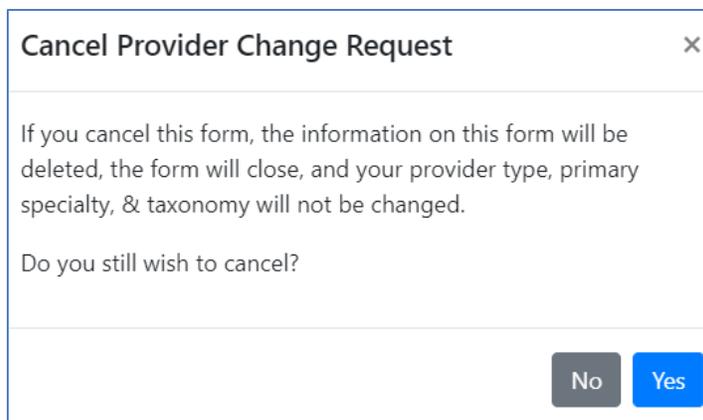
When you have completed the change request form, click on the **Submit** button in the lower right hand corner to proceed.



A dialog box titled "Confirm Submission" with a close button (X) in the top right corner. The text inside reads: "By confirming this option, this form will be sent for review for your requested changes. This application will become locked and will not be unlocked until the review is complete. You will be notified via e-mail of the next steps." Below this text is the question "Do you still wish to submit this change request?". At the bottom right are two buttons: a grey "No" button and a blue "Yes" button.

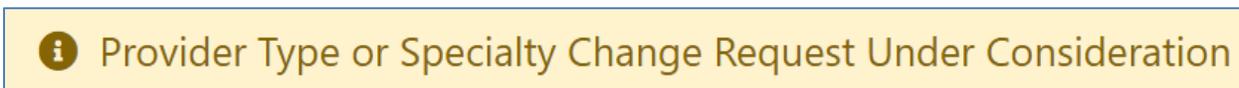
Click on the **Yes** button to proceed with the request. Otherwise, click on the **No** button to return to the change request form.

Alternatively, you can click on the **Cancel** button to cancel the request.



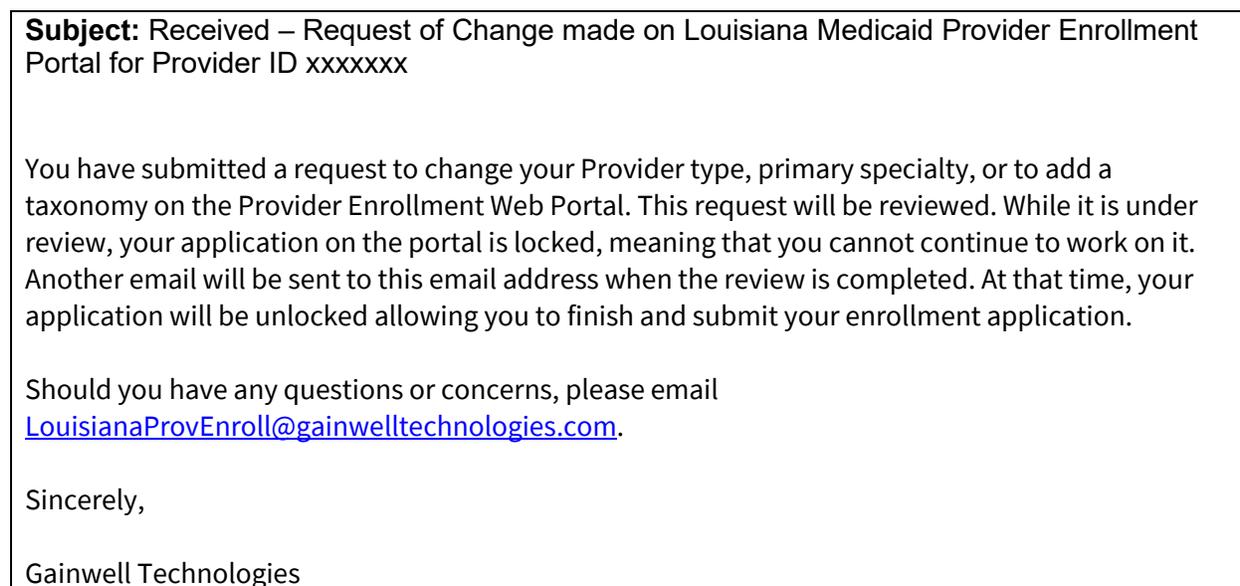
Click on the **Yes** button to continue with the cancellation. Other wise click on the **No** button to return to the Form screen.

If you elected to proceed with your change request, look for the yellow banner at the top of the Taxonomy page when you return:



#### 4.1.7 Check Your Email

Check your email for confirmation of the requested changes. The email is similar to that shown below:



Emails will also be sent upon denial or approval of your requested Provider Type, primary specialty, sub-specialty, or taxonomy changes. The emails are similar to those shown below:

**Subject:** Decision on your Provider Data Change Request for the Louisiana Medicaid Provider Enrollment Portal for Provider ID xxxxxxx

This email is to inform you that your Louisiana Medicaid enrollment application change for Provider type, Provider specialty or taxonomy that you requested via the Louisiana Medicaid Provider Enrollment Portal has been approved. Your information has been updated to:

**Requested Type:** 31 - PSYCHOLOGIST (LIC/MED) (IN-ST)  
**Requested Primary Specialty:** 7P - ABA THERAPY PSYCHOLOGIST  
**Requested Sub-Specialty:** 4W - Waiver Services  
**Requested Primary Taxonomy:** 103T00000X

Please log back into website [here](#) and complete your application for enrollment before September 30, 2022.

**Subject:** Decision on your Provider Data Change Request for the Louisiana Medicaid Provider Enrollment Portal for Provider ID xxxxxxx

This email is to inform you that your request for a change in Provider type, primary specialty, or taxonomy has been denied. This was done in accordance with existing LDH processes and procedures for enrolling with Louisiana Medicaid. Please contact Gainwell Provider Enrollment at 833-641-2140 or [LouisianaProvEnroll@gainwelltechnologies.com](mailto:LouisianaProvEnroll@gainwelltechnologies.com) for additional information.

Your online application at website here has been unlocked and you may now complete your application for submission. The last day to submit your application is September 30, 2022.

An email is also generated and sent if you requested a desired taxonomy that was not listed (see 4.1.5).

When the change request form is approved or denied, the application is unlocked/editable and you can continue with the application submission.

## 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, as shown below.

Please verify the following information and make changes if necessary:

Main Practice Address Information

Street Address 1: \*

Street Address 2:

City: \*

State: \*

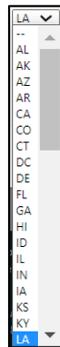
Zip: \*

Contact Name: \*

Contact Phone: \*

Contact Fax: \*

Some fields may be pre-populated, but if it 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 at the bottom of the screen.



## 6.0 Other Addresses

If the practice has multiple physical addresses in addition to the primary location (satellite, branch, or regional locations), enter them here. If you have only one physical address for this Provider Number, nothing needs to be entered here.

Please verify the following information and make changes if necessary:

If the practice has multiple physical addresses in addition to the primary location (satellite, branch, or regional locations), enter them here.

If you only have one practice site, you may skip this page.

Click Add New Row, or use the edit and delete buttons to correct an existing entry.

#	Address	Contact Name	Phone	Fax
+ Add New Row				

Previous Next Save Progress

Click the **+Add New Row** button to open the Edit Site window and add another address and the contact information (note required fields marked with an asterisk).

Edit Site

Street Address 1: \*

Street Address 2:

City: \*

State: \*

Zip: \*

Contact Name: \*

Contact Phone: \*

Contact Fax: \*

Cancel Save

You can cancel this operation with the **x** function in the upper right corner of the Edit Site window or the **Cancel** button in the lower right.

When you are finished entering the required data, click on the **Save** button.

The additional address or addresses will now be displayed on the Other Addresses screen, similar to that shown below:

**Please verify the following information and make changes if necessary:**

If the practice has multiple physical addresses in addition to the primary location (satellite, branch, or regional locations), enter them here.

If you only have one practice site, you may skip this page.

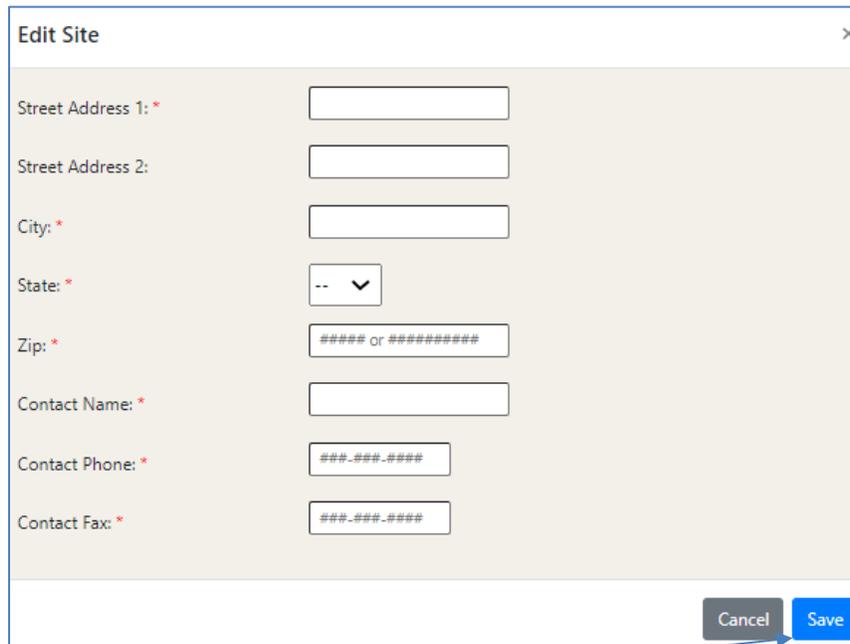
Click *Add New Row*, or use the *edit and delete buttons* to correct an existing entry.

#	Address	Contact Name	Phone	Fax		
2	1st Street Miami, FL 12345	John Smith	123-123-1223	234-234-2345		
3	2nd Street Chicago, IL 654321234	James Johnson	654-654-6543	234-234-2346		

You are enabled to edit or delete the entry or entries with the control functions provided to the right of each row.

## 6.1 Edit Site

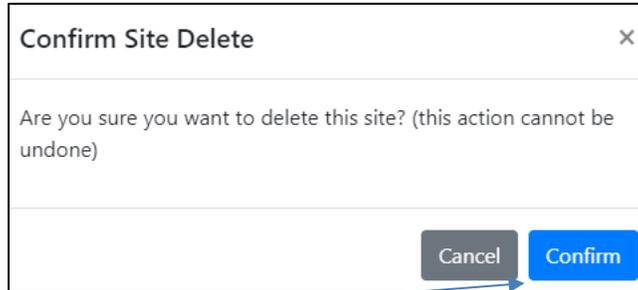
The **Edit** function opens the Edit Site window, shown with the existing data, which can be corrected as needed.



Make changes and click the **Save** button. The changes are immediately displayed.

## 6.2 Delete Site

The **Delete** function opens the Confirm Site Delete window.



Click on the **Confirm** button to delete the data in the row. The row will be immediately removed from the Other Addresses screen.

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



## 7.0 Mailing Address

The **Mailing Address** screen enables the capture of the primary mailing address for the practice. The **Mailing Address** screen is also used to capture Provider SSN, Date of Birth, Address information, Contact Name, Contact Phone, and Contact Fax, as shown below. If the email address is incorrect, use the account management tool to correct it (see [https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid\\_Provider\\_Login\\_Admin\\_Manage\\_Users.pdf](https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid_Provider_Login_Admin_Manage_Users.pdf)).

Only the primary practice mailing address should be entered here. Satellite, branch, or regional location addresses should be entered in the Other Addresses tab.

The screenshot shows a web form for entering a provider's mailing address. At the top, there are four columns of information: Name (redacted), Provider ID (redacted), Provider Type (20 - PHYSICIAN (IND & GP)), Sub-Specialties (None), Provider NPI (redacted), Provider Specialty (29 - Pulmonary Diseases), and Current Status (Information Gathering Started and saved for later). Below this is a red heading: "Please verify the following information and make changes if necessary:". The main section is titled "Main Mail-To Address Information" and contains several input fields: Provider SSN (33333333), Date of Birth (3/3/2003), Street Address 1 (PO Box 591159), Street Address 2 (empty), City (SAN ANTONIO), State (TX dropdown), Zip (78259), Contact Name (Testa Napp), Contact Phone (225-216-6081), Contact Fax (225-216-6082), and Contact Email (testing@test.com). At the bottom, there are "Previous" and "Next" buttons on the left, and a "Save Progress" button on the right, which is highlighted with a blue arrow.

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

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



## 8.0 Ownership Disclosure – “Yes” Answers

In the **Ownership Disclosure** section of the application, use the radio button to answer “Yes” or “No” to the questions. If “Yes”, you must be prepared to respond with information including the DBA Name(s) and address(es), the Tax ID(s), the Social Security Number(s), % ownership, the location (state) and the Plan Number(s).

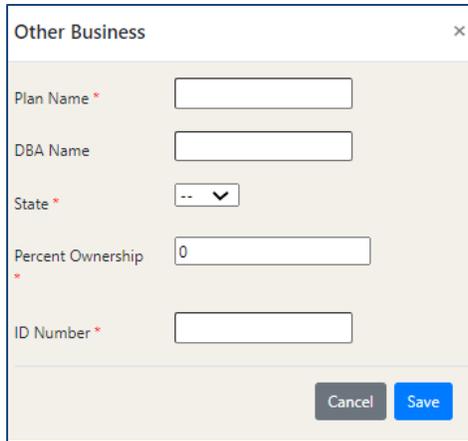
Depending on your responses, the application will expand to display further questions.

### 8.1 Yes (5% or More Ownership Interest)

Click the **Yes** radio button if the enrolling individual has any direct, indirect, or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in Federal/State funded healthcare program(s). The enrollment application responds by displaying a screen similar to the one shown below.

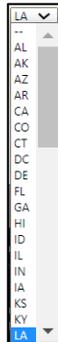
Plan Name	Doing Business As/Address	% Ownership	State	ID Number
Testing	Test	89	AK	35676543

Click on the **+Add New Row** button to enter ownership data for the first other business interest. The system responds by opening the Other Business window, as shown below:

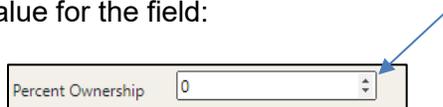


Enter the Plan Name (usually Medicaid or Medicare). Enter the Doing Business As (DBA) Name. If the DBA Name is different from the IRS business name, use the business “sign” name, i.e., the name on the business letterhead and/or the physical facility signage. Enter the Tax ID of the business. Select the State abbreviation in which the business is conducting operations. Enter the Percent Ownership in the business of the enrolling individual, and the seven digit Louisiana Medicaid ID Number (or 10 digit NPI) of the enrolling individual.

Type your responses into the text boxes. Use the down arrow to open the State drop down box to select a state.



The Percent Ownership text box will accept a typed entry, but up and down arrows are provided as an optional way to select a value for the field:



Other Business

Plan Name \*

DBA Name

State \*

Percent Ownership \*

ID Number \*

Once the fields have been populated with correct data, click the **Save** button.

**Disclosure of Ownership for Individuals**

Does the enrolling individual have any direct, indirect, or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in Federal/State funded healthcare program(s)?

Yes  No

Please complete the following for each entity/business: (click Add New Row, or use the edit and delete buttons to correct an existing entry)

Plan Name	Doing Business As/Address	% Ownership	State	ID Number	
test plan		99	LA	8789987	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Your information will be displayed on the Disclosure of Ownership page with the **Edit** and **Delete** functions, similar to that shown to the left.

### 8.1.1 Edit

The **Edit** function re-opens the Other Business window, shown with the existing data (previously entered).

Other Business

Plan Name \*

DBA Name

State \*

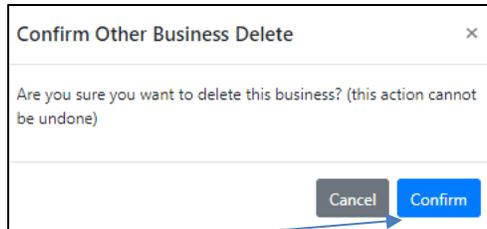
Percent Ownership \*

ID Number \*

Make any changes and then click on the **Save** button.

### 8.1.2 Delete

The **Delete** function opens the Confirm Other Business Delete window.



Click on the **Confirm** button to delete the data in the row. The row is immediately removed.

Continue Adding, Editing, and Deleting other businesses as needed.

## 8.2 Yes (Relative With Ownership Interest of 5% or Greater)

Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed above?

Yes  No

Click on the **Yes** radio button if the enrolling individual is related to a person with an ownership or controlling interest of 5% or greater in any of the entities/businesses entered on the Disclosure of Ownership page. The application responds with a screen similar to the one shown below:

..

Is the enrolling individual related to any person(s) with an ownership or controlling interest of 5% or greater in any of the entities/businesses listed above?

Yes  No

Please complete the following for each related individual: *(click Add New Row, or use the edit and delete buttons to correct an existing entry)*

Full Name	Maiden Name	Relationship	% Ownership	Date of Birth	Social Security Number
<input type="button" value="+ Add New Row"/>					

Click on the **+Add New Row** button to enter ownership data for the first relative. The system responds by opening the **Edit Relative** window, as shown below:

All fields are required. Enter the relative's Full Name, Maiden/Other Name, Relationship (for instance, son, mother, father, daughter), Percent Ownership, relative's Date of Birth, and relative's SSN. Then click on the **Save** button.

The Percent Ownership text box will accept a typed entry, but up and down arrows are provided as an optional way to select a value for the field:

Once the fields have been populated with correct data, click the **Save** button.

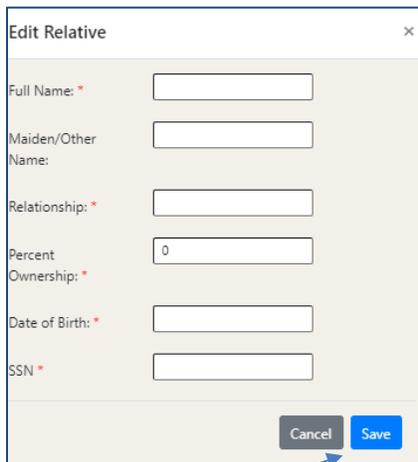
Your information will be displayed with the **Edit** and **Delete** functions, similar to those shown below:

Please complete the following for each related individual: (click Add New Row, or use the edit and delete buttons to correct an existing entry)

Full Name	Maiden Name	Relationship	% Ownership	Date of Birth	Social Security Number	
Ralph Lauren		son	0	6/6/2006	333333333	 Edit  Delete

### 8.2.1 Edit

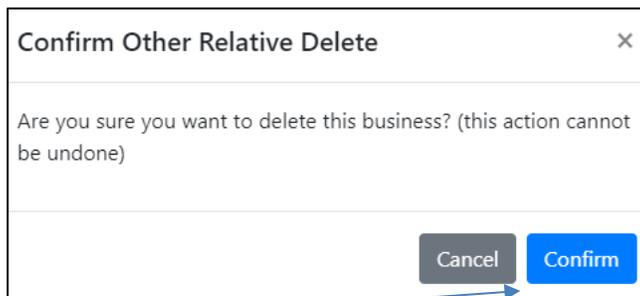
The **Edit** function re-opens the **Edit Relative** window, shown with the existing data, which can be corrected as needed.



Make any changes and then click on the **Save** button.

### 8.2.2 Delete

The **Delete** function opens the **Confirm Other Relative Delete** window.



Click on the **Confirm** button to delete the data in the row. The row will be immediately removed.

Continue Adding, Editing, and Deleting relatives as needed.

## 8.3 Enrolling Individual Questionnaire

Carefully read the instructions at the beginning of the questionnaire section. For each **“Yes”** answer, you must submit a written statement providing the details and you must attach all official legal documents regarding the occurrence.

Enrolling Individual 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 details **MUST** be provided in the box below for questions answered "YES" and supporting documentation **MUST** be attached. (Failure to provide details and an attachment will result in a suspended application)*

All questions are required. Use the text box to submit details regarding each “Yes” answer. If necessary, use box re-size function to expand or reduce the size of the text box to fit your requirement.

### 8.3.1 Attach Documentation

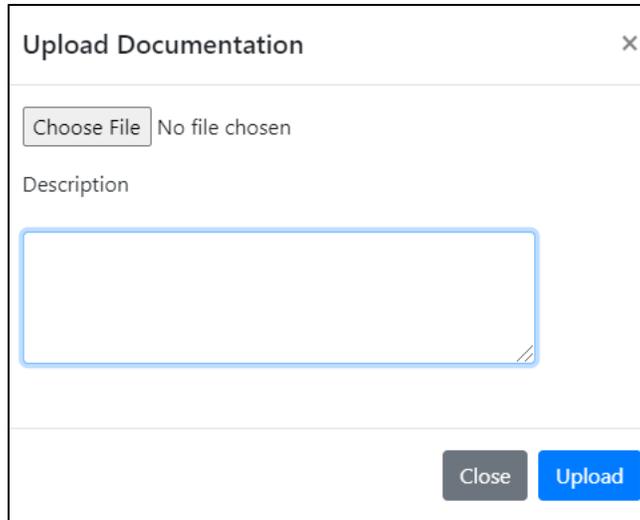
Allowed file extensions for uploads are pdf, jpg, gif, png, doc, docx, tif and tiff.

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

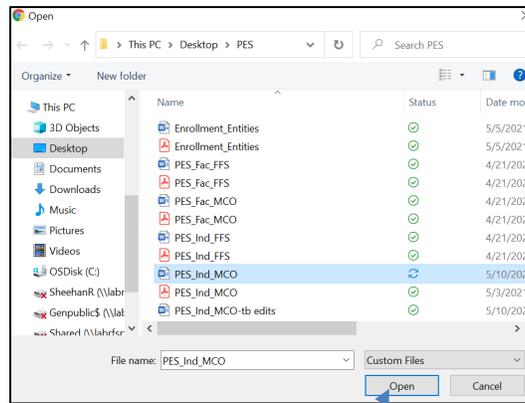
*A valid license, if applicable, **MUST** be uploaded here.*

Uploaded files:

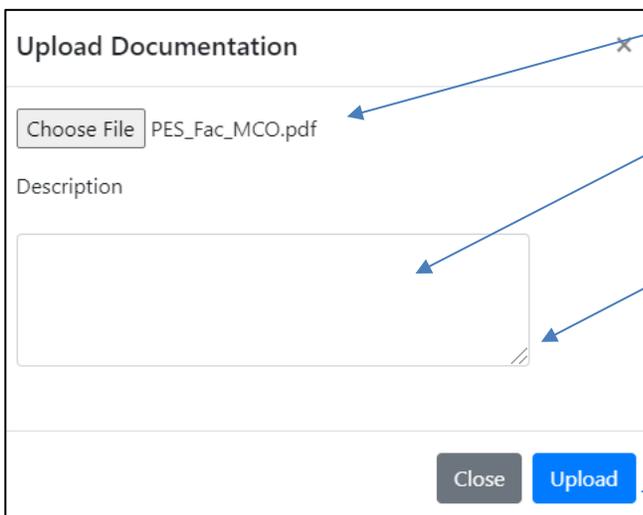
Click on the **Attach Documentation** button to open the **Upload Documentation** window. Attach all official legal documents regarding the occurrence of a Yes answer, including any reinstatements.



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



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.



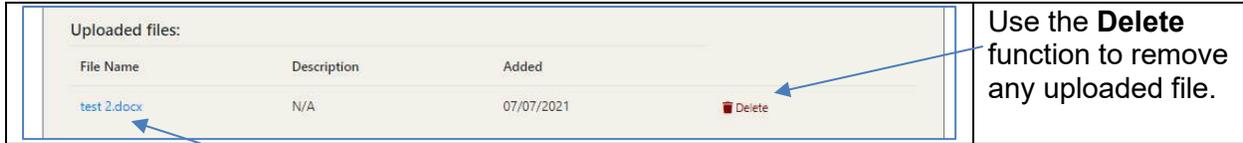
Type a description of the document into the text box.

Use box re-size function to expand or reduce the size of the text box to fit your requirement.

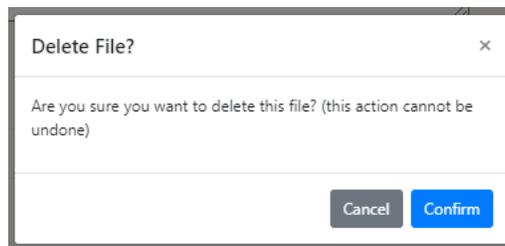
Then click on the **Upload** button.

### 8.3.2 Uploaded Files

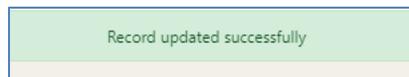
After you have uploaded files, they are displayed in a manner similar to that shown below:



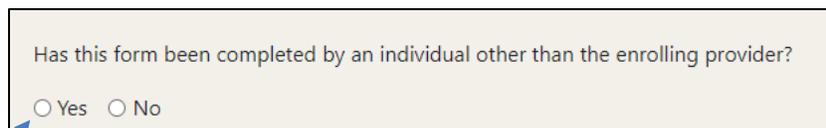
If you misplace the file, you are enabled to click on the file name to download it to your computer.



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



### 8.4 Yes (Form Completed by Individual Other Than Enrolling Provider?)



Click on the **Yes** radio button if a person other than the enrolling individual Provider is the one filling out the online Provider Enrollment form. The page expands to reveal the following questions:

Complete the section below for the individual completing this form:

Full Name: \*

Maiden/Other Name:

SSN: \*

Date of Birth: \*

Person completing this form is: \*  Staff  Third Party/Independent Agent  Other (Specify)

Phone Number: \*

Email Address: \*

Enter Full Name, Maiden/Other Name, SSN, and Date of Birth. Click on a radio button to specify whether the person entering the form is Staff, Third Party/Independent Agent, or Other (Specify). If Other (Specify) is selected, then the text box is activated, and you can type in the specific function of the person entering the data. Enter the Phone Number and the Email address of the person filling out the online form.

This completes the **Ownership Disclosure** section pertaining to “**Yes**” answers.

*This section is now complete. Click the "Next" button to proceed to the next section.*

Click on the **Save Progress** button.

## 9.0 Ownership Disclosure – “No” Answers

In the **Ownership Disclosure** section of the application, use the radio buttons to answer Yes or No to the questions. Depending on your responses, the application will expand to display further questions.

### 9.1 No (5% or More Ownership Interest)

Click the **No** radio button if the enrolling individual has no direct, indirect, or controlling ownership interest of 5% or more in any other healthcare entities/businesses currently enrolled in Federal/State funded healthcare program(s). The enrollment application responds by expanding to display more of the Ownership Disclosure form, starting with the relatives with an ownership interest question, as shown below:

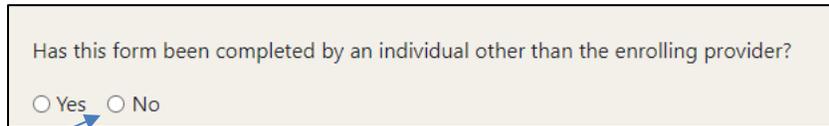
### 9.2 No (Relatives with Ownership Interest)

Click on the **No** radio button if the enrolling individual Provider is not related to a person or persons with significant ownership interest in the entities/businesses. The screen expands to reveal the next ownership question (see below).

### 9.3 Enrolling Individual Questionnaire

See 8.3, above.

### 9.4 No (Form Completed by Individual Other Than Enrolling Provider?)



Has this form been completed by an individual other than the enrolling provider?

Yes  No

Click on the **No** radio button if a person other than the enrolling individual Provider is the one filling out the online Provider Enrollment form. Click on the **Save Progress** button.



Previous Next Save Progress

## 10.0 Ownership Attestation

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

**Attestation of Ownership Information**

I, the undersigned, certify the following:

WITH MY SIGNATURE BELOW, I ATTEST:

1. THAT I HAVE DISCLOSED ALL NECESSARY INFORMATION;
2. THAT I AM THE INDIVIDUAL IDENTIFIED IN SECTION I AND, AS SUCH, HAVE THE AUTHORITY TO ENTER INTO A PROVIDER AGREEMENT WITH THE LOUISIANA MEDICAID PROGRAM;
3. THAT I HAVE REVIEWED THE INFORMATION ON THIS INDIVIDUAL DISCLOSURE FORM AND ATTEST THAT IT IS TRUE, ACCURATE AND COMPLETE;
4. THAT I UNDERSTAND THAT KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN THE DENIAL OF ANY REQUEST TO PARTICIPATE IN LOUISIANA'S MEDICAID PROGRAM, OR WHERE THE INDIVIDUAL ALREADY PARTICIPATES, A TERMINATION OF THE PROVIDER AGREEMENT OR CONTRACT WITH LDH OR THE SECRETARY.

I Agree

Sign Attestation

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:

I Agree

Sign Attestation

Then click on the **Sign Attestation** button.

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

Previous Next Save Progress

## 11.0 License Information and Other Programs

The License Information and Other Programs section gathers License Information and data concerning other Federal/State-Funded Healthcare Programs.

**License Information**

- A valid license, if applicable, **MUST** be uploaded in the "Attach Documentation" bar located under "Enrolling Individual Questionnaire" (Ownership Disclosure Tab)
- The license information entered below **MUST** match exactly as it appears on the issued license

*Failure to upload a valid license or entering incorrect license information will cause a suspension, delaying the enrollment process.*

Please enter the license information requested below (required):

Name on License: \*

License Number: \*

License State: \*

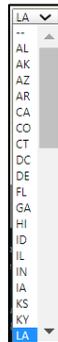
**Other Federal/State-Funded Healthcare Programs (e.g. Medicare, other State Medicaid)**

Is the Social Security Number(s) listed currently enrolled in any other Federal/State funded healthcare programs?

Yes  No

Click the "Next" button below to proceed.

Enter the Name on the License and the License Number into the text boxes. Click on the down arrow to open the drop-down box to select the state from which the license was issued (see below).



## 11.1 Enrolled in Other Programs

**Other Federal/State-Funded Healthcare Programs (e.g. Medicare, other State Medicaid)**

Is the Social Security Number and/or Tax ID number(s) listed currently enrolled in any other Federal/State funded healthcare programs?

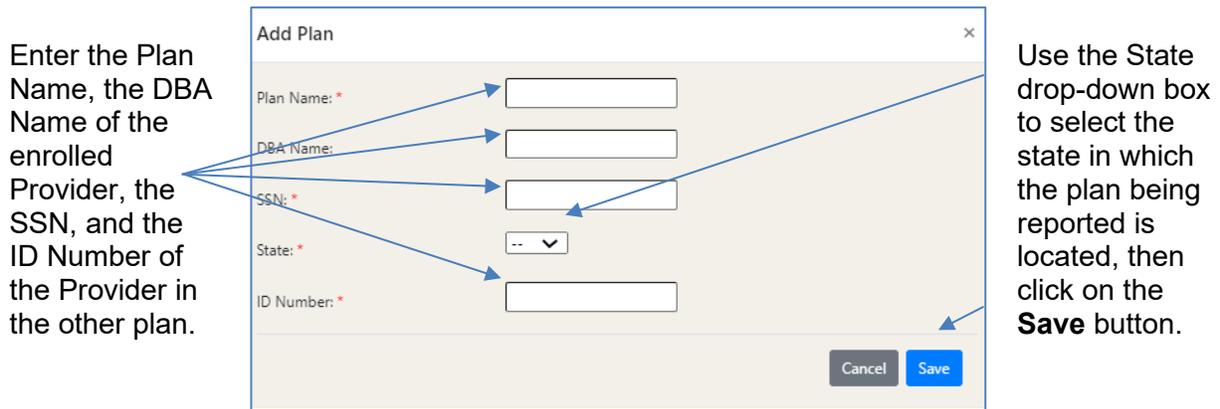
Yes  No

Click on the **Yes** radio button if the enrolling Provider is currently enrolled in Federal or State programs other than Louisiana Medicaid.

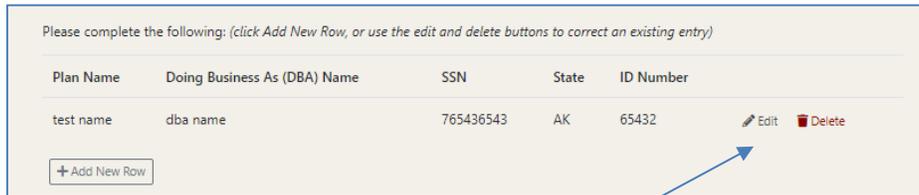
The screen expands to reveal the Add Plan tool, as shown below:



Click on the **+Add New Row** button to open the Add Plan window, as shown below:

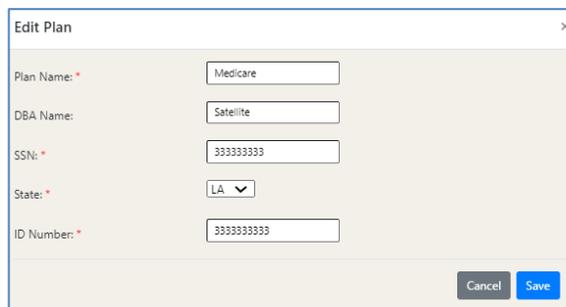


Once you have entered and saved the Other Plan data, it is displayed in a manner similar to that shown below:



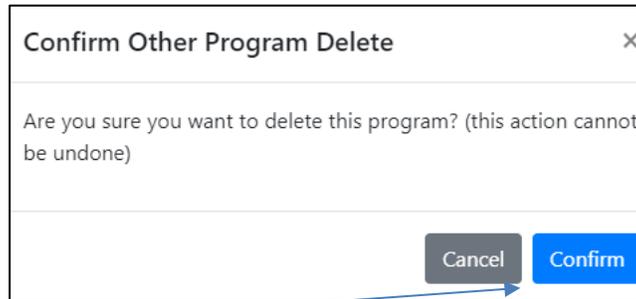
### 11.1.1 Edit

If you need to edit this information, click **Edit** function to re-open the Edit Site window, shown with the existing data, which can be corrected and saved as needed.



### 11.1.2 Delete

If you need to delete an item, click the **Delete** function to open the **Confirm Other Program Delete** window.



Click on the **Confirm** button to delete the data in the row. The row will be immediately removed.

Continue Adding, Editing, and Deleting other programs as needed.

## 11.2 Not Enrolled in Other Programs

**Other Federal/State-Funded Healthcare Programs (e.g. Medicare, other State Medicaid)**

Is the Social Security Number and/or Tax ID number(s) listed currently enrolled in any other Federal/State funded healthcare programs?

Yes  No

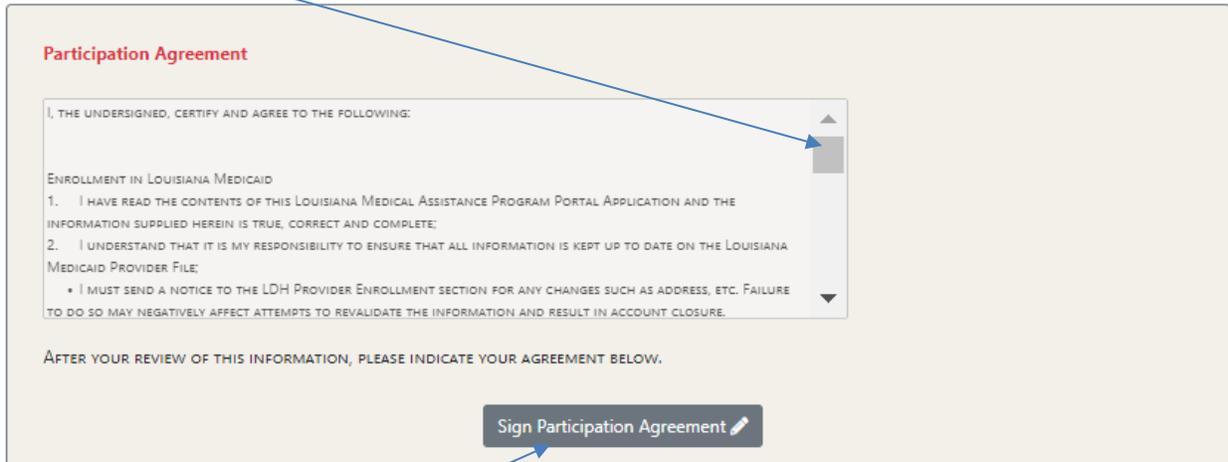
Click on the **No** radio button if the enrolling Provider is not currently enrolled in Federal or State programs other than Louisiana Medicaid.

Then click on the **Save Progress** button.

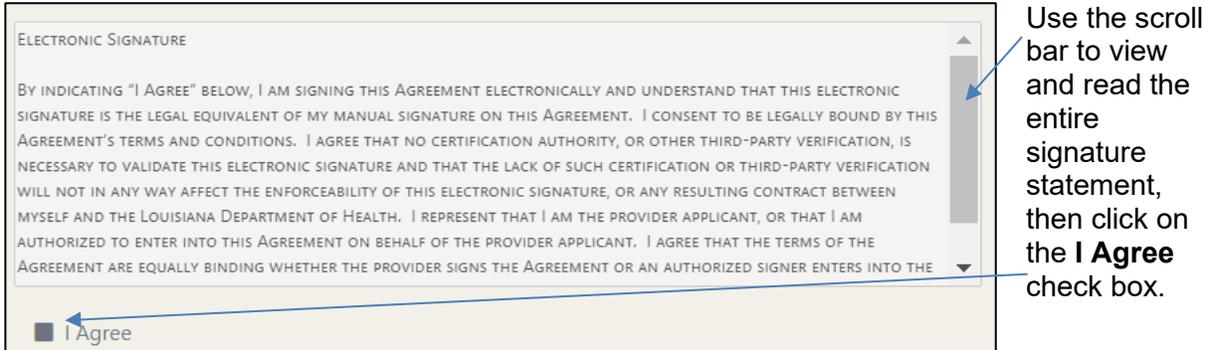
## 12.0 Participation Agreement

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

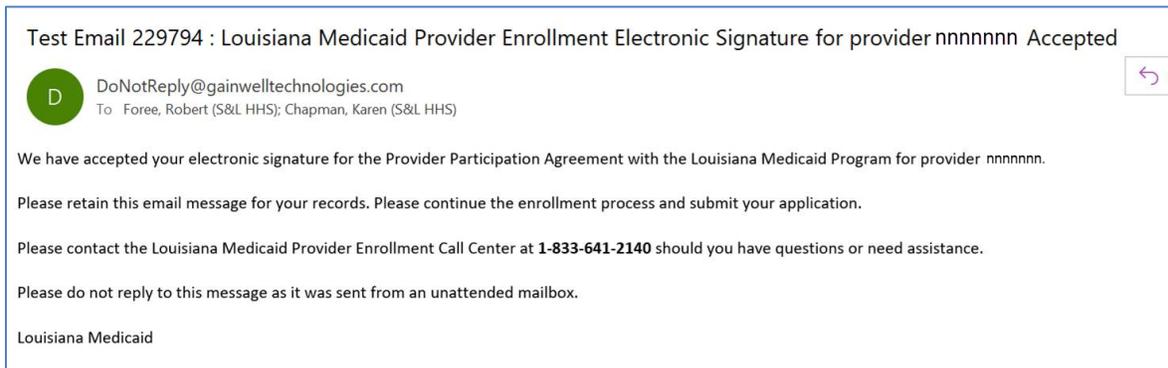
Use the scroll bar to view and read the entire agreement.



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:



An email similar to the one shown below will be sent to the email address on file:



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

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**

Code:  **Submit Code**

If you did not receive the verification code, check your email spam folder or if verification code has expired, please request new code by clicking the Request New Code button :

**Request New Code**

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 shown.

**Close**

Click on the **Close** button and check your email for the code.

Code:  **Submit Code**

Type the code sent to the email address on file (sample email shown below) and click on the **Submit Code** button.

Test Email 229793 : Louisiana Medicaid Provider Enrollment Verification Code for provider nnnnnnn

DoNotReply@gainwelltechnologies.com  
To: Foree, Robert (S&L HHS); Chapman, Karen (S&L HHS)

**Louisiana Medicaid Provider Enrollment Verification Code**

You requested a verification code for provider nnnnnnn. Please enter the below code in the Verification Code box on the Electronic Signature panel to complete the self-service action.

VERIFICATION CODE: **213983**

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 the self-service process to request a new code.

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

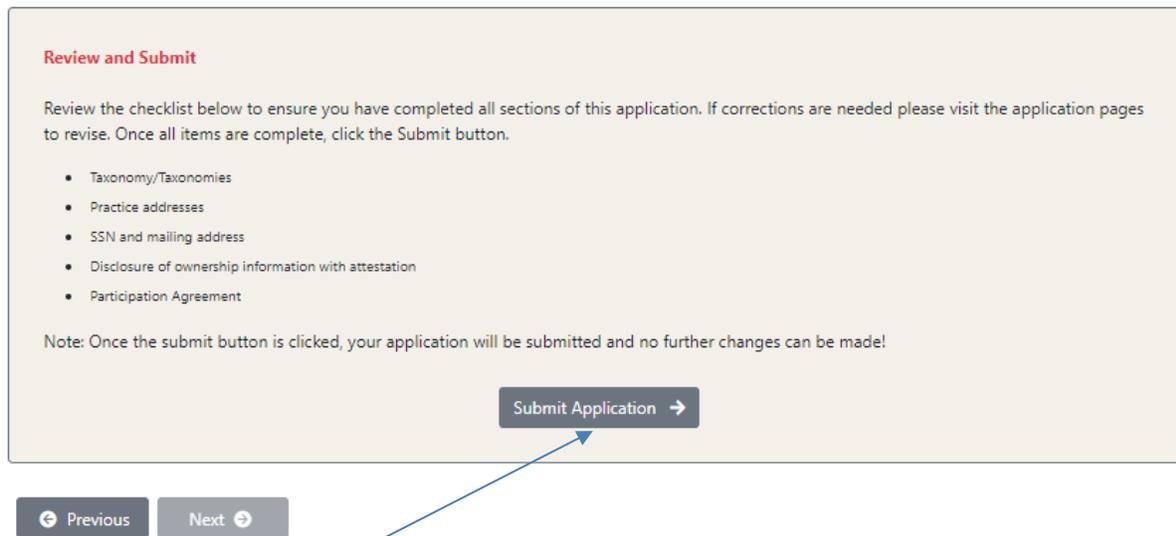
If you do not receive your code within five minutes, carefully check the various folders of your email account to see if the code is in one of them. If you can't find the code, verify that your email address is correct and then click on the **Request New Code** button. If the email address is incorrect, use the account management tool to correct it (see [https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid\\_Provider\\_Login\\_Admin\\_Manage\\_Users.pdf](https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid_Provider_Login_Admin_Manage_Users.pdf)).



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



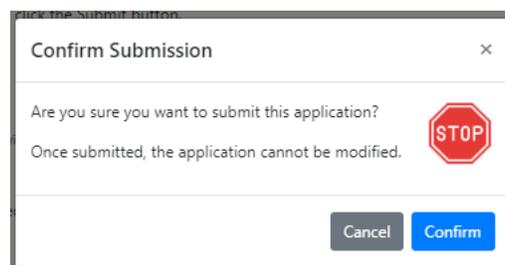
## 13.0 Review & Submit



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

Note: If you are not able to click the **Submit Application** (i.e., the button is not activated), it means that a portion or portions of the online form are incomplete. Use the navigation tabs to identify the section or sections that need further attention. If any tabs do not have a check mark, they are incomplete. Use the **Previous** and **Next** buttons to navigate to a page that needs work.

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



## 13.1 Submission Results

Your submission may result in any of the following:

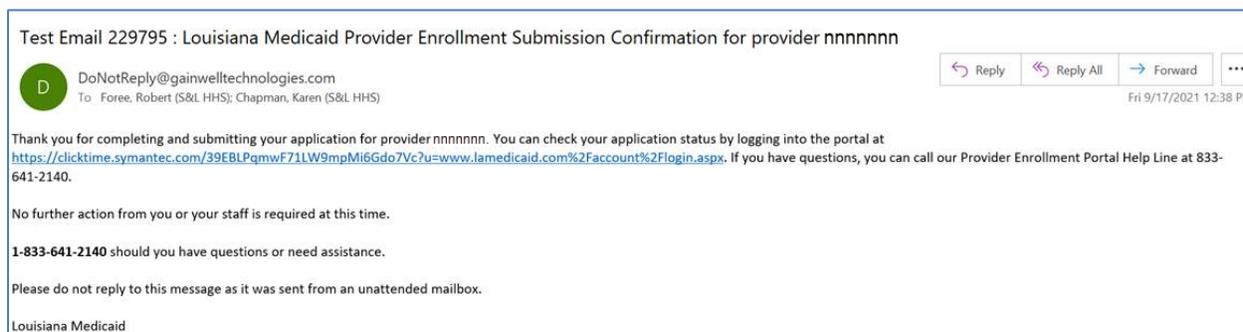
 Your submission has been received

 Screening is in process

 Your enrollment with the State is complete

 Your enrollment with the State is denied and a letter is being mailed

You will receive an email (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.



## 14.0 Louisiana Medicaid Provider Enrollment Portal Help Desk

The Louisiana Medicaid Provider Enrollment Portal Help Desk is available to assist you Monday – Friday 8 a.m. to 5 p.m. CST. The toll-free number is 833-641-2140.