ENROLLMENT PACKET FOR THE LOUISIANA MEDICAID PROGRAM

(Louisiana Medicaid Program)

Basic Enrollment Packet Entities/Businesses

(FAOI, Atypical FAOI, Group Practice, Billing Agent/Clearing House)

(With Instructions)

(Common Forms for All Entity Provider Types)

(Enrollment packet is subject to change without notice)

PRISM
Provider Recipient Integrated System for Medicaid

To Whom It May Concern:

This is the Basic Enrollment Packet for the Louisiana Medical Assistance Program (also known as the Louisiana Medicaid program). You should carefully review these materials, including all instructions, before completing the necessary forms.

We encourage all providers to submit their enrollment application online. Completing the online application ensures you complete all required steps prior to submitting the application and reduces processing time. **Paper applications will not be processed until after all online applications have been processed.**

Please visit our website for further instructions to complete your online application: www.medicaid.la.gov/PRISM

After completing the paper enrollment packet materials, please return all forms with original signatures to:

PRISM Provider Enrollment Unit
PO Box 91108
Baton Rouge, LA 70821-9108

Please be sure to include National Provider Identifiers (NPI), both Type 1: Individual and Type 2: Organizational, you want linked to the Medicaid provider number. Claims will not automatically cross electronically from Medicare to Medicaid unless these NPI numbers are linked in the claims system.

The Medicaid Program requires all providers to be state certified for claims to be processed. The PRISM Provider Enrollment Unit, in conjunction with the Department of Health and Hospitals (DHH), will take necessary steps to certify you as a provider and participant in the Louisiana Medical Assistance Program once all required documents have been received. Upon certification, you will be notified of your enrollment via U.S. Mail, email (if provided), or the PRISM website.

In the event additional information is needed to process your application, whether received online or by paper, applications will be returned to the provider for correction or additional documentation. Electronic applications are returned to the provider using the online PRISM system, while paper applications are returned by mail.

Please visit www.lamedicaid.com for Provider manuals.

If you have any questions concerning the completion of this enrollment packet, please contact the PRISM Provider Enrollment Unit at the above address or at (888) 780-7858. Thank you for your interest in becoming a Louisiana Medicaid provider.

Sincerely,

PRISM Provider Enrollment Unit
Louisiana Medicaid Program

Statutorily Mandated Revisions to all Provider Agreements

— The 1997 Regular Session of the legislature passed and the Governor signed into law the Medical Assistance Program Integrity Law (MAPIL) cited as LSA-RS 46:437.1-46:440.3. This legislation has a significant impact on all Medicaid providers. All providers should take the time to become familiar with the provisions of this law.

— MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in LSA-RS 46:437.11-46:437:14. The provider agreement provisions of MAPIL statutorily establish that the provider agreement is a contract between the Department and the provider and that the provider voluntarily entered into that contract. Among the terms and conditions imposed on the provider by this law are the following:

1) comply with all federal and state laws and regulations;
2) provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
3) have all necessary and required licenses or certificates;
4) maintain and retain all records for a period of at least five (5) years;
5) allow for inspection of all records by governmental authorities;
6) safeguard against disclosure of information in patient medical records;
7) bill other insurers and third parties prior to billing Medicaid;
8) report and refund any and all overpayments;
9) accept payment in full for Medicaid recipients providing allowances for copay authorized by Medicaid;
10) agree to be subject to claims review;
11) the buyer and seller of a provider are liable for any administrative sanctions or civil judgments;
12) notification prior to any change in ownership;
13) inspection of facilities; and
14) posting of bond or letter of credit when required.

— MAPIL's provider agreement provisions contain additional terms and conditions. The above is merely a brief outline of some of the terms and conditions and is not all inclusive.

— The provider agreement provisions of MAPIL also provide the Secretary with the authority to deny enrollment or revoke enrollment under specific conditions.

— The effective date of these provisions was August 15, 1997. All providers who were enrolled at that time or who enroll on or after that date are subject to these provisions. All provider agreements which were in effect before August 15, 1997 or became effective on or after August 15, 1997 are subject to the provisions of MAPIL and all provider agreements are deemed to be amended effective August 15, 1997 to contain the terms and conditions established in MAPIL.

— Any provider who does not wish to be subjected to the terms, conditions and requirements of MAPIL must notify provider enrollment in writing within ten (10) working days of the date of this letter that the provider is withdrawing from the Medicaid program. If no such written notice is received, the provider may continue as an enrolled provider subject to the provisions of MAPIL.

Office for Civil Rights Policy Memorandum

— The Department of Health and Human Services (DHHS), Office for Civil Rights, recently issued a policy memorandum regarding nondiscrimination based on national origin as it relates to individuals who are limited-English proficient. Enclosed is the Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Statement, which expresses our Agency's commitment to ensuring that there is no discrimination in the delivery of healthcare services through CMS programs.

— We have committed ourselves to full compliance with the requirements contained in this policy statement. As our partner with the administration of the Medicaid program, you likewise are obligated to comply with those statutory civil rights laws. As stipulated in the policy statement, these laws include: Act of 1990 as amended and Title IX of the Education Amendments of 1972. The Office for Civil Rights of the DHHS has previously advised CMS that detailed implementation regulations for the Rehabilitation Act of 1973, as amended, are located at 45 Code of Federal Regulations, Part 85.

— It has been asked that we share this policy statement with you and what you do likewise with healthcare providers and all others involved in the administration of CMS programs.

Centers for Medicare and Medicaid Services (CMS) Civil Rights Compliance Policy Statement

— The Health Care Financing Administration's vision in the current Strategic Plan guarantees that all our beneficiaries have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all CMS program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of CMS funds. These laws include: Title VI of the Civil Rights Act, as amended; Section 504 of the Rehabilitation Act, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all CMS operating components. Promoting attention to and ensuring CMS program compliance with civil rights laws are among my highest priorities for CMS, its employees, contractors, State agencies, healthcare providers, and all other partners directly involved in the administration of CMS programs.

— CMS, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability. CMS will, with your help, continue to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

— To achieve its civil rights goals, CMS will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities including: collecting data on access to, and the participation of minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing CMS publications, program regulations, and instructions to assure support for civil rights; and working closely with the DHHS, Office for Civil Rights, to initiate orientation and training programs on civil rights. CMS will also allocate financial resources to the extent feasible to: ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

— DHHS will seek voluntary compliance to resolve issues of discrimination whenever possible. If necessary, CMS will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

— CMS's mission is to assure healthcare security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries; i.e., our customers. We will enhance our communication with constituents, partners and stockholders. We will seek input from healthcare providers, states, contractors, and DHHS Office for Civil Rights, professional organizations, community advocates and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best healthcare possible regardless of race, color, national origin, age, sex, or disability.

State of Louisiana
(Business/Entity)

Instructions for Louisiana Medicaid PE-50 Provider Enrollment Form

PREPARATION

Please read the instructions in their entirety before completing forms. Complete Form PE-50 as an **original** document. The completed form may be photocopied for your records. Inaccurate/ incomplete forms will be returned to you for correction or completion.

GENERAL INFORMATION

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

A Medicaid provider number can have only one (1) mailing address. Therefore, this address **MUST** be the address where the business/entity wishes to receive all Remittance Advice notices for claims billed under the Medicaid provider number.

All fields on the PE-50 form **MUST** be completed unless they are labeled as optional.

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

Enrollment Type – Check the appropriate box to indicate if this application is for a new enrollment, re-enrollment, annual enrollment or change of ownership (CHOW).

- **New Enrollment** is for an entity or business with no prior Louisiana Medicaid provider number.
- **Re-Enrollment** is for a provider who has had a Louisiana Medicaid provider number in the past but whose number is closed, or a provider who will re-validating their information for the 2013 PRISM Provider Enrollment rollout.
- **Annual Enrollment** is a yearly validation of the provider's information.
- **A CHOW** is generally identified by a new Federal Tax ID number having been assigned and the purchase of an existing enrolled provider.

Provider Type Description (Required Field) – Review the following table and enter the appropriate provider description. Entries of provider types other than those listed in this table will result in rejection of this application.

NOTE: The table below is lists Atypical Facility/Agency/Organization/Institution (FAOI), Billing Agent-Clearing House, Group, and FAOI categories for entity/business providers only.

Atypical FAOI
Assistive Devices PT 17
Case Mgmt - Infants & Toddlers (In-State Only) PT 07 (Atypical)
Case Mgmt – Elderly (In-State Only) PT 08
Non-Emergency Medical Transportation PT 42 (In- State Only)
Waiver – Environmental Modifications (In-State Only) PT 15
Waiver - Personal Emergency Response System PT 16
FAOI
ADHC – Adult Day Health Care Waiver (In-State Only) PT 85
Ambulance Transportation PT 51
Ambulatory Surgical Center (In-State Only) PT 54
CMHC/Partial Hospitalization (In-State Only) PT 18
CCW-Caregiver Temporary Support PT AN
DME Providers (Out-of-State enrolls for Crossovers Only*) PT 40
EPSDT Health Services (In-State Only) PT 70
Family Planning Clinic PT 71
Hemodialysis Center (In-State Only) PT 76
Home Delivered Meals Waiver PT AM
Home Health Agency (In-State Only) PT44
Hospice Services (In-State Only) PT 09
Hospital PT 60
Hospital - Distinct Part Psychiatric (In- State Only) PT 69
Hospital - Mental Health Hospital (Free-Standing) PT 64
ICF/DD Group Home (In-State Only) PT 88
Independent Lab PT 23
Mobile X-Ray/Radiation Therapy Center PT25
Multi-Systemic Therapy (In-State Only) PT12
Optical Supplier (In-State Only) PT 75
Pediatric Day Health Care (PDHC) Facility PT 04
Personal Care Services (EPSDT/LTC/PCS/PAS) (In-State Only)* PT 24
Pharmacy (Out-of-State enrolls for Crossovers only) PT 26
Rehabilitation Center (In-State Only) PT 65
Waiver – Adult Day Habilitation (In-State Only) PT 14
Waiver - Children's Choice (In-State Only) PT 03
Waiver - Personal Care Attendant (PCA) Self-Directed (In-State Only)* PT 82
Waiver – Pre-Vocational Habilitation (In-State Only) PT 13
Waiver - Respite Care (Center-Based only) (In-State Only) PT 83
Waiver – Shared Living (In-State only) PT 11
Waiver - Substitute Family Care (In-State Only) PT 84
Waiver - Supervised Independent Living (In- State Only) PT 89
Waiver - Supported Employment (In-State Only) PT 98

Group
Chiropractor Group PT 30
CRNA Group PT 91
Doctors of Osteopathy (DO) Group PT 19
Dental Group PT 27
Early Steps Group (In-State Only) PT 29
Federally Qualified Health Center (FQHC) PT 72
Optometrist Group PT 28
Nurse Practitioner Group PT 78
Physician (MD) Group PT 20
Podiatrist Group PT 32
Rural Health Center (Independent) (In-State Only) PT 87
Rural Health Clinic (Provider Based) (In- State Only) PT 79
School Based Health Center (In-State Only)* PT 38
Billing Agent/Clearinghouse
Third-Party EDI Billing Agent/Submitter/Clearinghouse PT 21

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

NPI Tie Breaker (Taxonomy or Zip + 4) – Providers can obtain one NPI for each Medicaid ID number **or** use the same NPI for multiple Medicaid ID numbers. If the same NPI is used for multiple Medicaid provider numbers, the provider must use the tie-breaker (either Taxonomy or Zip + 4) for registering the NPI **and** on the EDI claims submission. This allows the claim/payment to be directed to the correct Medicaid provider number.

SECTION A – ENTITY/BUSINESS INFORMATION AND PRACTICE LOCATION

Doing Business As Name of Enrolling Entity – Enter the Doing Business As (DBA) Name. If a license is required for the practice/business, enter the DBA Name or Operating Name so that it matches the name on the business license.

Area Code and Telephone # - Enter the telephone number at the practice location of the business named in *Doing Business As Name of Enrolling Entity.*

Social Security # – Enter the Social Security Number of the owner.

Business/Practice Street Address – Enter the street address of the main location of the enrolling business. Occasionally, there will be an instance when a document or correspondence may be sent to the street address. If mail cannot be received at the Business/Practice Street Address because there is no receptacle and the postal carrier will not bring the mail inside the building, include a brief note of explanation and provide an alternative delivery address for the physical location only.

Medicare ID# (if applicable) – Enter the Medicare number or the organizational NPI assigned to the enrolling business/entity (if applicable). Be sure this Medicare number or NPI is the exact number that will be used to bill Medicare for the business/entity listed in Section A.

Business/Practice City – Enter the city in which your *Business/Practice Street Address* is physically located.

Business/Practice State – Enter the state in which your *Business/Practice Street Address* is physically located.

Business/Practice Zip Code – Enter the zip code in which your *Business/Practice Street Address* is physically located.

Parish/County – Enter the parish/county in which your *Business*/*Practice Street Address* is physically located (out-of-state providers see county codes below).

Parish Code – Enter the parish code of your physical location (see list below and enter appropriate code for the parish entered in the *Parish* field).

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

Out-of-State Providers: Use the chart below to determine the county/state codes.

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

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

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

State Status – Check “In” if Business/Practice Street Address is located within Louisiana or “Out” if it is located outside Louisiana.

Location Type – Check Urban if your Business/Practice City is an urban (city) location or Rural if it is a rural (away from city centers) location.

License # – If applicable, enter the license number for the business/entity identified in the Doing Business As Name of Enrolling Entity field.

Primary Provider Type Taxonomy – Refer to the checklist in the Provider Specific Packet for the taxonomy associated with your provider specialty. The checklist is located on the PRISM website, www.medicaid.la.gov/PRISM.

Secondary, Third, Fourth, and Fifth Specialty/Subspecialty – Refer to the checklist in the Provider Specific Packet for the possible taxonomy associated with your provider specialty or subspecialty.

Effective Date – This is the date that you want the provider number to be activated. In some instances, this date is regulated by program guidelines.

SECTION B – PAY-TO NAME AND MAILING ADDRESS

Provider Pay-To Name – Enter the name registered with the IRS. This is the name to which year-end 1099s are issued. Enter the name EXACTLY as found on the top line of the pre-printed IRS documentation enclosed with the application. Do not abbreviate or add punctuation not found on the IRS documentation. If the Pay-To Name on the PE-50 **DOES NOT** match the IRS documentation exactly, the application may be returned to you for correction.

Attn or Other (optional) – This information can be used to help get your mail delivered to a complex address (i.e., a certain person, department, floor, particular area, or section, etc.).

Provider Mailing Address – Enter the address to which Remittance Advices and other correspondence should be mailed.

Provider Mailing City – Enter the city in which your *Provider Mailing Address* is located.

Provider Mailing State – Enter the state in which your *Provider Mailing Address* is located.

Provider Mailing Zip – Enter the zip code in which your *Provider Mailing Address* is located.

IRS Reporting # – Enter the Federal Tax ID number assigned to you by the IRS. This number is used in reporting payment amounts for this provider number to the IRS. A copy of a pre-printed document from the IRS showing the Employer Identification Number (EIN)/Tax ID Number (TIN) and the name that's registered to the EIN is required.

Provider Year-End Date – Enter the Fiscal Year-end month of your business. **This is a required field for providers who complete an Annual Cost Report.** You must enter the month noted on your CMS letter if Medicare is required.

SECTION C – HOSPITALS AND/OR LTCs

Hospitals Only – Only hospitals need respond. Check the appropriate box for the entity/business entered in the Provider Name field in Section A.

Hospital & LTCs # Certified Beds – Both hospitals and LTCs must respond. Enter the number of certified beds of the entity/business entered in the Provider Name field in Section A.

Hospitals & LTCs Name of Administrator – Both hospitals and LTCs must respond. Enter the name of the individual who serves as administrator of the entity/business in the Provider Name field in Section A.

SECTION D – CONTACT INFORMATION

Contact Person – Enter the name of the person who should be contacted for additional information regarding this enrollment application.

Contact Phone # – Enter the phone number of the person who should be contacted for additional information regarding this enrollment application.

Contact Fax # - Enter the fax number of the person who should be contacted for additional information regarding this enrollment application.

Contact Email – Enter the email address of the person who should be contacted for additional information regarding this enrollment application.

SECTION E – PROVIDER ATTESTATION OF INFORMATION

Read the information included in this section.

Print the Name of the Authorized Representative – Print the name of the authorized representative who can enter into a binding agreement with Louisiana Medicaid.

Authorized Representative's Signature – The authorized representative must sign the form. Signatures must be original, blue ink preferred (not BLACK). Stamped signatures and initials are not accepted.

Date of Signature – Enter the date this agreement was signed.

Entity or Business
Louisiana Medicaid PE-50 Provider Enrollment Form

Rev.02/13

Louisiana Medicaid Provider # (if known)								This enrollment packet is for ☐ Enrollment ☐ Re-Enrollment ☐ Annual Enrollment ☐ Change of Ownership (CHOW)						
								Provider Type Description:						
National Provider Identifier (NPI)												**NPI Tie Breaker (Taxonomy or Zip + 4)**		

A Entity/Business Information & Location

"Doing Business As" Name of Enrolling Entity			Area Code & Telephone #	Social Security #
Business/Practice Street Address				Medicare ID# (if applicable)
Business/Practice City		Business/Practice State	Business/Practice Zip Code	
Parish/County	Parish/County Code	State Status ☐ In ☐ Out	Location Type ☐ Urban ☐ Rural	License #
Primary Provider Type Taxonomy (see checklist in Provider-Type Specific Packet)		Secondary Specialty/SubSpecialty Taxonomy (see checklist in Provider-Type Specific Packet) (Optional)		Third Specialty/SubSpecialty Taxonomy (see checklist in Provider-Type Specific Packet) (Optional)
Fourth Specialty/SubSpecialty Taxonomy (see checklist in Provider-Type Specific Packet) (Optional)		Fifth Specialty/SubSpecialty Taxonomy (see checklist in Provider-Type Specific Packet) (Optional)		Effective Date

B Pay-To Name & Mailing Address

Provider Pay-To Name (**MUST** match the first line on the IRS document EXACTLY)		Attn or Other (Optional)	
Provider Pay-To/Mailing Address	Provider Pay-To/Mailing City	Provider Pay-To/Mailing State	Provider Pay-To/Mailing Zip Code
IRS Reporting #	Provider Year-End Date		

C Hospitals and/or LTCs

Hospitals Only

☐ Profit (2) ☐ Nonprofit (3) ☐ Public (4) (In-State Only) ☐ LSU Hospitals (7) ☐ State-owned excluding LSU (9) (In-State Only)

Hospital & LTCs # Certified Beds: _____	**Hospitals & LTCs** Name of Administrator: _____ (Print Full Name of Administrator)

D Contact Information

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

Contact Person:

Contact Phone #:

Contact Fax #: Contact Email:

E Provider Attestation of Information

I, the undersigned, certify the following

1. I have read the contents of this enrollment packet including the PE-50 Addendum and the information contained herein is true, correct, and complete;
2. I understand that it is my responsibility to maintain current information on the Louisiana Medicaid files and failure to do so may result in delayed payments or closure of the Medicaid Provider Number;
3. I am an authorized party for the entity/business in Section A and can legally bind this entity to this agreement through my signature below; and
4. I understand that the Louisiana Medicaid files will be updated with information supplied on these forms.

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

Print the Name of the Authorized Representative	**Authorized Representative's Signature**	**Date of Signature**

PE-50 ADDENDUM – PROVIDER AGREEMENT (Entity/Business)

REQUIRED FIELDS Must be identical to information on Sec. A of PE-50

SS# (9 digits) | | | | | | | | | |

--OR--

IRS# (9 digits) | | | | | | | | | |

Must be identical to information on Sec. B of PE-50

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

Enrollment in Louisiana Medicaid

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

   I will report any of the above conditions to Program Integrity at the Department of Health and Hospitals prior to enrolling in Louisiana Medicaid or upon discovery once enrolled.
8. I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, the Social Security Numbers of any owner(s), manager(s), and board of directors, etc., must be provided.
   - I understand that failure to provide the Social Security Numbers will result in the rejection of my enrollment or re-enrollment request.

Providing Services to Louisiana Medicaid Recipients

9. I understand that I must comply with disclosure requirements outlined in 42 CFR, Section 455.105, which state that Providers and Fiscal Agents must submit updated disclosures as well as updated ownership and control disclosures within 35 days upon written request from DHH, at time of change of ownership or at any time.
10. I agree to conduct my activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL Louisiana R.S. Title 46, Chapter 3, Part VI-A) as required to protect the fiscal and programmatic integrity of the medical assistance programs;
11. I understand that services and/or supplies provided by me must be medically necessary and medically appropriate for each individual patient based on needs presented on the date the service is provided and/or delivered;
12. I agree to charge no more for services to eligible recipients than is charged on the average for similar services to others;
13. I understand that as the provider I am held responsible for any and all claims submitted under any Louisiana Medicaid provider number issued to me;
14. I agree to maintain all records necessary for full disclosure of services provided to individuals under the program and to furnish information regarding those records as well as payments claimed/received for providing such services that the State Agency, the DHH Secretary, the Louisiana Attorney General, or the Medicaid Fraud Control Unit may request for five years from the date of service;
15. I agree to report and refund any discovered overpayments;
16. I agree to participate as a provider of medical services and shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by me as a Medicaid patient. I agree to accept a client's Medicaid card as payment in full for covered services rendered. I agree to bill Medicaid for **all** services covered by Medicaid that will be provided to eligible Medicaid clients;
17. I agree to accept Medicaid payment for covered services as payment in full and not seek additional payment from any recipient for any unpaid portion of a bill, with the exception of state-funded spend-down Medically Needy recipients as indicated by the agency's form 110-MNP or any recipient co-payments as established by the DHH;
18. I agree to adhere to the published regulations of the Department of Health and Hospitals (DHH) Secretary and the Bureau of Health Services Financing, including, but not limited to, those rules regarding recoupment and disclosure requirements as specified in 42 CFR 455, Subpart B;
19. I agree to adhere to the federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the federal Department of Health and Human Services, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of

electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA;

20. I understand the Louisiana Medicaid Program must comply with Department of Health and Human Services (DHHS) regulations promulgated under Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; and the American Disabilities Act of 1990 which require that:
    - No person in the United States shall be excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of age, color, handicap, national origin, race or sex under any program or activity receiving Federal financial assistance.

    Under these requirements, Louisiana's Department of Health and Hospitals, Bureau of Health Services Financing cannot pay for medical care or services unless such care and services are provided without discrimination based on age, color, handicap, national origin, race or sex. Written complaints of non-compliance should be directed to Secretary, Department of Health and Hospitals, PO Box 91030, Baton Rouge, LA 70821-9030 or DHHS Secretary, Washington, DC or both.
21. The Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requiements in 1902(a)(68) of the Social Security Act, set forth in that subsection and as the Secretary of the US Department of Health and Human Services may specify. As an enrolled provider/entity, it is your obligation to inform all of your employees and affiliates of the provisions of the Federal False Claims Act, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. When monitored or audited, you will be required to show evidence of compliance with this requirement.

Medicaid Direct Deposit (EFT) Authorization Agreement

22. I have reviewed the Medicaid Direct Deposit (EFT) Authorization Agreement and the Medicaid Provider Requirements and Conditions as listed below and agree to this agreement:
    - I understand that payment and satisfaction of any claims will be from Federal and State Funds; and any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.
    - I understand that DHH may revoke this authorization at any time.
    - I hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account and the depository name referenced on the EFT Authorization Agreement form. These credits will pertain only to direct deposit transfer payments that the payee has rendered for Medicaid services.
    - I certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature below is authorized by the stated Board of Directors to enter into or change this agreement.
    - I agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I further understand that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility and failure to notify the Provider Enrollment Unit as noted may result in Medicaid payments being electronically transmitted to incorrect accounts. I understand that such changes may not be able to be accommodated if less than 15 business days notice is given.

Certification of Claims (Paper & Electronic)

23. I certify that all claims provided to Louisiana Medicaid recipients will be necessary, medically needed and will be rendered by me or under my personal supervision;
24. I understand that all claims submitted to Louisiana Medicaid will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws;
25. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate, and complete.

Acknowledgement of Penalties for Violations of Medicaid Laws, Rules, Policies, and Contractual Provisions

26. I understand and acknowledge that my participation as a provider in the Louisiana Medical Assistance Program is conditional upon my adherence to all applicable statutes, promulgated and unpromulgated rules, provisions contained within policy and provider manuals, and applicable provisions contained within contracts with, or pertaining to, Coordinated Care Networks or Managed Care Organizations, all of which have the force of law;
27. I understand and acknowledge that any violation of any of the aforementioned applicable statutes, promulgated and unpromulgated rules, provisions contained within policy and provider manuals, and applicable provisions contained within contracts with, or pertaining to, Coordinated Care Networks or Managed Care Organizations may result in sanctions levied against me including, but not limited to, recoupment of overpayments, withholding of payments pending, monetary penalties and/or fines, termination of this agreement, or exclusion for a minimum of five years from the Louisiana Medical Assistance Program.

Print Name of Authorized Representative

Signature of Authorized Representative

Date of Signature

PEUEFT00

LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

INSTRUCTIONS

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

FOR AN ENTITY/BUSINESS THE PERSON SIGNING THIS FORM (AS THE AUTHORIZED REPRESNTATIVE) MUST BE LISTED AS AN OWNER AND/OR MANAGER ON THE DISCLOSURE OF OWNERSHIP FORM

PEUEFT01

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

1. Medicaid Provider Number (7 digits)

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

3. Name of Individual Enrolling or the Doing Business As Name of Enrolling Entity/Business: _____

4. Contact Person: _____

5. Contact Person's Phone Number: _____

ACCOUNT INFORMATION
(All fields must be completed)

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

7. Reason for change in account information:

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

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

9. Attach Copy of Voided Check (Deposit Slips Are Not Acceptable)

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

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

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

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

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

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

10. Print Name of Individual Enrolling or the Authorized Representative of Business/Entity

11. Signature of Individual Enrolling or the Authorized Representative of Business/Entity

12. Date of Signature

BE SURE THAT ALL FIELDS ARE COMPLETED
FOR AN ENTITY/ BUSINESS, THE PERSON SIGNING THIS FORM (AS THE AUTHORIZED REPRESENTATIVE) MUST BE LISTED AS AN OWNER AND/OR MANAGER ON THE DISCLOSURE OF OWNERSHIP FORM

(Revised 02/13)

PRISM
Provider Recipient Integrated System for Medicaid

DEPARTMENT OF HEALTH AND HOSPITALS
Medicaid

Louisiana Medicaid Program

Disclosure of Ownership Information Form For Entity/Business

Mail to:
PRISM Medicaid Solutions
Provider Enrollment
P.O. Box 91108
Baton Rouge, LA 70821-9998

(Forms are subject to change without notice)

PEUDOOE00

Reference Material for
Louisiana Medicaid Ownership Disclosure Information
For an Entity/Business

Louisiana Medicaid follows the regulations as outlined in The Code of Federal Regulations (CFR).

The information being requested on this Louisiana Medicaid **Disclosure of Ownership form** can be found in Title 42 (Public Health), Part 455 (Program Integrity: Medicaid), Subpart B (Disclosure of Information by Providers) in the CFR at the following web address**:**

http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=35ef6cec8b4fa9f7959798ceb12999d1&rgn=div5&view=text&node=42:4.0.1.1.13&idno=42#42:4.0.1.1.13.2

Contents

Notice Regarding Disclosure of Social Security Numbers

Louisiana Medicaid policy, including Louisiana's Medical Assistance Programs Integrity Law (MAPIL Louisiana R.S., Title 46, Chapter 3, Part V1-A) and Administrative Rules, (*Louisiana Register*, Vol. 29, No. 4, April 20, 2003), as well as Louisiana Provider Update January/February 2009 (available at LAMEDICAID.com) requires potential Medicaid providers, including Officers, Trustees, Partners and Boards of Directors, furnish social security numbers. (Links are available below.) A Social Security number is also required for any person listed on the Disclosure of Ownership Form.

Please refer to the following web sites, if clarification is needed:

42 USC 1320 a – 3: http://www.law.cornell.edu/uscode/42/1320a-3.html

Social Security Act 1128 a: http://www.ssa.gov/OP_Home/ssact/title11/1128A.htm

MAPIL Louisiana R.S., Title 46:437.1-14. http://legis.la.gov/lss/lss.asp?doc=100852

Louisiana Register, Vol. 29, No. 4, April 20, 2003: http://www.doa.louisiana.gov/osr/reg/register.htm

Louisiana Update January/February 2009: http://www.lamedicaid.com/ProviderUpdate/provider_update0109.pdf

State of Louisiana
Instructions for Louisiana Medicaid Ownership Disclosure Information
Entity/Business

Please note: This is a multi-page form. All of the pages must be completely filled out and submitted or the application cannot be accepted. Please review the instructions in their entirety before completing the form. Every field on the Disclosure of Ownership Form must be completed, and every question must be answered. Failure to complete the form in its entirety will result in a rejection.

Please refer to the web sites listed on the previous page for information regarding full disclosure of ownership, social security number requirements, and the Louisiana Medicaid Assistance Program Integrity Law (MAPIL).

Note: Please enter your Provider Name at the top of each page which provides a space for that purpose.

SECTION I – ENROLLING PROVIDER INFORMATION

Louisiana Medicaid Provider Number – Enter your seven- (7) digit Medicaid provider number, if known. If this application is for a new Medicaid provider number, leave this field blank.
Tax-Payer ID Number – Enter the nine- (9) digit Tax ID number for this provider.
National Provider Identifier – Enter your ten- (10) digit National Provider Identifier (NPI). This number can be obtained by going to https://nppes.cms.hhs.gov
This enrollment packet is for a – Check the appropriate box from among New Enrollment, Annual Enrollment , Re-Enrollment , or Change of Ownership (CHOW). If CHOW, provide the date of the CHOW and the current Louisiana Medicaid Provider number in the spaces provided.
Provider Primary Taxonomy Type – Enter the Louisiana Medicaid Provider Taxonomy Type for this entity/business.
Telephone Number(s) of Enrolling Entity/Business - Enter the area code and telephone number(s) at the street address of this enrolling entity/business.
Name of Enrolling Entity/Business – Enter the legal name of the entity/business in the space labeled "Legal Name of Entity/Business." Enter the DBA Name in the space labeled "Doing Business As (DBA) Name." If a license is required, the name entered must match the operating name on the entity/business license.
Entity/Business Street Address - Enter the physical business street address of the entity/business requesting enrollment
City, State, Zip - Enter the city, state and zip code of the physical business street address
Email Address to receive official DHH Notices - Enter the email address at which official DHH notices are to be sent. (NOTE: Failure to keep this email address current may result in your not receiving timely notifications regarding your enrollment, provider alerts, important policy changes, etc.)
Entity/Business Website – Enter URL of the entity/business website.
Is this enrolling entity/business publicly traded? A publicly traded company is one which is traded on the open market, also called publicly held or public company. Check either the Yes box or the No box.
Privately owned or Non-profit Providers Only – Identify the type of entity/business as it is registered with the Internal Revenue service. Check only one box from among Sole Proprietorship, Partnership/Limited Liability Partnership, Corporation, Limited Liability Corporation (LLC), or Non-profit. Answer any questions associated with the type of entity/business in the space(s) provided. Optional: Check the Comments box and write in any comments in the space provided. Continue to Section II.
Louisiana Government Providers Only – Identify the type of entity/business if Louisiana government owned. Select only one from among City and/or Parish, LEA (Local Education Agency), LSU, OBH, OPH, OAAS, OCDD, Villa, Other DHH agency, or Other State-owned entity. Check the appropriate box, and fill out the blank with the appropriate information as needed. Print the Name and Title of the person authorized to enroll the agency in Louisiana Medicaid, and then go to Section VIII.

SECTION II – ENROLLING ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

A - D. Read all questions carefully and respond by checking the appropriate boxes. If yes to any question, complete or attach the required documentation.

SECTION III – ENROLLMENT IN HEALTHCARE PROGRAMS

A. Is this Tax ID currently enrolled in a Federal/State funded healthcare program? Check the Yes box or the No box. If yes, check off the plan or plans (Louisiana Medicaid, Medicare Part A, Medicare Part B, Medicare Part C, Medicare Part D (for pharmacies only), CHAMPUS, **and/or** Other Government Funded Program. In each instance checked, provide the Doing Business As (DBA) Name, the Plan Numbers for Louisiana Enrollments, and the Plan Numbers for Other State Enrollments.
B. Is the enrolling entity/business located out of the state of Louisiana? Check the Yes box or the No box. If yes, has this out-state entity/business been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes box or the No box. If yes, provide the domicile state name, the domicile state Medicaid Provider Number, and the domicile state Medicare Provider Number in the spaces provided.

SECTION IV – PREPARER INFORMATION – INDIVIDUAL COMPLETING DISCLOSURE OF OWNERSHIP INFORMATION

List the full name (including maiden name and hyphenated last name if applicable), social security number, date of birth, and job title. Check one box to identify whether the person completing the form is staff, owner, third party/independent agent, or other. If you check other, please specify by writing the relationship in the space provided. List the entity/business address, entity/business telephone number, and the entity/business email address of the person completing this form. Finally, enter any additional entity/business telephone number(s) and entity/business email address(es).

SECTION V – OWNERSHIP INFORMATION

Carefully read the Louisiana Medicaid policy statements and definitions of ownership so that you can properly fill out Sections V(a), V(b), and V(c).

SECTION V(A) – INFORMATION ON ALL OWNERS

Make a photocopy of Section V(a) in case more space is needed. List all owners with a direct or indirect stake/shareholding/ownership/etc. of 5% or greater in the enrolling entity/business named in Section I. In the top table, list individuals. Note that for each individual listed, a two-page Section V(b) must be filled out. In the bottom table, list entities/businesses that have an ownership interest in the entity/business named in Section I. Note that for each entity/business listed, Section V(c) must be filled out. In the bottom table, space is also provided to list individuals who have at least a 5% interest or greater in the entities/businesses listed on the left-hand part of the lower table. For each of these individuals as well a Section V(b) must be filled out.

SECTION V(B) – INFORMATION ON INDIVIDUAL OWNER

An entire Section V(b) (consisting of two pages) must be completed for each and every individual owner, whether the individual owns a direct stake in the enrolling entity or owns a stake in an entity that owns a stake in the enrolling entity. Make a copy of the blank form for each owner you report.

A. OWNER – person with 5% or greater direct or indirect ownership as a stakeholder – Enter the First Name, Middle Name, Maiden Name, Last Name and Hyphenated Last Name (if applicable) in the spaces provided. Enter the Title/Job Position within this entity/business, the Social Security Number, and Date of Birth in the spaces provided. Check the Yes or No box to indicate whether this owner is a U.S. citizen. Enter the current address of the owner in the spaces provided. Enter the Telephone Number and Email address of the owner in the spaces provided.
B. Are any individual owners with direct, indirect or controlling interest, managing employees, or subcontractors identified for this entity/business related to one another as spouse, parent, child or sibling? – Check the Yes or No box. If yes, list all individuals and how they are related in the spaces provided.
C.- E. Has the owner named above ever – Read the questions carefully and check the Yes or No boxes. If yes to any question, attach the requested documentation.

F. **Has the owner named above ever** – Read the question carefully and check the Yes or No box. If yes, enter the name(s) in the spaces provided.
G. **Is this individual owner currently enrolled in a Federal/State funded healthcare program? –or – Does this individual owner have controlling interest in an entity/business that participates in a Federal/State funded healthcare program? –** Check the Yes or No box. If yes, check off the plans, list the DBA Name(s), the Tax ID(s) or SSN(s), and the plan number(s) in the spaces provided.
H. **Does this owner reside out-of-state (not in Louisiana)?** – Check the Yes or No box. If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes or No Box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided.

SECTION V(C) – INFORMATION ON THE ENTITY/BUSINESS OWNER

A. **OWNER – an entity/business with 5% or greater direct or indirect ownership** – Enter the Entity/Business Name, the DBA Name, and the Tax ID Number in the spaces provided. Enter the current address of the Entity/Business in the spaces provided. Enter the Telephone Number and Email address of the entity/business contact person in the spaces provided.
B-D. **Has the owner named above ever –** Read the questions carefully and check the Yes or No boxes. If yes to any question, attach the requested documentation.
E. **Has the owner named above ever** – Read the question carefully and check the Yes or No box. If yes, enter the DBA name(s) in the spaces provided.
F. **Does this owner have ownership or controlling interest in any other entity participating in a Federal/State Funded healthcare program?** -- Check the Yes or No box. If yes, check off the plans, list the DBA Name(s), the Tax ID(s), and the plan number(s) in the spaces provided.
G. **Does this owner reside out-of-state (not in Louisiana)?** – Check the Yes or No box. If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes or No Box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided.

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Carefully read the Louisiana Medicaid policy statements and definitions of managers/agents so that you can properly fill out Sections VI(a) and VI(b).

SECTION VI(A) – INFORMATION ON ALL MANAGERS/AGENTS

Make a photocopy of Section VI(a) if more space is needed to list individuals.

In the spaces provided, 1 through 10, list each individual or agent who is a part of management. For each individual, check the Yes or No box to indicate whether the person is also an owner. If the manager is also an owner and was reported in Section V, then it is not necessary to fill out Section VI(b); otherwise, Section VI(b) is required for each manager listed in VI(a).

SECTION VI(B) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Make a photocopy of Section VI(b) for each manager/agent you report.

MANAGER or AGENT – Check the box for Manager or Agent. Enter the title/job position within this entity/business, the social security number, and the full name (including maiden name and hyphenated last name if applicable) in the spaces provided. Check the Yes box or the No box to specify whether this owner is a U.S. citizen. Enter the current address of the manager, street, city and Zip Code in the spaces provided. Enter the email address, telephone number, and date of birth of the manager in the spaces provided.
A-C. **Has the manager/agent named above ever –** Read the questions carefully and check the Yes or No boxes. If yes to any question, attached the requested documentation.
D. **Has the manager/agent named above ever –** Read the question carefully and check the Yes or No box. If yes, enter the name(s) in the spaces provided.
E. **Does this manager/agent have ownership or controlling interest in any other entity currently participating in a Federal/State Funded healthcare program?** -- Check the Yes or No box. If yes, check off the plans, list the DBA Name(s), and the plan number(s) in the spaces provided.
F. **Does this manager/agent reside out-of-state (not in Louisiana)?** – Check the Yes or No box. If yes, has this out-of-state manager/agent been issued any Medicaid or Medicare provider numbers by the domicile state? Check the Yes or No Box. If yes, enter the Domicile State name, the Medicaid Provider Number, and the Medicare Provider Number in the spaces provided.

SECTION VII – SUBCONTRACTOR INFORMATION

Read Federal Regulations 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2). Read Section VII carefully, as you are entering into an agreement with the Louisiana Department of Health and Hospitals by which you agree to and may be requested to provide the specified subcontractor information.

SECTION VIII – AUTHORIZED REPRESENTATIVES

List the individuals who are 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. Every person listed here must be either an owner or a manager as disclosed in the Disclosure of Ownership forms. Check one box for each person to indicate whether the individual is an owner, a manager, or other (specify the title in the space provided).

SECTION IX – PROVIDER SIGNATURE

Carefully review all sections of the Disclosure of Ownership. Requires original signature of the authorized representative (no stamps or initials) and the date.
Please sign in colored ink (not black).

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LOUISIANA MEDICAID OWNERSHIP DISCLOSURE INFORMATION—ENTITY/BUSINESS

SECTION I – ENROLLING PROVIDER INFORMATION

Louisiana Medicaid Provider Number (7 digits)
(Leave blank if applying for new number)

Taxpayer ID Number (9 digits)

National Provider Identifier (NPI) (10 digits)

This Disclosure is for
☐ New Enrollment ☐ Annual Enrollment ☐ Re-Enrollment ☐ Change of Ownership (CHOW) _____ _____
Date of CHOW | Current Medicaid Provider Number

Provider Primary Taxonomy Type:	**Telephone Number of Enrolling Entity/Business**			
Name of Enrolling Entity/Business:	**Legal Name of Entity/Business**	**Doing Business As (DBA) Name**		
	Entity/Business Street Address	**City**	**State**	**Zip**
	Provider's FAX Number	**Provider's telephone number to request medical records**		
	Email Address to receive official DHH Notices	**Entity/Business Website**		

Is this enrolling entity/business publicly traded? See instructions. ☐ Yes ☐ No

Privately owned or Non-profit Providers Only
Identify Type of Entity/Business – as registered with the Internal Revenue Service
Select only one (1) – multiple selections may result in a rejection for clarification

☐ **Sole Proprietorship**
☐ **Partnership/Limited Liability Partnership**: How many members are identified with this partnership?_____
☐ **Corporation:** Revenue greater than or equal to $5M annually _____ Revenue less than $5M annually _____
In the Articles of Incorporation: How many stakeholders/individual owners are identified? _____
How many Board of Director members are identified? _____
How many officers are identified? _____
☐ **Limited Liability Company (LLC)**
In the Articles of Organization: How many members are identified? _____
How many managers are identified? _____
☐ **Non-profit:** How many members are appointed to the governing board? _____**(Must attach IRS verification showing the non-profit status)
☐ **Comments:** _____

Privately owned or Non-profit – continue on to Section II

-- OR --

Louisiana Government Providers Only
Identify Type of Entity/Business if Louisiana Government owned
Select only (1) – multiple selections may result in a rejection for clarification

☐ **CITY and/or PARISH**	**DHH**	**Other State-owned entity:**
☐ **LEA (Local Education Agency)**	☐ OBH ☐ OPH	
☐ **LSU**	☐ OAAS ☐ OCDD	
Hospital - _____	☐ Villa	_____
	Other _____	

Print the Name and Title of the person authorized to enroll in Louisiana Medicaid on behalf of this Governmental Agency

Print Name	**Print Title**

Louisiana Government ONLY (including LSU) – move on to Section VIII – the Signature page.

Provider Name: _____

SECTION II – ENTITY/BUSINESS CRIMINAL CONVICTION DISCLOSURE AND ADDITIONAL INFORMATION

Has this enrolling entity/business or any entity/business affiliated with the above tax ID, ever:

A. Been convicted of a healthcare related felony or any other criminal offense, State and/or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post-trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? ☐ Yes ☐ No

If yes, attach explanation details of conviction or plea, including date of occurrence and state in which conviction occurred. Court documentation is required.

B. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification? ☐ Yes ☐ No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and state in which this action occurred, regarding the disciplinary action for all individuals/entities/agents/subcontractors, managing employees and/or businesses involved. Reinstatement letter required.

C Been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? ☐ Yes ☐ No

If yes, attach documents (notice of enrollment rejection, suspension, termination from participation, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals//entities/businesses involved. Reinstatement letter required.

D. Used or previously been known by any name other than the legal name or the Doing Business As (DBA) name documented in this application? ☐ Yes ☐ No

If yes, list all names and Tax IDs below:

Name	Tax ID
Name	Tax ID
Name	Tax ID

SECTION III - ENROLLMENT IN HEALTHCARE PROGRAMS

A. Is the Tax ID in Section I currently enrolled in a Federal/State funded healthcare program? ☐ Yes ☐ No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s), and the plan number(s):

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Louisiana Enrollments	Plan Numbers for Other State Enrollments	
				State	ID#
☐Medicaid					
☐Medicare Part A					
☐Medicare Part B					
☐Medicare Part C					
☐Medicare Part D (Pharmacies only)					
☐TriCare					
☐Other Government Funded Program					

B. Is this enrolling entity/business located out-of-state (i.e., out of Louisiana)? ☐ Yes ☐ No

If yes, has this out-of-state entity/business been issued any Medicaid or Medicare provider numbers by the domicile state? ☐ Yes ☐ No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

**** Attach Additional Sheets as Needed. ****

Provider Name: _____

SECTION IV - PREPARER INFORMATION – INDIVIDUAL COMPLETING THE DISCLOSURE OF OWNERSHIP

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Social Security Number	Date of Birth	Job Title

The person completing this form is (please check one):

☐ Staff ☐ Owner ☐ Third Party/Independent Agent ☐ Other (explain) _____

Entity/Business Address	Entity/Business City	Business State	Business Zip

Entity/Business Telephone Number	Entity/Business Email Address
Additional Entity/Business Telephone Number(s)	Additional Entity/Business Email Address(es)

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Please Read before proceeding to SECTION V – OWNERSHIP INFORMATION

Be sure to make a photocopy of the following form (Section V(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT) before you fill it out the first time; you need one page for each manager/agent. If you have a five-person management team, you need to submit five completed Section V(b) forms. You may NOT submit a list of names; each manager/agent must be reported with a full page of information (no attachments – use the form provided).

Section V seeks to identify the owners of this enrolling entity/business.

Medicaid requires that an enrolling entity/business fully disclose **ALL** persons and entities that have an ownership interest (either separately or in combination) of 5% or more of this enrolling entity/business.

Owners are individuals and/or organizations having direct, indirect, or controlling ownership interest in this disclosing entity/business.

- Direct ownership is defined as the possession of stock, equity in capital, or any interest in the profits of this disclosing entity/business.
- Indirect ownership is defined as an ownership interest in an entity/business that has direct or indirect ownership in this disclosing entity/business.
- Controlling interest is defined as having operational direction or management or the ability and authorization:
    - To amend or change the corporate identity.
    - To nominate or name members of the board, directors, or trustees
    - To amend or change the bylaws, constitution, or other operating or management direction
    - To control the sale of any or all of the assets or property upon dissolution of the entity/business.
    - To dissolve or transfer this disclosing entity/business to new ownership or control.
    - Et cetera.

Owners may also be individuals associated with the enrolling entity/business:

- Whose personal assets are used to satisfy the entity/business creditors.
- Who join together to carry on an entity/business and expect to share in the profits and losses of the entity/business.
- Who report their share of profits and losses of the entity/business on their own personal tax returns.
- Who own corporate stock.
- Who are policy makers.
- Who have veto powers.
- Who have voting power.
- Who have any other responsibilities similar to the ones described above.

Ownership might be implied by titles like the following:

- Founder
- Incorporator
- Member
- Owner
- Shareholder

This list is not all-inclusive, and other titles that imply or assume similar powers or responsibilities may apply.

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith*; or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

Provider Name: _____

SECTION V(a) – INFORMATION ON ALL OWNERS

List all owners with a direct or indirect stake/shareholding/ownership/etc. of 5% or greater in the enrolling entity/business named in Section I.

Individuals/members/stockholders/stakeholders with ownership
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
Make a photocopy of this page if more space is needed to list individuals.
Fill out Section V(b) for each individual listed above.

– and/or –

List all entity/business owners with a direct or indirect stake/shareholding/ownership/etc. of 5% or greater in the enrolling entity/business named in Section I.

Note: The enrolling entity/business cannot be listed as an owner below.

Entities/Businesses with an ownership stake	Individual owners of the entity/business identified on the left.
1.	a.
	b.
	c.
	d.
2.	a.
	b.
	c.
	d.
3.	a.
	b.
	c.
	d.
4.	a.
	b.
	c.
	d.
5.	a.
	b.
	c.
	d.
Make a photocopy of this page if more space is needed to list entities/businesses and/or individuals.	
Fill out Section V(c) for each entity/business listed above.	

Provider Name: _____

SECTION V(b) – INFORMATION ON INDIVIDUAL OWNER

Complete Section V(b) (2 pages) for each individual owner. Make a copy of the blank form for each owner you report.

A. OWNER – a person with 5% or greater direct or indirect ownership as a stakeholder					
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Title/Job Position within this entity/business		Social Security Number			Date of birth
Is this owner a U.S. citizen? ☐ Yes ☐ No					
Current Address of Owner					
City					
State		Zip Code			
Telephone Number		Email address			

B. Are any **individual owners** with direct, indirect or controlling interest, **managing employees**, or **subcontractors** identified for this entity/business related to one another as spouse, parent, child or sibling? ☐ Yes ☐ No

If yes, list all individuals and how they are related below:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
Relationship:			Job Title:		

Has the owner named above ever:

C. Been convicted of a felony or convicted of any other criminal offense under this name or any other name in any state or U.S. Territory, regardless of a post-trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? ☐ Yes ☐ No

If yes, attach explanation details of conviction or plea, including date of occurrence and state in which conviction occurred. Court documentation is required.

D. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification? ☐ Yes ☐ No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and state in which this action occurred, regarding the disciplinary action for all individuals/entities/agents/subcontractors, managing employees and/or businesses involved. Reinstatement letter required.

Provider Name: _____

SECTION V(b) – INDIVIDUAL OWNER INFORMATION, continued

Name of Individual Owner: _____

Has the owner named above ever:

E. Been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? ☐ Yes ☐ No

If yes, attach documents (notice of enrollment rejection, suspension, termination from participation, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals//entities/businesses involved. Reinstatement letter required.

F. Used or been known by any other name including married, maiden, hyphenated, or alias? ☐ Yes ☐ No

If yes, enter name(s) below:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

G. Is this individual owner currently enrolled in a Federal/State funded healthcare program? ☐ Yes ☐ No

– or –

Does this individual owner have controlling interest in an entity/business that participates in a Federal/State funded healthcare program? ☐ Yes ☐ No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s) or SSN(s), and the plan number(s):

Plan	Doing Business As (DBA) Name	Tax ID or SSN	Plan Numbers for Louisiana Enrollments	Plan Numbers for Other State Enrollments	
				State	ID#
☐ Medicaid					
☐ Medicare Part A					
☐ Medicare Part B					
☐ Medicare Part C					
☐ Medicare Part D (Pharmacies only)					
☐ TriCare					
☐ Other Government Funded Program					

H. Does this owner reside out-of-state (not in Louisiana)? ☐ Yes ☐ No

If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state? ☐ Yes ☐ No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

Provider Name: _____

SECTION V(c) – INFORMATION ON THE ENTITY/BUSINESS OWNER

Complete Section V(c) for each entity/business owner. Make a copy of the blank form for each owner you report.

A. OWNER – an entity/business with 5% or greater direct or indirect ownership		
Entity/Business Name	DBA Name	Tax ID Number (required)
Current Address of Entity/Business		
City		
State	Zip Code	
Telephone Number	Email address of entity/business contact person	

Has the owner named above ever:

B. Been convicted of a felony or convicted of any other criminal offense under this name or any other name in any state or U.S. Territory, regardless of a post-trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? ☐ Yes ☐ No

If yes, attach explanation details of conviction or plea, including date of occurrence and state in which conviction occurred. Court documentation is required.

C. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, voluntary surrender of a license or certification? ☐ Yes ☐ No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and state in which this action occurred, regarding the disciplinary action for all individuals/entities/agents/subcontractors, managing employees and/or businesses involved. Reinstatement letter required.

D. Been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? ☐ Yes ☐ No

If yes, attach documents (notice of enrollment rejection, suspension, termination from participation, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals//entities/businesses involved. Reinstatement letter required.

E. Used or been known by any other name or Doing Business As (DBA) name(s)? ☐ Yes ☐ No

If yes, enter name(s) below:

DBA Name:	DBA Name:

F. Does this owner have ownership or controlling interest in any other entity participating in a Federal/State Funded healthcare program? ☐ Yes No

If yes, check off the plans, list the DBA Name(s), the Tax ID(s), and the plan number(s):

Plan	Doing Business As (DBA) Name	Tax ID	Plan Numbers for Louisiana Enrollments	Plan Numbers for Other State Enrollments	
				State	ID#
☐Medicaid					
☐Medicare Part A					
☐Medicare Part B					
☐Medicare Part C					
☐Medicare Part D (Pharmacies only)					
☐TriCare					
☐Other Government Funded Program					

G. Does this owner reside out-of-state (not in Louisiana?) ☐ Yes ☐ No

If yes, has this out-of-state owner been issued any Medicaid or Medicare provider numbers by the domicile state? ☐ Yes ☐ No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

Please Read before proceeding to

SECTION VI – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Be sure to make a photocopy of the following form (Section VI (b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT) before you fill it out the first time; you need one page for each manager/agent. If you have a five-person management team, you need to submit five completed Section VI (b) forms. You may NOT submit a list of names; each manager/agent must be reported with a full page of information (no attachments – use the form provided).

VI seeks to identify the management structure of this enrolling entity/business.

Manager– defined under 42 §CFR 455.101 as "a general manger, business manager/agent, administrator, director, or other individual who exercises operational or manager/agential control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency".

Agent - Defined under 42 §CFR 455.101 as any person who has been delegated the authority to obligate or act on behalf of a provider.

Medicaid requires that an enrolling entity/business fully disclose **ALL** persons that provide management expertise to the enrolling entity/business.

Members of management, or agents, are non-owners who are part of a chain of command within a company and may perform tasks similar to the ones shown below:

- Analyze performance
- Develop directional policy
- Direct and control management activities
- Manage risk
- Oversee operations
- Participate in the election and/or removal of officers and employees
- Supervise
-

Members of management, or agents, may hold job titles similar to the ones shown below:

- Administrator
- Board of directors Board of trustees Chairman or chairperson
- Chief Business Officer (CBO), Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Operating Officer (COO) and Director
- Manager/agent
- Officer
- Trustee

When reporting a name, use the individual's FULL LEGAL NAME, i.e. *John R. Smith*, not *J.R. Smith* or *Johnny Smith;* or Jenny Rae Jones-Smith, not J.R. Jones-Smith or Jenny Jones-Smith.

These lists are not all-inclusive, and other activities and titles that imply or assume similar powers or responsibilities may apply.

Provider Name: _____

SECTION VI(a) – INFORMATION ON ALL MANAGERS/AGENTS

List each individual or agent who is part of management.

Managers/Agents	Is this manager also an owner?
1.	☐ Yes ☐ No
2.	☐ Yes ☐ No
3.	☐ Yes ☐ No
4.	☐ Yes ☐ No
5.	☐ Yes ☐ No
6.	☐ Yes ☐ No
7.	☐ Yes ☐ No
8.	☐ Yes ☐ No
9.	☐ Yes ☐ No
10.	☐ Yes ☐ No
Make a photocopy of this page if more space is needed to list individuals.	
Fill out Section VI(b) for each individual listed above unless the manager is also an owner and was reported in Section V.	

Provider Name: _____

SECTION VI(b) – INFORMATION ON EACH INDIVIDUAL OR AGENT WHO IS PART OF MANAGEMENT

Complete Section VI(b) for each manager/agent. Make a copy of the blank form for each manager you report.

☐ **MANAGER – or –** ☐ **AGENT**	Title/Job Position within this entity/business	Social Security Number (required)

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Is this individual with management/agent duties a U.S. citizen? ☐ Yes ☐ No

Current Address of Manager/Agent		
City		
State	Email Address	
Zip Code	Telephone Number	Date of Birth (required)

Has the manager/agent named above ever:

A. Been convicted of a healthcare related felony or any other criminal offense, State or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post-trial motion, a plea of guilty or *nolo contendere* or participation in a First Offense pardon program? Court documentation required. ☐ Yes ☐ No

If yes, attach explanation of conviction or plea, including date of conviction and state in which it occurred

B. Had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification? ☐ Yes ☐ No

If yes, attach a copy of the license sanction document (consent decree, revocation, suspension order or surrender notice) with an explanation, providing details, including the date and state in which this action occurred, regarding the disciplinary action for each individual/entity/agent/subcontractor, managing employees/businesses involved. Reinstatement letter required.

C. Been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, terminated, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicare, Medicaid or other healthcare program(s) in any state or U.S. Territory? ☐ Yes ☐ No

If yes, attach documents (notice of enrollment rejection, suspension, termination from participation, exclusion) with an explanation providing details, including date and state in which action occurred, for all individuals/entities/businesses involved. Reinstatement letter required.

D. Ever used or been known by any other name including married, maiden, hyphenated, or alias? ☐ Yes ☐ No

If yes, enter name(s) below:

First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)
First Name	Middle Name	Maiden Name	Last Name	-	Hyphenated Last Name (if applicable)

Provider Name: _____

SECTION VI(b) - Manager Information, continued

Manager Name: _____

E. Does this manager/agent have ownership or controlling interest in any other entity currently participating in a Federal/State Funded healthcare program? ☐ Yes ☐ No

If yes, check off the plans, list the DBA Name(s), and list Plan Numbers.

Plan	Doing Business As (DBA) Name	Tax ID or SSN	Plan Numbers for Louisiana Enrollments	Plan Numbers for Other State Enrollments	
				State	ID#
☐ Medicaid					
☐ Medicare Part A					
☐ Medicare Part B					
☐ Medicare Part C					
☐ Medicare Part D (Pharmacies only)					
☐ TriCare					
☐ Other Government Funded Program					

F. Does this manager/agent reside out-of-state (not in Louisiana?) ☐ Yes ☐ No

If yes, has this out-of-state manager/agent been issued any Medicaid or Medicare provider numbers by the domicile state? Yes ☐ No

If yes, please provide the Domicile State name and Provider Numbers.

Domicile State:	Medicaid Provider Number:	Medicare Provider Number:

PEUDOOE00

SECTION VII – SUBCONTRACTOR INFORMATION

DEFINITIONS:

Subcontractor-

1. An individual, agency or organization that you have:
    a. contracted with or
    b. delegated some of your management functions or responsibilities of providing medical care to your patients.

– or –

2. An individual, agency or organization with which you have entered into a contract, agreement, purchase order, or lease to obtain:
    a. equipment,
    b. supplies,
    c. space, including real estate, or
    d. services provided under the Medicaid agreement.

Wholly Owned Supplier-

A supplier (i.e., an individual, agency or organization from which a Medicaid provider purchases goods and services used in carrying out its responsibilities under Medicaid, e.g., a commercial laundry, manufacturer of hospital beds, pharmaceutical firm) whose total ownership interest is held by a Medicaid provider or by a person, persons, or other entity with an ownership or control interest in a Medicaid provider.

Provider Name: _____

SECTION VII – SUBCONTRACTOR INFORMATION

Subcontractor information may be found in Federal Regulations 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2)

Pursuant to 42 CRF § 455.105, by enrolling in the Medicaid program, you are entering into an agreement with the Louisiana Department of Health and Hospitals by which you agree to and may be requested to provide the following information within 35 calendar days within the date of the request by the Department or the Secretary of Health and Human Services.

1. The ownership of any subcontractor with whom you have had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request; and

2. Any significant business transactions between you and any wholly owned supplier, or between you and any subcontractor, during the 5 year period ending on the date of the request.

3. Any wholly owned supplier or subcontractor with which the entity had significant business transactions of $75,000 or more, within the past 5 years.

Louisiana State Medicaid regulations allow the Department 90 calendar days after receipt of a complete application to determine whether to enroll an applicant in the program.

Provider Name: _____

SECTION VIII – AUTHORIZED REPRESENTATIVES

THE FOLLOWING INDIVIDUALS ARE 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.

Note: Every person listed here must be either an owner or a manager as disclosed in the Disclosure of Ownership forms.

List each person authorized to sign and identify their position in your practice.	
1.	☐ Owner ☐ Manager ☐ Other _____
2.	☐ Owner ☐ Manager ☐ Other _____
3.	☐ Owner ☐ Manager ☐ Other _____
4.	☐ Owner ☐ Manager ☐ Other _____
5.	☐ Owner ☐ Manager ☐ Other _____
6.	☐ Owner ☐ Manager ☐ Other _____
7.	☐ Owner ☐ Manager ☐ Other _____
8.	☐ Owner ☐ Manager ☐ Other _____
9.	☐ Owner ☐ Manager ☐ Other _____
10.	☐ Owner ☐ Manager ☐ Other _____

Please sign in blue ink (not black)

_____ _____

Print Name of Authorized Representative | Title/Position

_____ _____

Signature of Authorized Representative | Date of Signature

Provider Name: _____

SECTION IX – PROVIDER SIGNATURE

With my signature below, I attest:

1. That I have disclosed all necessary information;
2. That I am the authorized representative of this entity/business 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 entity/business 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 entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That I understand that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That I understand that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable federal or state laws;
7. That I understand it is my responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That I understand that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That I understand if this number is closed due to inaccurate information, I will have to complete a new Provider Enrollment Packet in its entirety for consideration to reactivate this provider number;
10. I understand that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. *(See Federal Regulations 42 CFR § 455.104(a) (1)), (2).* A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. *(See Federal Regulations 42 CFR § 455.104(a)(2).* Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That I understand that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, I must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day to day operations.
12. I attest that I am a United States citizen or have legal status and work privilege in the US and I understand that it is my responsibility to ensure that all my managers, employees, agents, affiliates or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
13. I understand that it my responsibility to ensure that I have disclosed on this form if I, or any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Manager, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
14. I understand that I shall report any of the above conditions to the Department of Health and Hospitals (DHH), and once enrolled, I understand that upon discovery of any of the above conditions, it is my responsibility to report them immediately in writing to DHH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
15. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any federally funded healthcare program, I am required to submit this information and the requested documentation.
16. I understand that I am being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." I understand that this criminal statute means that if I, or any managers, employees, agents, affiliates, or subcontractors, are excluded now or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program.
17. I also understand that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs.
18. I also understand that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00; and
19. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Please sign in colored ink (not black)

_____ _____

Print Name of Authorized Representative | Title/Position

_____ _____

Signature of Authorized Representative | Date of Signature

Louisiana's Medicaid Program

INSTRUCTIONS FOR PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

Prior to submitting electronic claims to Louisiana Medicaid, a seven-digit submit number (450XXXX) must be obtained from the PRISM Provider Enrollment Unit. The submitter number must be linked to all provider numbers for whom claims will be submitted.

The following form(s) is (are) to be completed if the individual enrolling **OR** entity/ business enrolling plans to submit claims electronically to Louisiana Medicaid.

EDI Contract

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Molina Medicaid Solutions. (Leave blank if applying for a new Provider Number.)
National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.
Name of Individual Enrolling – enter the name of the individual enrolling or the provider name associated with the Provider Number and NPI listed above.

---OR IF YOU ARE ENROLLING AS AN ENTITY/ BUSINESS ---

Doing Business As Name of Enrolling Entity/Business – enter the name of the entity/business enrolling or the business provider name associated with the provider number and NPI listed above.
Name of Contact Person – enter the name of the person designated as the point of contact for questions regarding this request.
Contact Phone Number – enter the phone number of the Contact Person.
Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)
Billing Agent / Submitter Business Name – enter the business name of the billing / submitter agent.
Signature of Provider – enter the individual provider's signature or the authorized representative's signature on page 2. Note: An individual provider must sign their own form, not an authorized representative or other agent.
Date of Signature – enter the date the provider signed the form on page 2.

EDI Power of Attorney

Louisiana Medicaid Provider Number – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Molina Medicaid Solutions. (Leave blank if applying for a new provider number.)
National Provider Identifier (NPI) – enter the NPI of the provider for which claims will be electronically submitted. Note: Atypical providers leave this blank.
Name of Individual Enrolling – enter the name of the individual enrolling or the provider name associated with the Provider Number and NPI listed above.

---OR IF YOU ARE ENROLLING AS A BUSINESS/ENTITY---

Doing Business As Name of Enrolling Entity – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.
Practice Street Address – enter the business/physical location address of the provider name entered.
Submitter Number – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid submitter number you want to link to. (Leave blank if applying for a new submitter number.)
Billing Agent / Submitter Business Name – enter the business name of the billing / submitter agent.
Billing / Submitter Agent Contact Person – enter the name of the person designated as the point of contact for the Billing / Submitter Agent business.
Billing / Submitter Phone Number – enter the phone number of the Billing / Submitter Agent contact person.
Enter the Parish (or County) Name where the Notary Public is located
Enter City, State and Date of Notarization
Signature of Provider – enter the individual provider's signature or the authorized representative's signature. Note: An individual provider must sign their own form, not an authorized representative or other agent.
Notary Public Signature – the Notary Public should sign the form and affix his/her seal.

If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized. Please complete the enclosed Limited Power of Attorney in its entirety to be mailed with your completed EDI Contract.

PEUEDI01

PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (EDI CONTRACT FOR INDIVIDUALS AND BUSINESS/ENTITY)

Louisiana Medicaid Provider Number (7 digits)

National Provider Identifier (NPI) (10 digits)

4	**5**	**0**				

Submitter Number (7 digits)
(leave blank if applying for new number)

Name of Individual Enrolling **OR**
DBA Name of Enrolling Business/Entity:

Billing Agent/ Submitter Name / Name of Business that will be submitting claims (provider name or third party biller's name):

Name of Contact Person: _____

Contact Phone Number: _____

The Medicaid File can hold a maximum of three Submitter Numbers per Medicaid Provider Number at any one time. Current policy is to close old Submitter Numbers as new ones are opened unless otherwise requested by the provider. It is also vital to identify which Submitter Number will be designated to download the Electronic Remittance Advices (ERA).

In order for Lousiana Medicaid to gather this information, complete the following, if applicable:

When a new Submitter Number is issued, it will be set up to retrieve ERAs. If a previously assigned Submitter Number is to be used to retrieve ERAs, then place it in the spaces provided below.

4	5	0				

☐ By checking this box you are giving authorization to have 835s produced for the Individual listed above and available for download by either this new submitter number or the previously assigned submitter number.

List other Submitter Number(s) that are currently on file which will NOT be used for 835 ERA, but which need to remain open in the spaces below:

4	5	0				
4	5	0				

☐ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to submit my own claims electronically to Louisiana Medicaid.

☐ I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to use a Third Party (Clearinghouse, Billing Agent, Submitter, etc.) to submit my claims electronically to Louisiana Medicaid. **(Power of Attorney form is required.)**

On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 16 below. This is done in consideration for the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing's (hereinafter referred to as "State Agency") processing of provider claims, as well as other valuable considerations.

1. All published specifications set forth shall be met as to every entry sought to be processed. The effective date for my EDI submission will be set by Provider Enrollment once the contract has processed.

(Revised 02/13)

Provider Name: _____

2. The Provider, or his agent, shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers. The Provider's data processing agent for submission of medical assistance claims is stated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to the State Agency.
3. The Provider shall provide upon request of the Director of the State Agency any supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow charts, file descriptions, accounting procedures and the like.
4. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to submit electronic claims.
5. It is expressly understood that the State Agency or its Fiscal Intermediary (Molina Medicaid Solutions) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
6. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
7. The State Agency and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
8. The Provider agrees to submit to the State Agency, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
9. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
10. The Provider and the State Agency agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.
11. Further, for a period of five years, during the course of a federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested and produce such for examination and copying.
12. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify the State Agency's limited obligations as set in a certain Provider Agreement between the State Agency and the Provider.
13. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
14. I understand that all claims submitted under the conditions of this Agreement will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.
15. I attest that all information supplied with this Agreement is true, accurate and complete.
16. **Applicable to those receiving 835s:** I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information; payment information; and bank account information, provided by me and currently on file if enrolled in **E**lectronic **F**unds **T**ransfer, to the submitter identified above. This authorization will remain in effect until discontinued by written request or changed by a future request.

Print the Name of the Individual Provider **OR** Name of the Authorized Representative for the Business/Entity	Individual Provider's Signature **OR** of the Authorized Representative for the Business/Entity
	Date of Signature

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MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY (EDI POWER OF ATTORNEY)

This form is required by all providers who will have electronic claims submitted by a third party.

Louisiana Medicaid Provider Number (7 digits)	**4 5 0** Submitter Number (7 digits) (leave blank if applying for new number)
National Provider Identifier (NPI) (10 digits)	Billing / Submitter Agent Business Name:
Name of Individual Enrolling **OR** DBA Name of Enrolling Business / Entity:	Billing / Submitter Agent Contact Person:
Practice Street Address:	Billing / Submitter Agent Phone Number:

BE IT KNOWN that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the Parish of _____, State of Louisiana, therein residing:

PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing / Submitter Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program the applicable claims for the provider type for magnetic tape, diskette, or telecommunication submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

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

Signature of Individual Provider **OR** of the Authorized Representative for the Business/Entity

Print the Name of the Individual Provider **OR** of the Authorized Representative for the Business/Entity

Notary Public Signature

Notary Seal or Notary Identification Number (required)