EIS MedClaims

Medicaid billing made easy!

# SCHOOL DISTRICTS REVALIDATION APPLICATION

## THROUGH THE MEDICAID ENROLLMENT PORTAL

# LOUISIANA MEDICAID

Select the web address below to access the Medicaid website.
Medicaid | Department of Health | State of Louisiana | (lamedicaid.com)

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## LA Medicaid

- ABOUT US
- PROVIDER TOOLS
- TRAINING/POLICY UPDATES
- CLAIMS AND BILLING
- FEE SCHEDULES
- MEDICAID PROGRAMS & INITIATIVES
- RESOURCES
- SEARCH

Select the Provider Tools button to begin the provider verification

### Recent Policy

August 2021 Hurricane Ida Information for Medicaid Pharmacy 08/28/21 (Revised 09/03/21)

Provider Enrollment

LDH: Pfizer booster ...llowing new CDC guidance 09/27/21

HHS announces the ...ding 09/20/21

Vaccination Requirements to Expand for Healthcare Settings 09/17/21

LDH Invites All Providers to Participate in the Final Louisiana eScan Survey 09/14/21

Emergency Medical Services Eligibility & Claims during the COVID-19 Public Health Emergency 08/02/21

Update: Medicaid Provider Enrollment Portal Launched July 26, 2021 07/27/21

LTC Monthly Processing Schedule for Calendar Year 2022 07/27/21

Medicaid Check Write Schedule for Calendar Year 2022 07/27/21

Medicaid Check Write Schedule for Calendar Year 2021 07/27/21

HRSA opens PRF reporting portal for providers 07/20/21

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# Provider Tools

- HOME
- ABOUT US
- PROVIDER TOOLS
- TRAINING/POLICY UPDATES
- CLAIMS AND BILLING
- FEE SCHEDULES
- MEDICAID PROGRAMS & INITIATIVES
- RESOURCES
- SEARCH

| Provider Tools | |
|---|---|
| TPL Recovery Request | Provider Manuals |
| Fraud and Abuse | Provider Updates |
| MEVS | Remittance Advice |
| Provider Enrollment | REVS |
| Provider Locator Tool | Web Account Registration |
| Provider Login | Website Enrollment |

Now select the Provider Login

# LOUISIANA MEDICAID

You are here : Louisiana Medicaid > Provider Login

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Help

Notice

This is a class action notice for the A.A. et al. v Phillips et al. lawsuit.

## Provider Login

PRINT

**Please enter your 10-digit National Provider Identifier**

Enter the 10 digit NPI number or 7 digit Medicaid Number.

*Note: Non-FFS Behavioral Health Providers should use their NPI to login.*

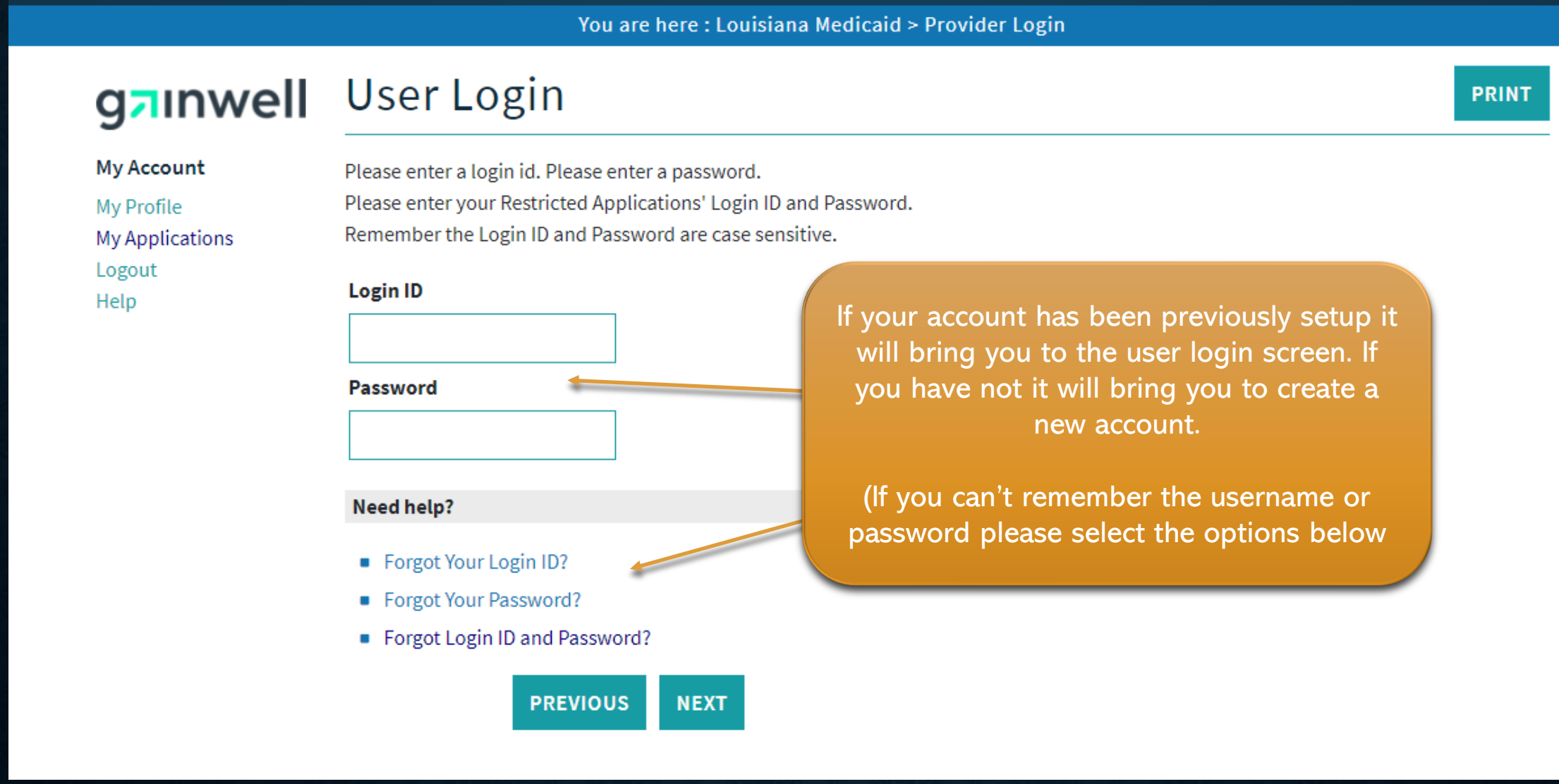
**For security purposes, please enter the characters from the CAPTCHA image**

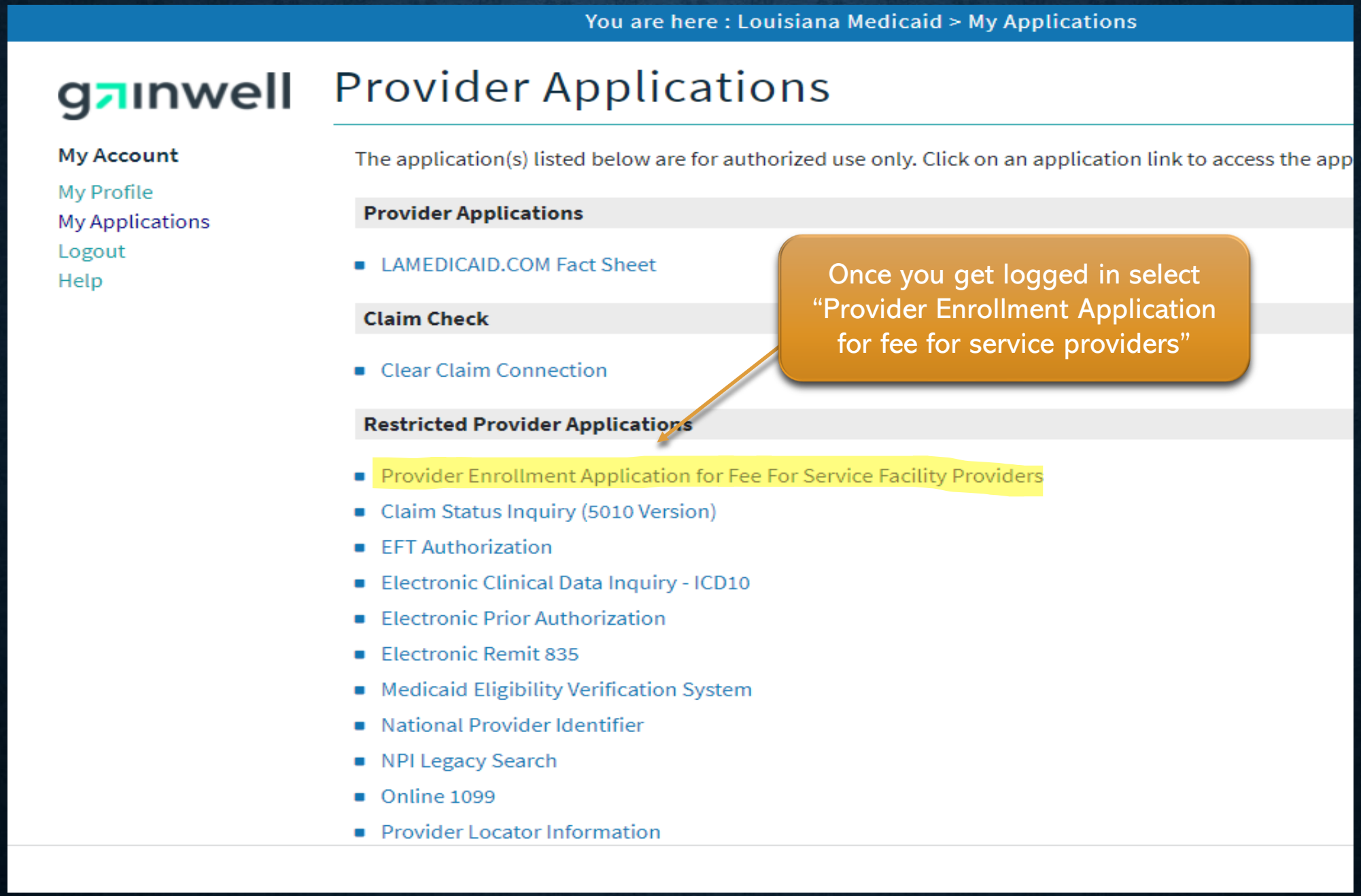

**NOTICE TO USERS**

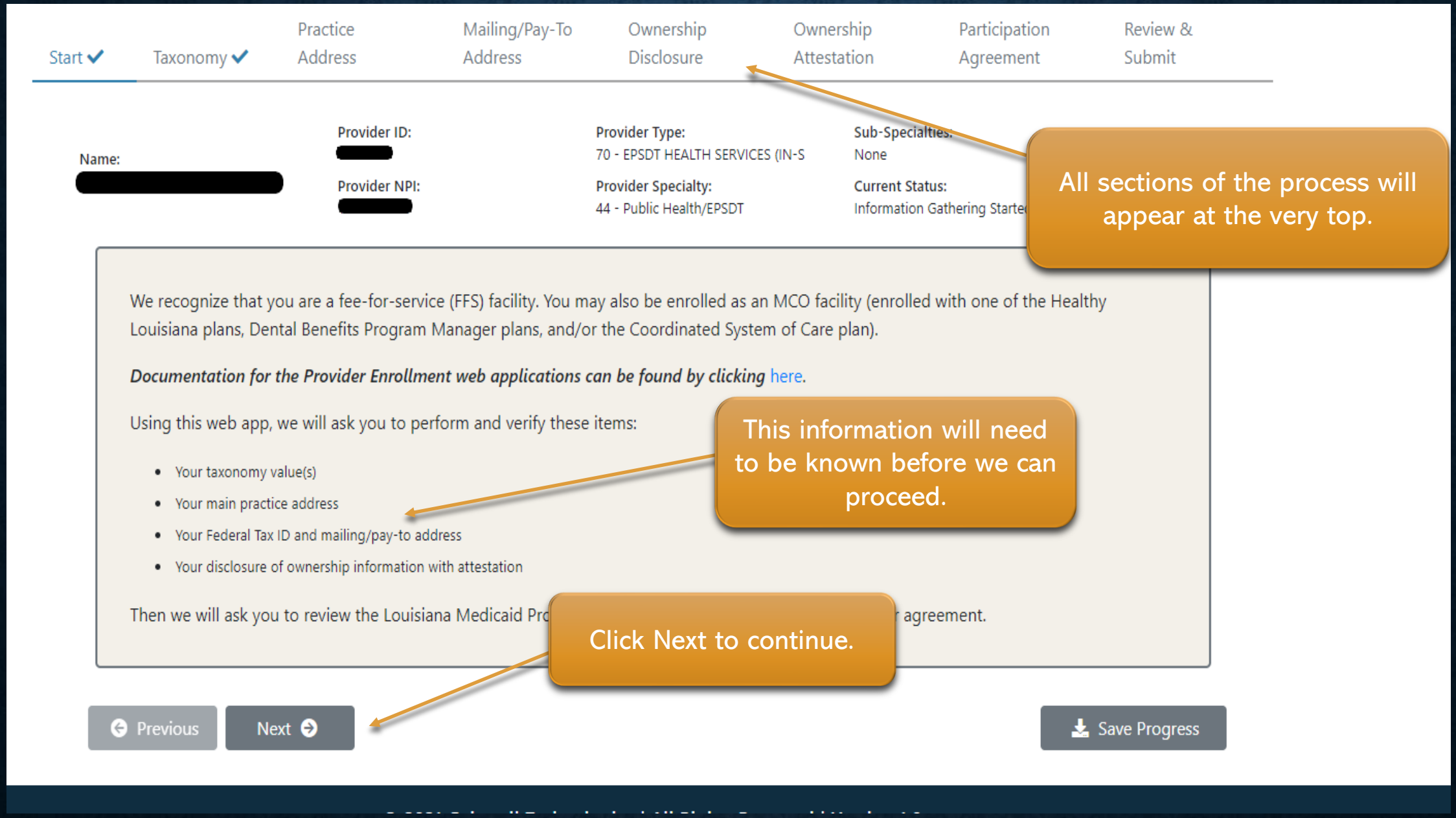
This is Louisiana's Medicaid information and is the property of Gainwell Technologies and Louisiana Department of Health. It is for authorized use only. **Users (authorized or unauthorized) have no explicit or implicit expectation of privacy.**

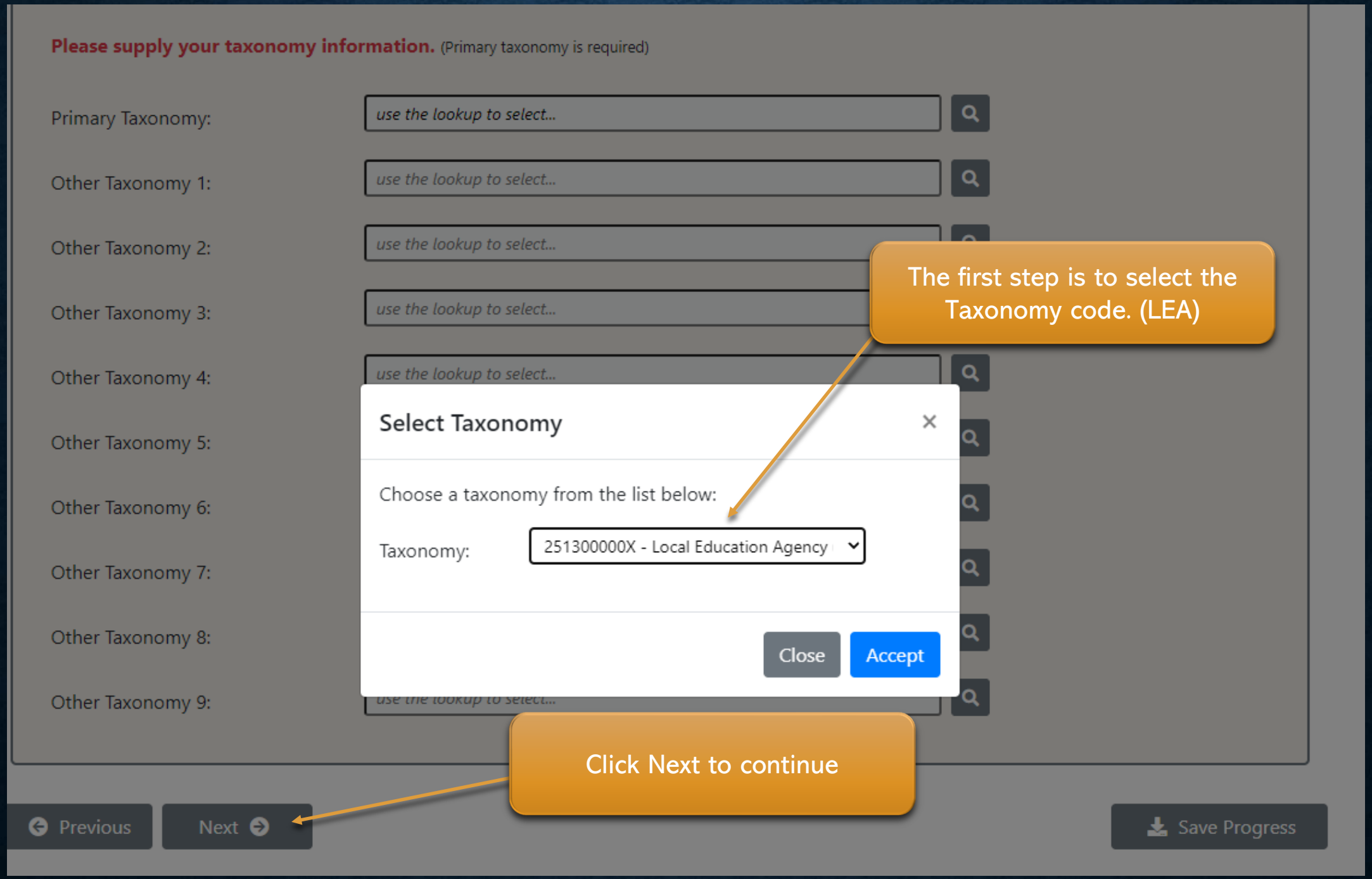
Any or all uses of this website and all files on this system may be intercepted, monitored, recorded, copied, audited, inspected, and disclosed to authorized site, Louisiana Department of Health, and law enforcement personnel, as well as authorized officials of other agencies, both domestic and foreign. **By using this system, the user consents to such interception, monitoring, recording, copying, auditing, inspection, and disclosure at the discretion of authorized site or Louisiana Department of Health**

# LOUISIANA MEDICAID




You are here : Louisiana Medicaid > My Applications
gainwell
Provider Applications
My Account
My Profile
My Applications
Logout
Help
The application(s) listed below are for authorized use only. Click on an application link to access the app
Provider Applications
LAMEDICAID.COM Fact Sheet
Claim Check
Clear Claim Connection
Restricted Provider Applications
Provider Enrollment Application for Fee For Service Facility Providers
Claim Status Inquiry (5010 Version)
EFT Authorization
Electronic Clinical Data Inquiry - ICD10
Electronic Prior Authorization
Electronic Remit 835
Medicaid Eligibility Verification System
National Provider Identifier
NPI Legacy Search
Online 1099
Provider Locator Information
Once you get logged in select "Provider Enrollment Application for fee for service providers"


Start ✓
Taxonomy ✓
Practice Address
Mailing/Pay-To Address
Ownership Disclosure
Ownership Attestation
Participation Agreement
Review & Submit
Name:
[redacted]
Provider ID:
[redacted]
Provider NPI:
[redacted]
Provider Type:
70 - EPSDT HEALTH SERVICES (IN-S
Provider Specialty:
44 - Public Health/EPSDT
Sub-Specialties:
None
Current Status:
Information Gathering Starte
All sections of the process will appear at the very top.
We recognize that you are a fee-for-service (FFS) facility. You may also be enrolled as an MCO facility (enrolled with one of the Healthy Louisiana plans, Dental Benefits Program Manager plans, and/or the Coordinated System of Care plan).
Documentation for the Provider Enrollment web applications can be found by clicking here.
Using this web app, we will ask you to perform and verify these items:
Your taxonomy value(s)
Your main practice address
Your Federal Tax ID and mailing/pay-to address
Your disclosure of ownership information with attestation
This information will need to be known before we can proceed.
Then we will ask you to review the Louisiana Medicaid Pro
agreement.
Click Next to continue.
Previous
Next
Save Progress


Please supply your taxonomy information. (Primary taxonomy is required)
Primary Taxonomy:
use the lookup to select...
Other Taxonomy 1:
use the lookup to select...
Other Taxonomy 2:
use the lookup to select...
Other Taxonomy 3:
use the lookup to select...
Other Taxonomy 4:
use the lookup to select...
Other Taxonomy 5:
Other Taxonomy 6:
Other Taxonomy 7:
Other Taxonomy 8:
Other Taxonomy 9:
Select Taxonomy
Choose a taxonomy from the list below:
Taxonomy:
251300000X - Local Education Agency
Close
Accept
The first step is to select the Taxonomy code. (LEA)
Click Next to continue
Previous
Next
Save Progress

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

Main Practice Address Information

Enter your Main Practice address

Street Address 1: *

Street Address 2:

City: *

State: * LA

Zip: *

Contact Name: *

Contact Phone: * ###-###-####

Contact Fax: * ###-###-####

Click Next to Continue

Previous Next Save Progress

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

**Mailing/Pay-To Address Information**

*Your fee-for-service (FFS) mail-to address is the same as your pay-to address on file. To change this address, submit the form at this link here*

Provider Tax ID: [redacted]

Street Address 1: [redacted]

Street Address 2:

City: [redacted]

State: LA

Zip: [redacted]

Contact Name: *

Contact Phone: * ###-###-####

Contact Fax: * ###-###-####

Enter your Tax ID and mailing address.

Please add a Contact person (This should be an authorized user)

## Disclosure of Ownership for Facilities

*Use the tabs below to complete each form. When all information in all tabs has been completed, click "Next":*

Facility | Individual Owners | Business Owners | Employee/Agent | Authorized Agents

*Is this disclosing entity/business publicly traded?*

○ Yes ◉ No

Select “No” to start the Ownership Disclosure section.

*Identify how this disclosing Entity/Business is registered with the Internal Revenue Service:*

**Privately Owned or Non-profit Providers:**

- ○ Sole Proprietorship
- ○ Partnership/Limited Liability Partnership
- ○ Limited Liability Corporation (LLC)
- ○ Nonprofit
- ○ Corporation

The next slide includes the correct “LEA” selection.

**Louisiana Government Providers:**

**Louisiana Government Providers:**

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

Select LEA (Local Education Agency)

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

**Enrolling Business/Entity Questionnaire**

| | |
|---|---|
| ○ Yes ◉ No | Ever been convicted of a criminal offense in any program under medicare, Medicaid, any Titled services in the Louisiana Medical Assistance Program? |
| ○ Yes ◉ No | Ever had any disciplinary action taken against any license or certification held in any State or US Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license of certification? |
| ○ Yes ◉ No | Ever been denied enro…cluded or voluntarily withdrawn to avoid disciplinary actio…any State or US Territory? |
| ○ Yes ◉ No | Currently have a nega…eral Funded program including Medicaid and Medicare? |
| ○ Yes ◉ No | Ever been the subject of any investigation under MAPIL (Louisiana's Medical Assistance Program Integrity Law) or by any law enforcement, regulatory, or State agency? |
| ○ Yes ◉ No | Currently have any open or pending healthcare court cases? |
| ○ Yes ◉ No | Ever been denied malpractice insurance? |
| ○ Yes ◉ No | Currently has or ever had any type of felony conviction(s)? |

Select "No" to all. If "Yes" please provide details below.

Provide details for any items answered "Yes":

## Disclosure of Ownership for Facilities

*Use the tabs below to complete each form. When all information in all tabs has been completed, click "Next":*

Facility | Individual Owners | Business Owners | Employee/Agent | Authorized Agents

*Does this facility have any individual owners with ownership of 5% or greater?*

○ Yes ◉ No

Answer should be “No” then select Next to continue.

Previous | Next | Save Progress

## Disclosure of Ownership for Facilities

*Use the tabs below to complete each form. When all information in all tabs has been completed, click "Next":*

Facility | Individual Owners | Business Owners | Employee/Agent | Authorized Agents

*Does this facility have any business owners with ownership of 5% or greater?*

○ Yes ◉ No

Answer should be “No” then select Next to continue.

Previous | Next | Save Progress

## Disclosure of Ownership for Facilities

*Use the tabs below to complete each form. When all information in all tabs has been completed, click "Next":*

Facility | Individual Owners | Business Owners | Employee/Agent | Authorized Agents

*Does this facility have any agents or individuals who are a part of management?*

○ Yes ◉ No

Answer should be “No” then select Next to continue.

Previous | Next | Save Progress

## Disclosure of Ownership for Facilities

*Use the tabs below to complete each form. When all information in all tabs has been completed, click "Next":*

Facility | Individual Owners | Business Owners | Employee/Agent | Authorized Agents

* *For each individual who is authorized to sign into legal, binding documents on behalf of this provider, such as direct deposit forms and/or changes to the disclosure of ownership forms, click "Add New" and complete the form. Use the "Edit" and "Delete" buttons to make changes:*

*Note: Each individual listed below must be disclosed in the previous s*

| Name | Position |
|---|---|

+ Add New Authorized Individual

This is where we add the Authorized users that will have access to the portal. Enter the information required.

Previous | Next

Select Next to continue

Save Progress

## Attestation of Ownership Information

I, the undersigned, certify the following:

WITH MY SIGNATURE BELOW, I ATTEST:

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

☑ I Agree

Sign Attestation

Once you check " I Agree" select the "Sign Attestation".

Previous

Next

Select Next to continue

Save Progress

## Participation Agreement

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, the provider will be required to show evidence of compliance with this requirement.

25. The Anti-Trust Assignment: The provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed by the State and/or its offices, agencies, departments or political subdivisions through any programs or payment mechanisms. For purposes of this assignment clause, the "provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

After your review of this information, please indicate your agreement below.

Sign Participation Agreement

Electronic Signature

By indicating "I Agree" below, I am signing this Agreement electronically and understand that this electronic signature is the legal equivalent of my manual signature on this Agreement.I consent to be legally bound by this Agreement's terms and conditions. I agree that no certification authority, or other third-party verification, is necessary to validate this electronic signature and that the
party verification will not in any way affect the enforceability of this elec
contract between myself and the Louisiana Department of Health. I repres
or that I am authorized to enter into this Agreement on behalf of the pro
of the Agreement are equally binding whether the provider signs the Agre

The "I Agree" checkbox will appear below once the "Sign Participation Agreement" is selected.

☐ I Agree

Previous Next Save Progress

Sign Participation Agreement

ELECTRONIC SIGNATURE

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

I Agree

A verification code must be submitted using the Contact users email address on file.

Click the "Request Verification Code" button below to have a verification code sent to the email addre the Email address can only be changed by the Admin user at LAMedicaid.com.

Email: [redacted] Request Verification Code

Code: Submit Code

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

Request New Code

Click next to continue.

Previous Next Save Progress

## Review and Submit

Review the checklist below to ensure you have completed all sections of this application. If corrections are needed please visit the application pages to revise. Once all items are complete, click the Submit button.

- Taxonomy/Taxonomies
- Practice address
- Federal Tax ID and mailing/pay-to
- Disclosure of ownership information with attestation
- Participation Agreement

Note: Once the submit button is clicked, your application will be submitted and no further changes can be made!

You are now ready to submit the application.

Submit Application →

← Previous  Next →

Your submission has been received

Start Taxonomy Address Address Disclosure Attestation Agreement Submit

Name: [redacted]

Provider ID: [redacted]

Provider NPI: [redacted]

Provider Type:
70 - EPSDT HEALTH SERVICES (IN-S

Provider Specialty:
44 - Public Health/EPSDT

Sub-Specialties:
None

Current Status:
Your submission has been received

**Review and Submit**

Review the checklist below to ensure you have completed all sections of this applica cation pages to revise. Once all items are complete, click the Submit button.

- Taxonomy/Taxonomies
- Practice address
- Federal Tax ID and mailing/pay-to
- Disclosure of ownership information with attestation
- Participation Agreement

Note: Once the submit button is clicked, your application will be submitted and no further changes can be made!

Submit Application →

You should see the confirmation that the submission has been received.

← Previous Next →