LOUISIANA DEPARTMENT OF HEALTH

Quick Reference Guide

Provider Portal for Trusted Users

Issued 9/14/18

Table of Contents

Introduction 3

Lesson 1: Accessing the Self-Service Portal for Providers 5

Lesson 2: Submit Provider Association Request Form 13

Lesson 3: Account Management 17

Manage My Account 17

Update Provider Profiles 21

Lesson 4: Submitting a New Form 26

Submitting New Forms 27

Lesson 5: Incomplete Forms 37

Lesson 6: Submitted Forms 39

Appendix 43

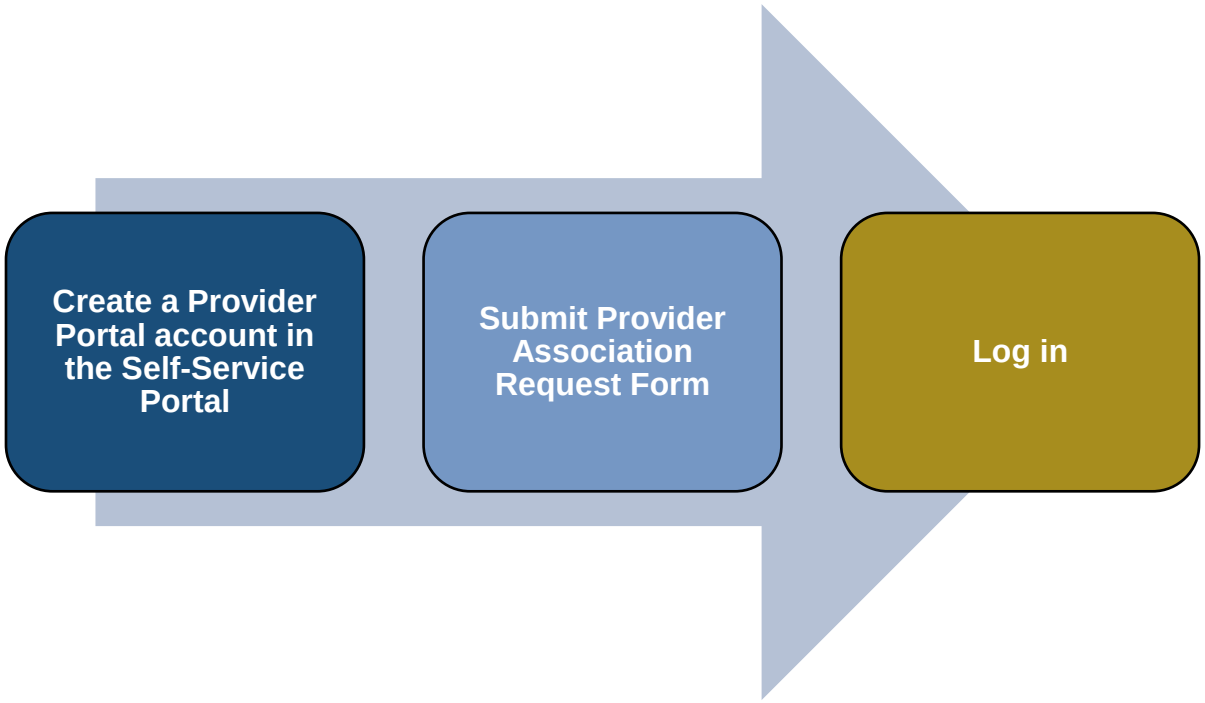
Introduction

Representatives of providers, hospitals, and Support Coordinator Agencies (SCAs) submit provider forms to Medicaid through the Provider Portal.

- **Provider Portal Trusted Users** are individuals who are authorized by Providers and Medicaid to submit forms to Medicaid. These submitted forms notify Medicaid of changes or new information for individuals who may be requesting or receiving Long Term Care, Waiver, and Newborn health coverage.

The types of provider forms available depend on the type of provider. All of the forms previously submitted through FNS will be submitted through the Provider Portal.

Before users are able to submit provider forms through the Provider Portal, they must register to be associated to a provider. The image below shows the process for obtaining full access to all Provider Portal functionality.



Once users have registered to be associated to a provider in the SSP, full access is granted to the **My Form Center** screen. From the **My Form Center** screen, users have access to the following functions:

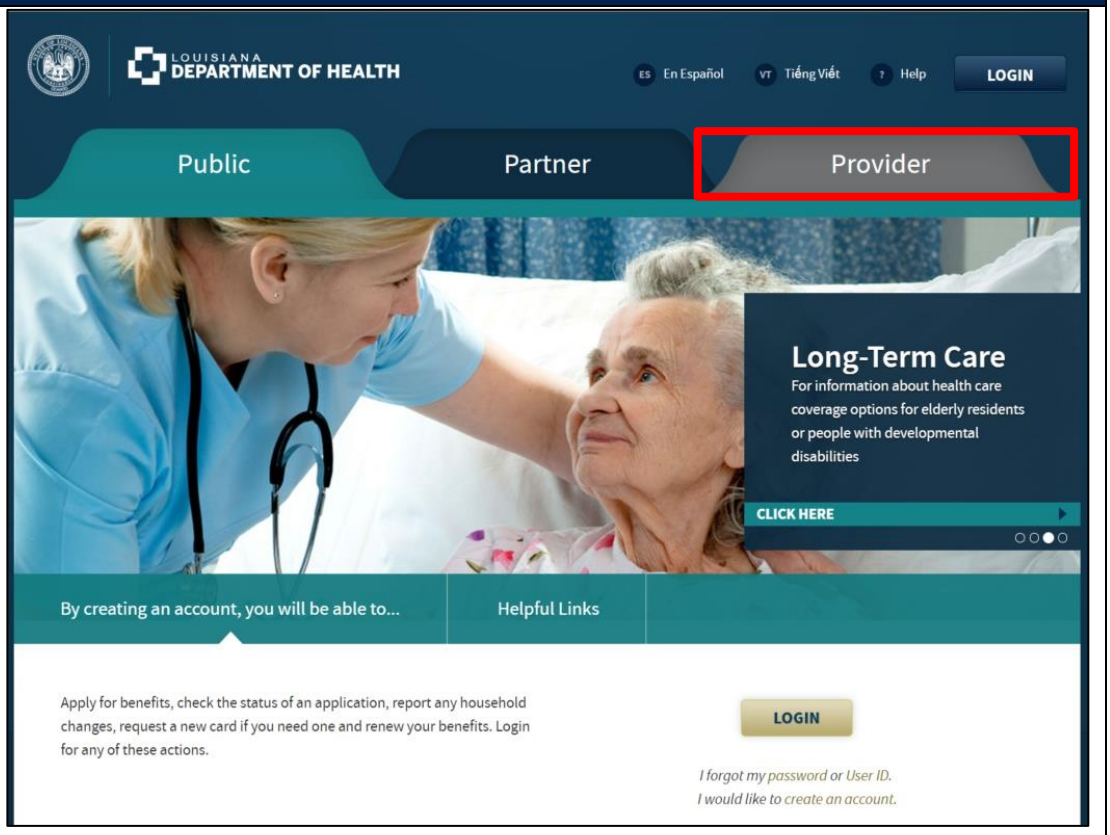
- **Register to be Associated to a Provider**: This allows users to submit provider registration forms or add additional provider associations to an account.
- **Manage My Account**: This allows users to update basic personal information such as name, address, email address, phone number, and PIN.

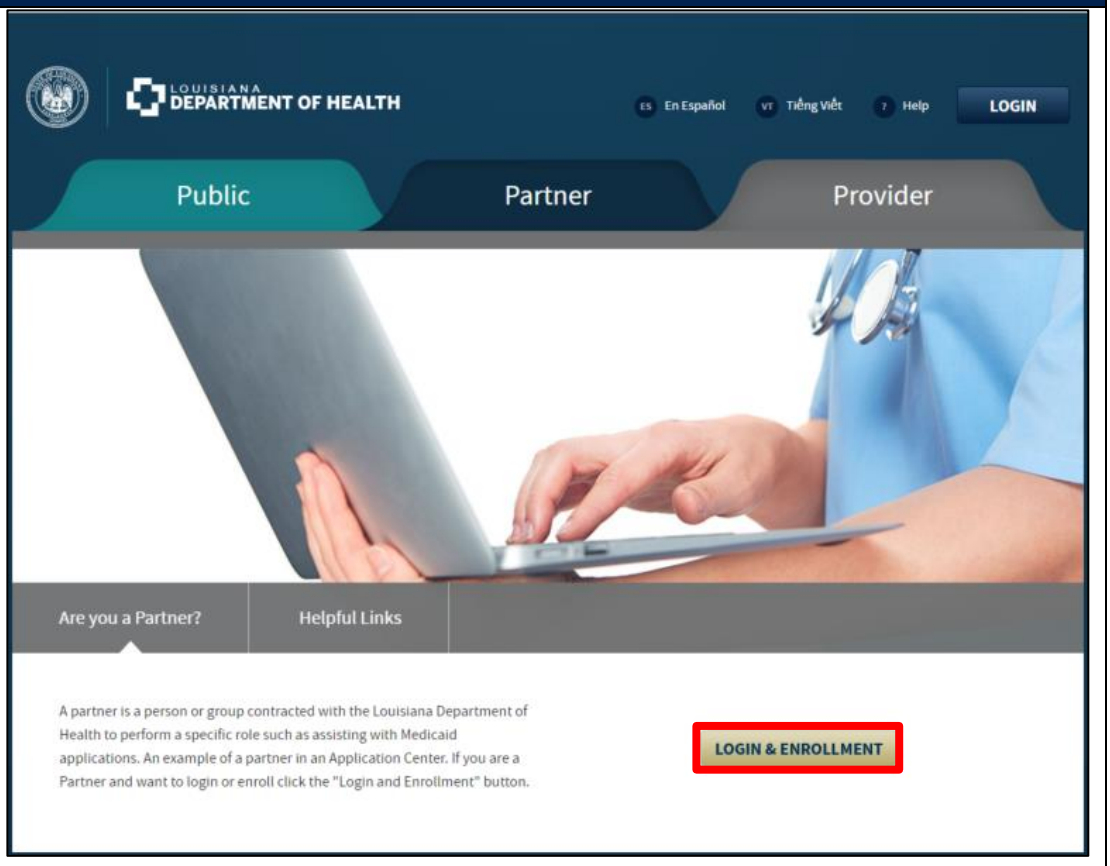
- **New Forms**: This allows users to submit specific forms (based on the provider type) on behalf of providers to whom users are associated.
- **Incomplete Forms**: This allows users to return to forms that were initiated by the user but that have not been submitted.
- **Submitted Forms**: This allows users to see all forms previously submitted by the user, and depending on the form, users may also have the option to make edits.
- **Update Provider Profiles**: This function allows users to update/delete any provider related information from their registered accounts.

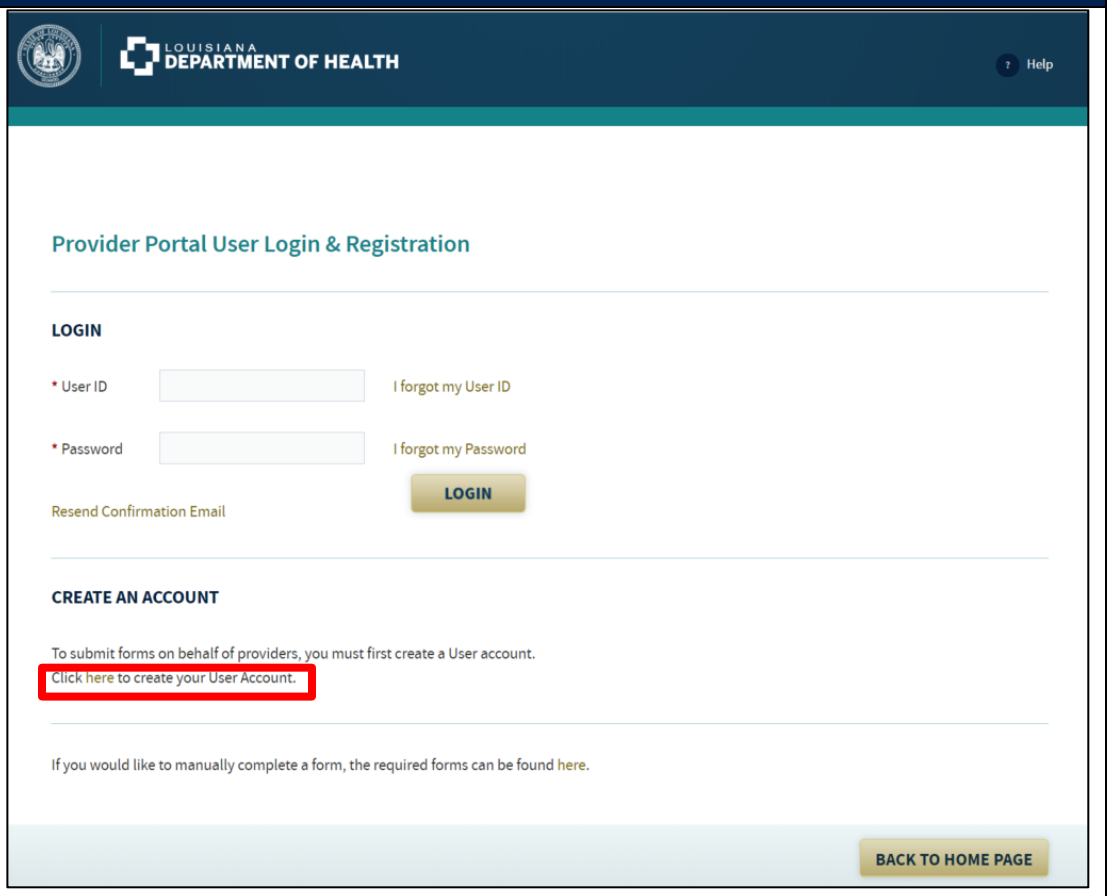
This QRG introduces the basics of accessing the Self-Service Portal (SSP) for Provider Portal Trusted Users and explains how to perform all functions in the Provider Portal.

Lesson 1: Accessing the Self-Service Portal for Providers

This lesson explains how to create a Provider Portal account in the Self-Service Portal, which is a requirement to access the Provider Portal.

STEPS	INSTRUCTIONS
1.	 From the **Self-Service Portal** home screen, click the **Provider** tab.

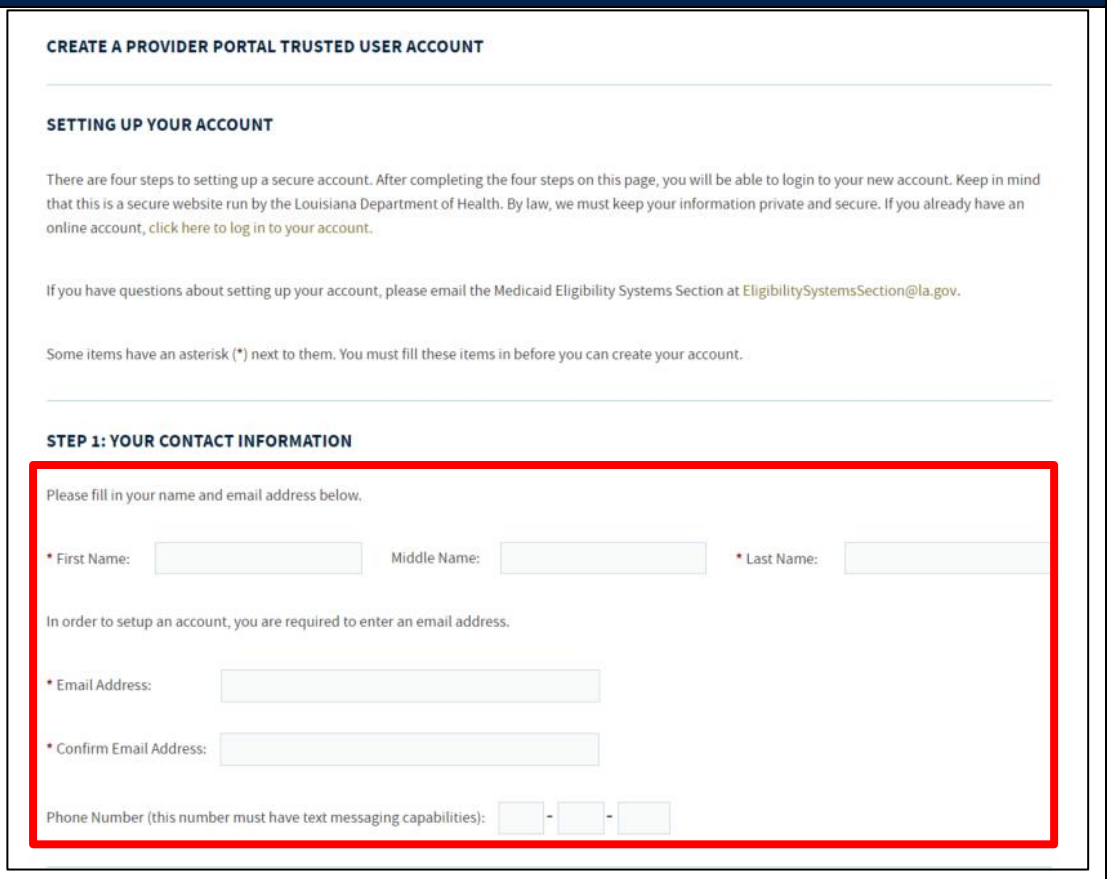
STEPS	INSTRUCTIONS
2.	 **Result:** The **Provider** tab displays. From the **Provider** tab, click the **Login & Enrollment** button.

STEPS	INSTRUCTIONS
3.	

Result: The **Provider Portal User Login & Registration** screen displays.

Click the **Click here to create your User Account** hyperlink in the **Create an Account** section.

STEPS	INSTRUCTIONS
4.	

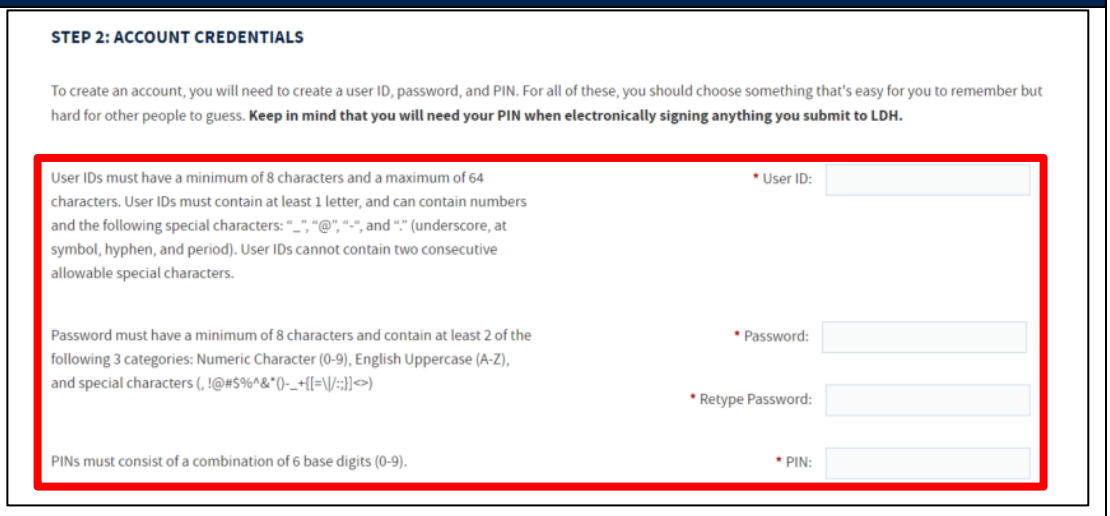
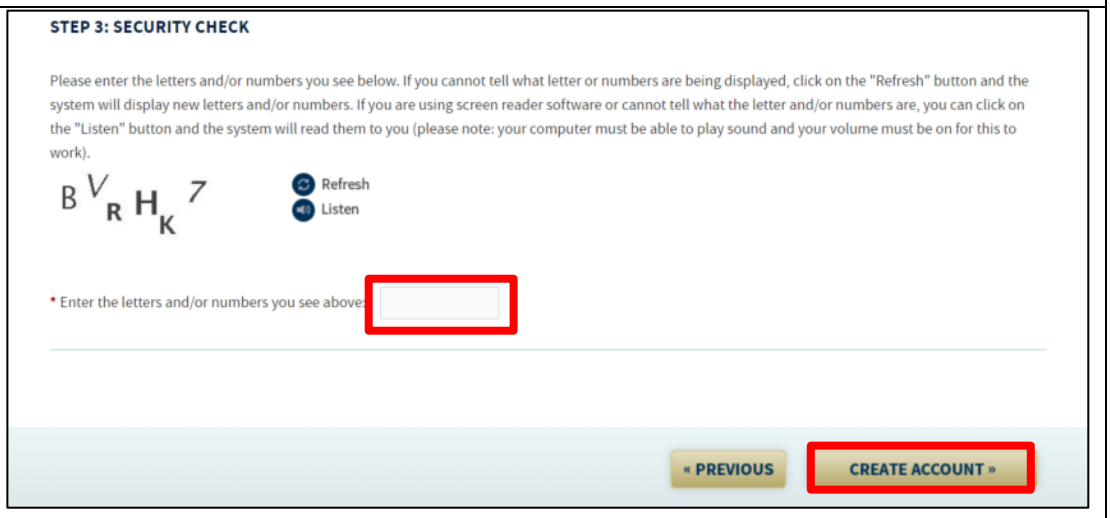
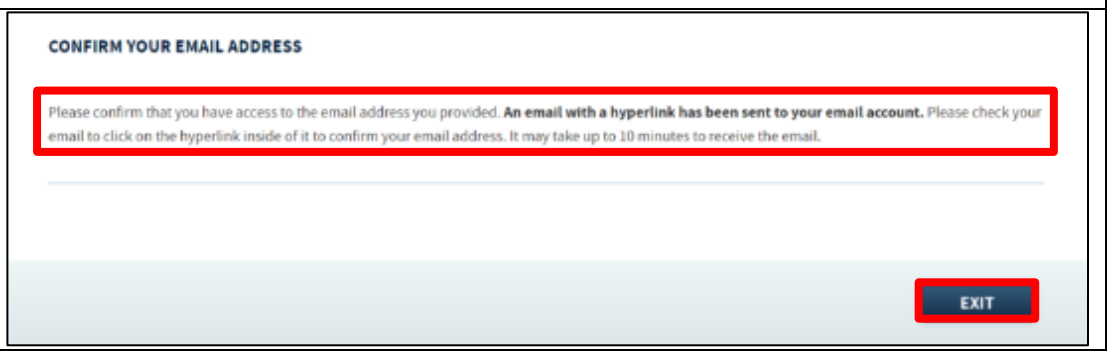


Result: The **Create A Provider Portal Trusted User Account** screen displays.

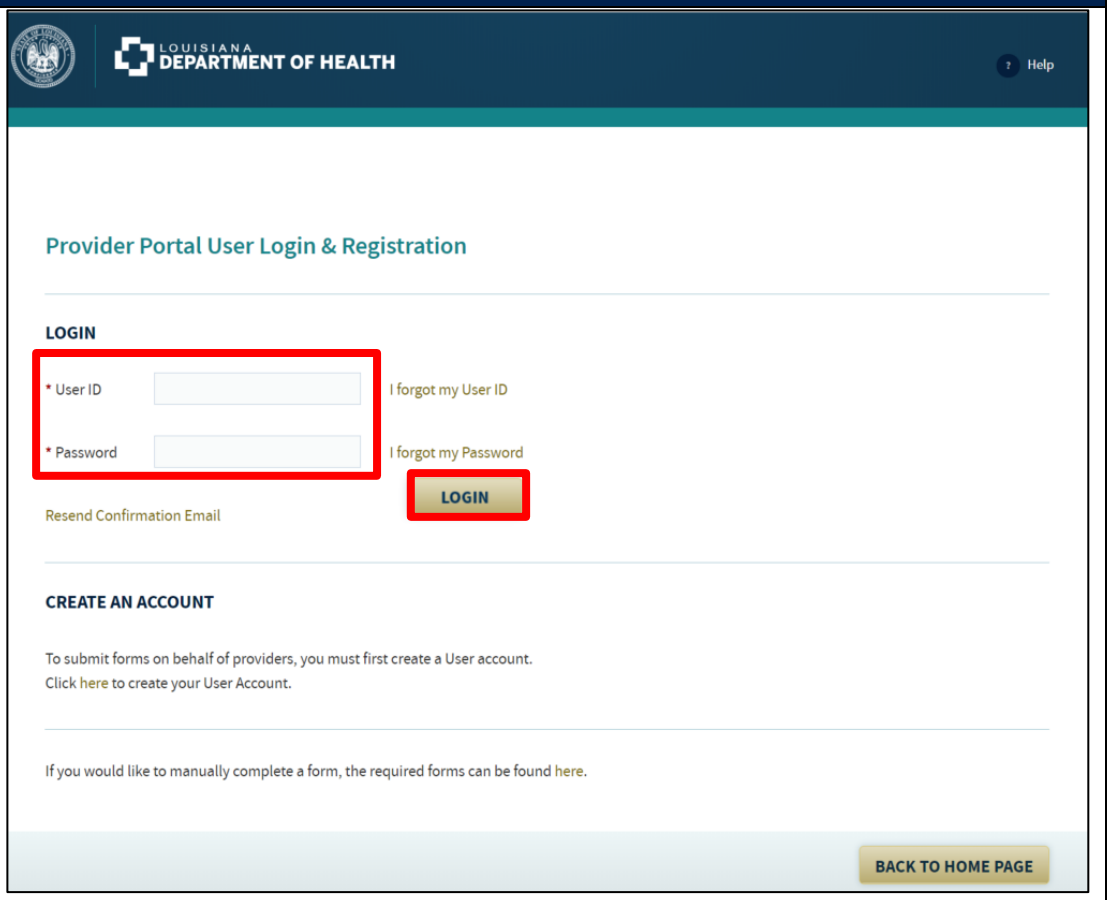
Note that the screen is lengthy and contains multiple sections. A summary of information displays in sections below. Any field marked with an asterisk (*) is required.

There are four steps to create a Trusted User account:

Section	Description
Step 1: Your Contact Information	Enter **First Name, Middle Name, Last Name**, **Email Address**, and **Phone Number**
Step 2: Account Credentials	Create a User ID, Password, and PIN
Step 3: Security Check	Enter the characters from the CAPTCHA image exactly as they display in the text field provided
Step 4: Confirm Your Email Address	Confirm the email address associated to the account by clicking the hyperlink in the confirmation email.

STEPS	INSTRUCTIONS
5.	 Create a **User ID, Password, and PIN** in the **Step 2: Account Credentials** section.
6.	 Enter the characters from the CAPTCHA image exactly as they display in the text field provided in the **Step 3: Security Check** section. Click the **Create Account** button.
7.	

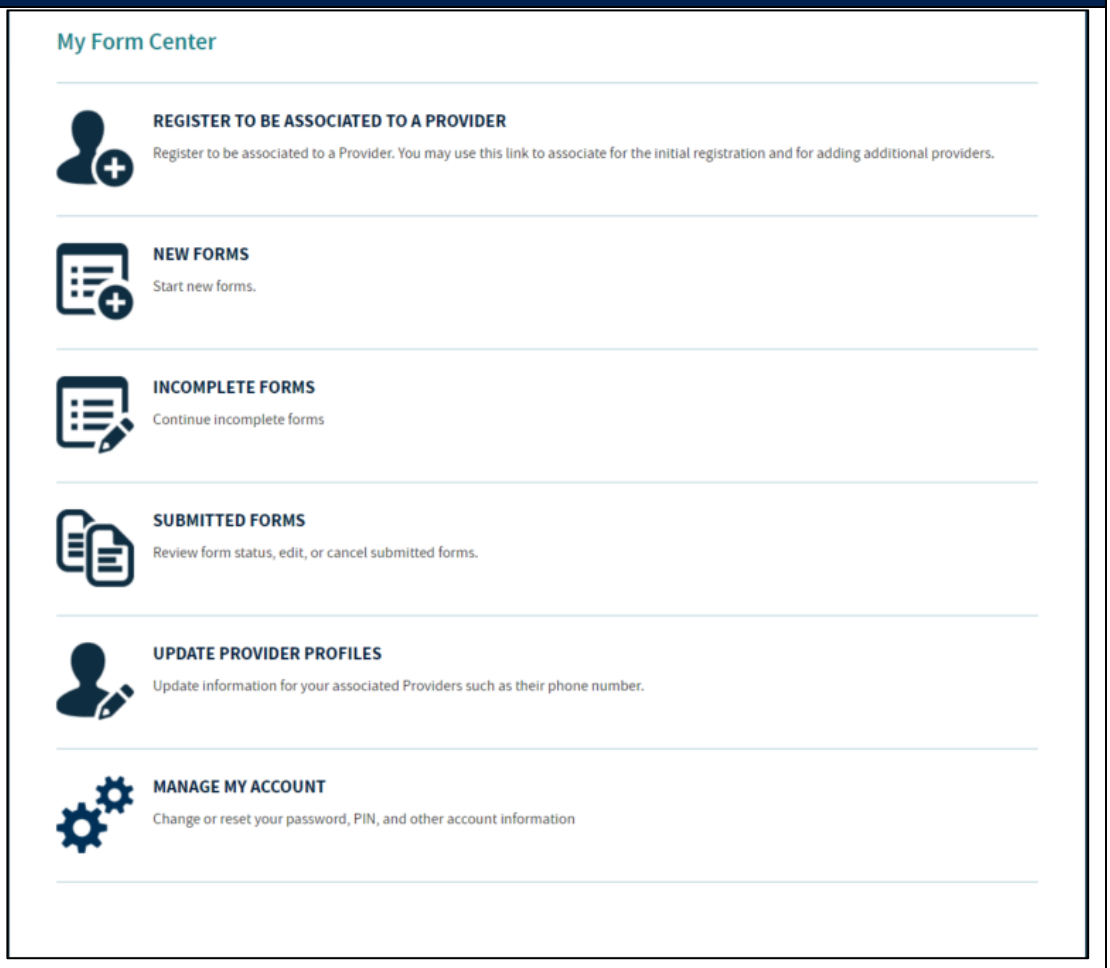
STEPS	INSTRUCTIONS
	Result: The **Confirm Your Email Address** screen displays. Click the **Exit** button after reviewing the text on the screen.
8.	 The user checks their email for a unique link to confirm their email address. The user clicks that link. **Result**: The **Account Update Successfully** screen displays**.** The user has created a trusted user account and can now log in to the Provider Portal. There is one final step. Users have to be associated to a provider, which is covered in Lesson 2. Click the **Next** button. **Process Tip!** For questions about setting up an account reach out to the Medicaid Eligibility Systems Section via email- medicaideligibilitysystemshelp@la.gov.

STEPS	INSTRUCTIONS
9.	

Result: The **Provider Portal User Login & Registration** screen displays.

Users enter their **User ID** and **Password** into the fields and click the **Login** button.

	Process Tip! Although users can log in to their accounts in SSP, they will not be able to submit forms for a provider until they receive a correspondence confirming their approval for that provider.

STEPS	INSTRUCTIONS
1.	

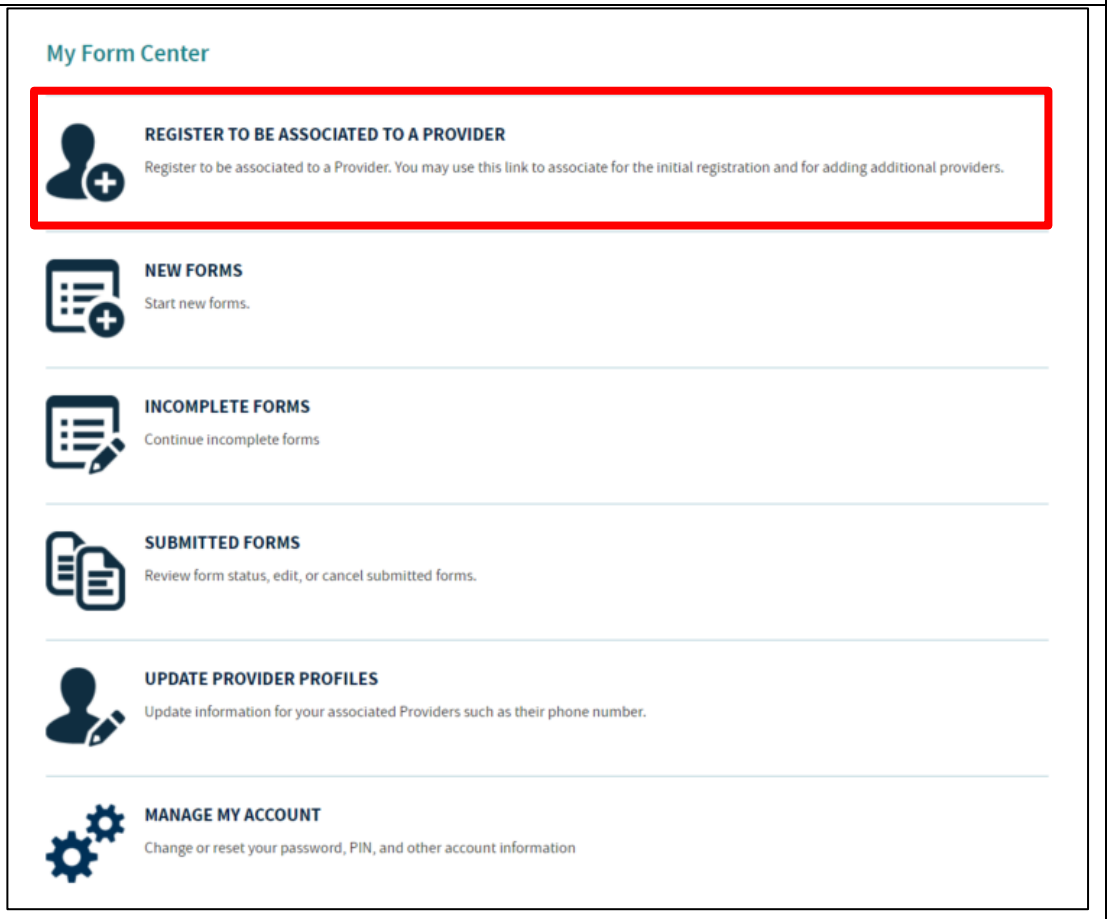
Result: The **My Form Center** screen displays.

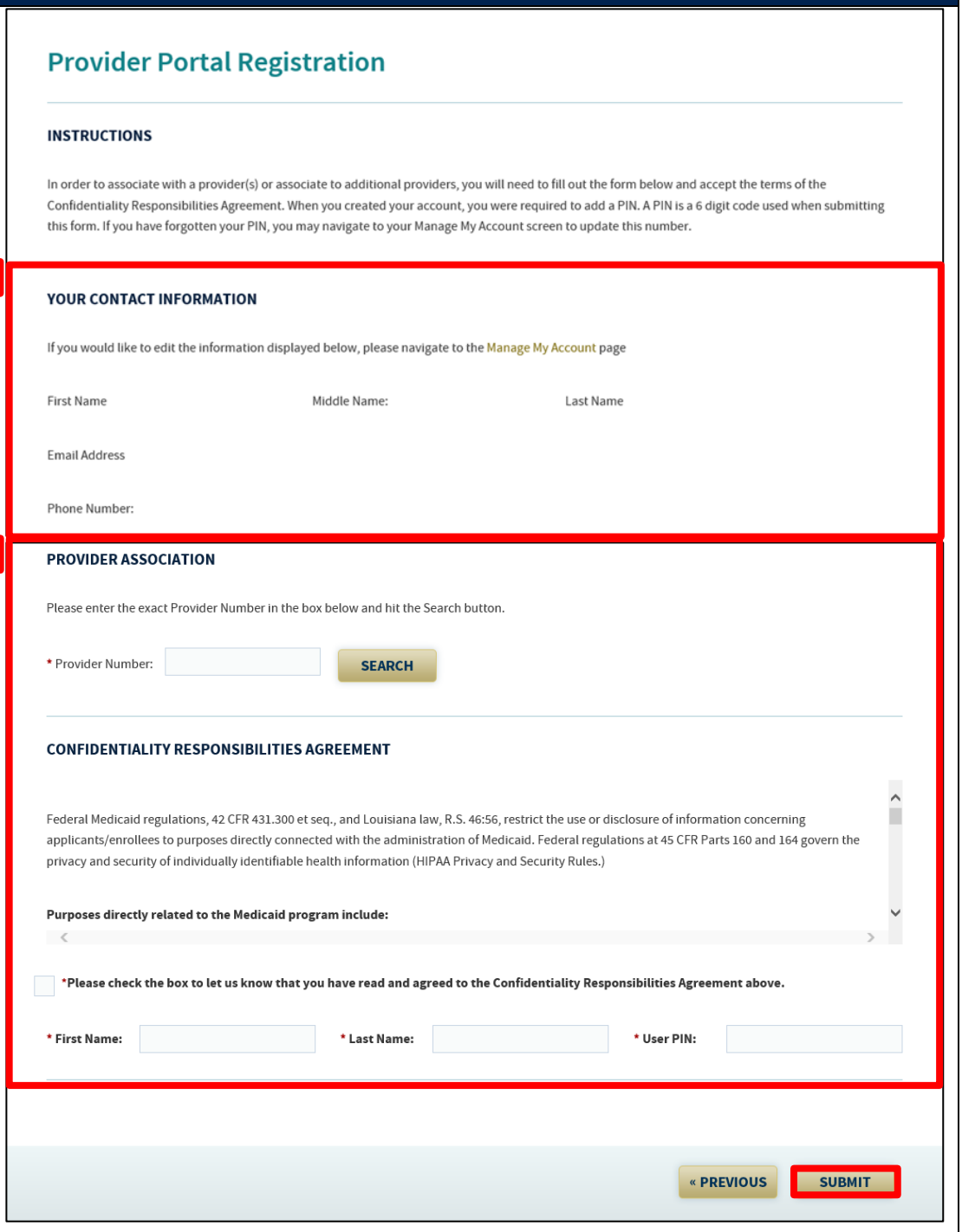
The first time a user accesses the Provider Portal as a representative, only the **Register to Be Associated to a Provider** and **Manage My Account** functions display.

	Process Tip! Until Trusted Users are associated to a provider, users only have the ability to register to be associated to a provider or make updates to personal information. In order to submit forms on behalf of a provider, Trusted Users **MUST** register to be associated to a provider. This is covered in Lesson 2.

Lesson 2: Submit Provider Association Request Form

This lesson explains how to submit a Provider Association Request form to be able to perform all of the functions in the Provider Portal.

STEPS	INSTRUCTIONS
1.	Follow steps 9-10 in *Lesson 1: Accessing the Self-Service Portal for Providers* to navigate to the **My Form Center** screen.
2.	 **Result:** The **My Form Center** screen displays. Click the **Register to be Associated to a Provider** hyperlink.

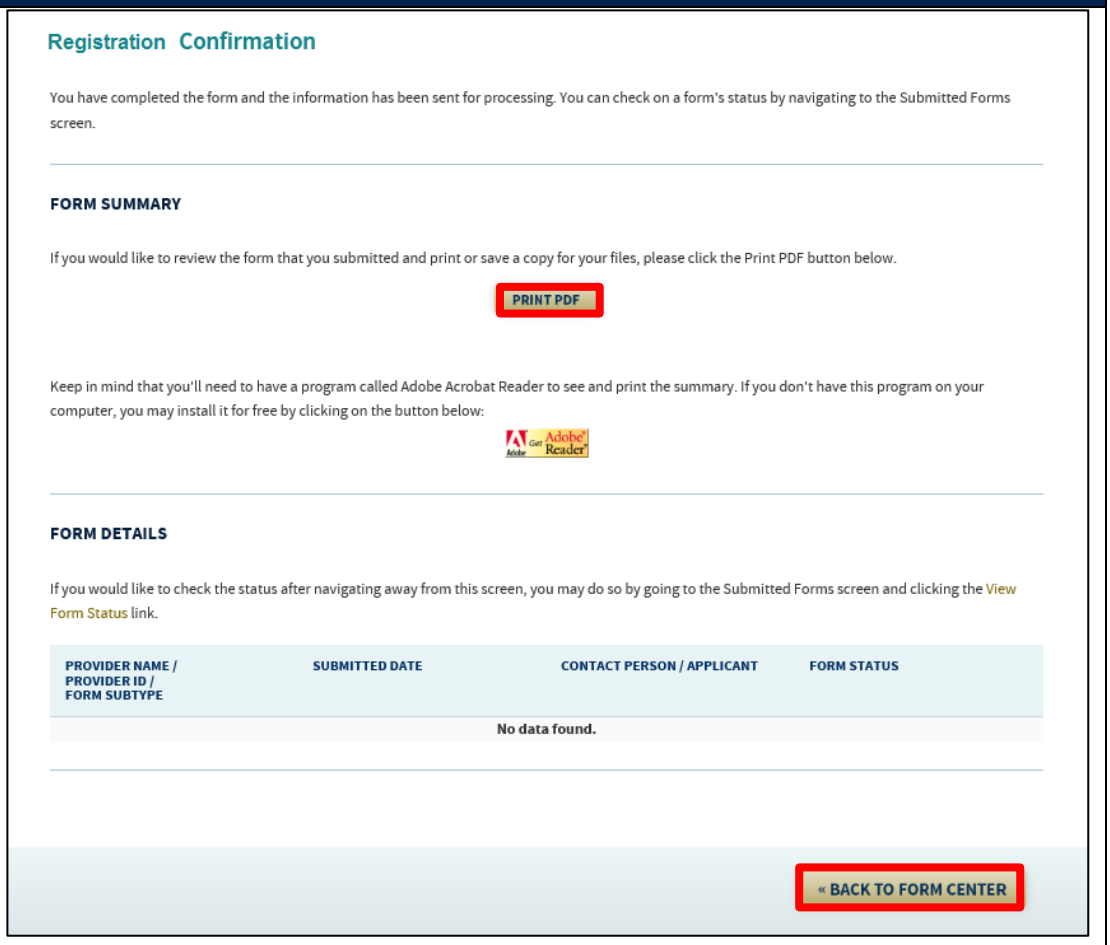
STEPS	INSTRUCTIONS
3.	

Result: The **Provider Portal Registration** screen displays.

STEPS	INSTRUCTIONS

Section	Description
1 **Your Contact Information**	The **Your Contact Information** section pre-populates the following information from the information entered when creating a Provider Portal account: • First Name • Middle Name • Last Name • Email Address • Phone Number
2 **Provider Association**	Enter the **Provider Number** that will be associated to the account, then click the **Search** button. **Note:** LaMEDS pre-populates the following information associated with the Provider Numer entered: • **Provider Name** • **Provider Address** • **Provider Type Code** After this information pre-populates, enter the following information for the provider: • **Manager's First Name** • **Manager's Last Name** • **Manager's Phone Number** To associate additional Providers, click the **Add** button. To remove a provider, click the **Delete** icon next to the **Search** button. Please note that association to at least one provider is required.
3 **Confidentiality Responsibilities Agreement**	Read the **Confidentiality Responsibilities Agreement** carefully and check the box next to the following statement: "**Please check the box to let us know that you have read and agreed to the Confidentiality Responsibilities Agreement above**". Sign the form by entering your **First Name**, **Last Name**, and **PIN** into the appropriate fields.

Click the **Submit** button to continue.

STEPS	INSTRUCTIONS
4.	

Result: The **Registration Confirmation** screen displays.

1. Review a PDF of the Registration Form by clicking the **Print PDF** button.
2. Click the **Back To Form Center** button to return to the Form Center.

After clicking the **Submit** button, the **Provider Association Request** form goes to Medicaid for processing. Once Medicaid has reviewed and processed the Provider Association Request, users receive an email informing them whether their request was approved or denied.

If users would like to request association to additional providers, navigate back to the **Provider Portal Registration** screen and repeat the same process outlined in this lesson.

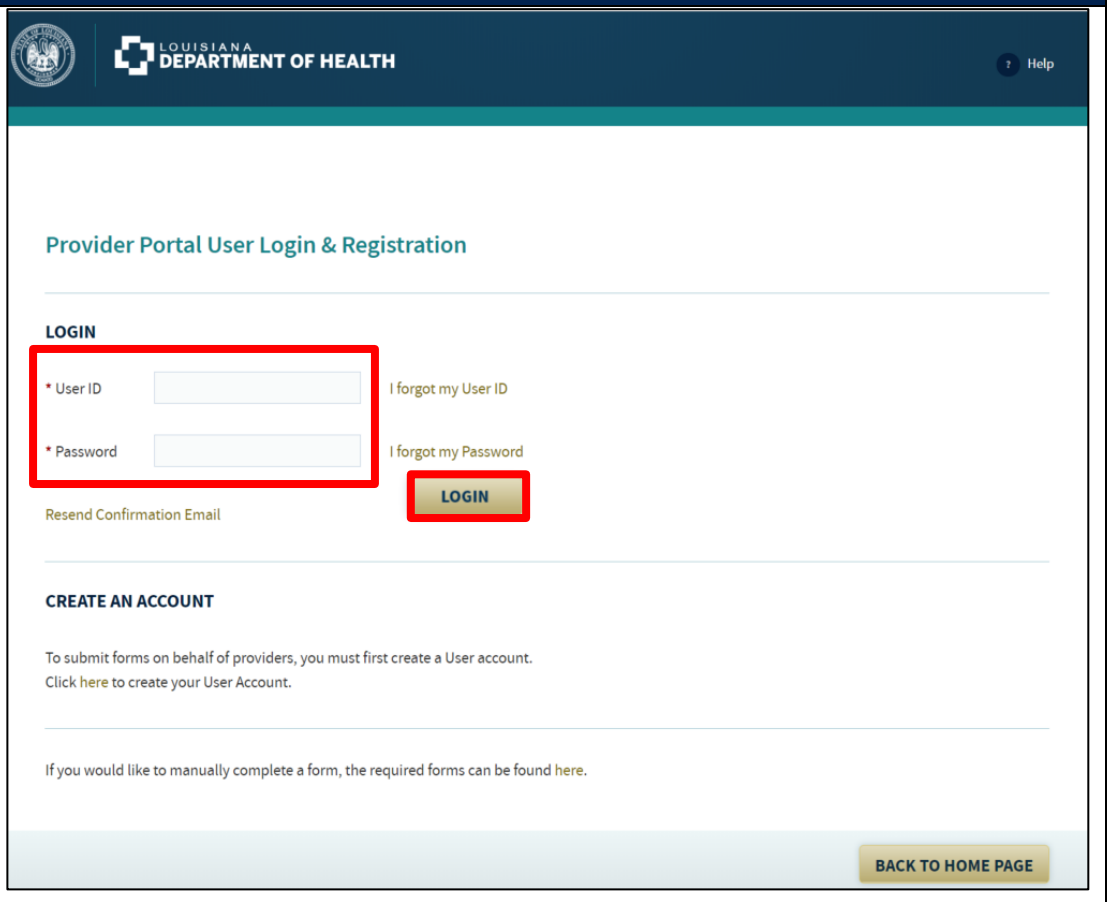
Lesson 3: Account Management

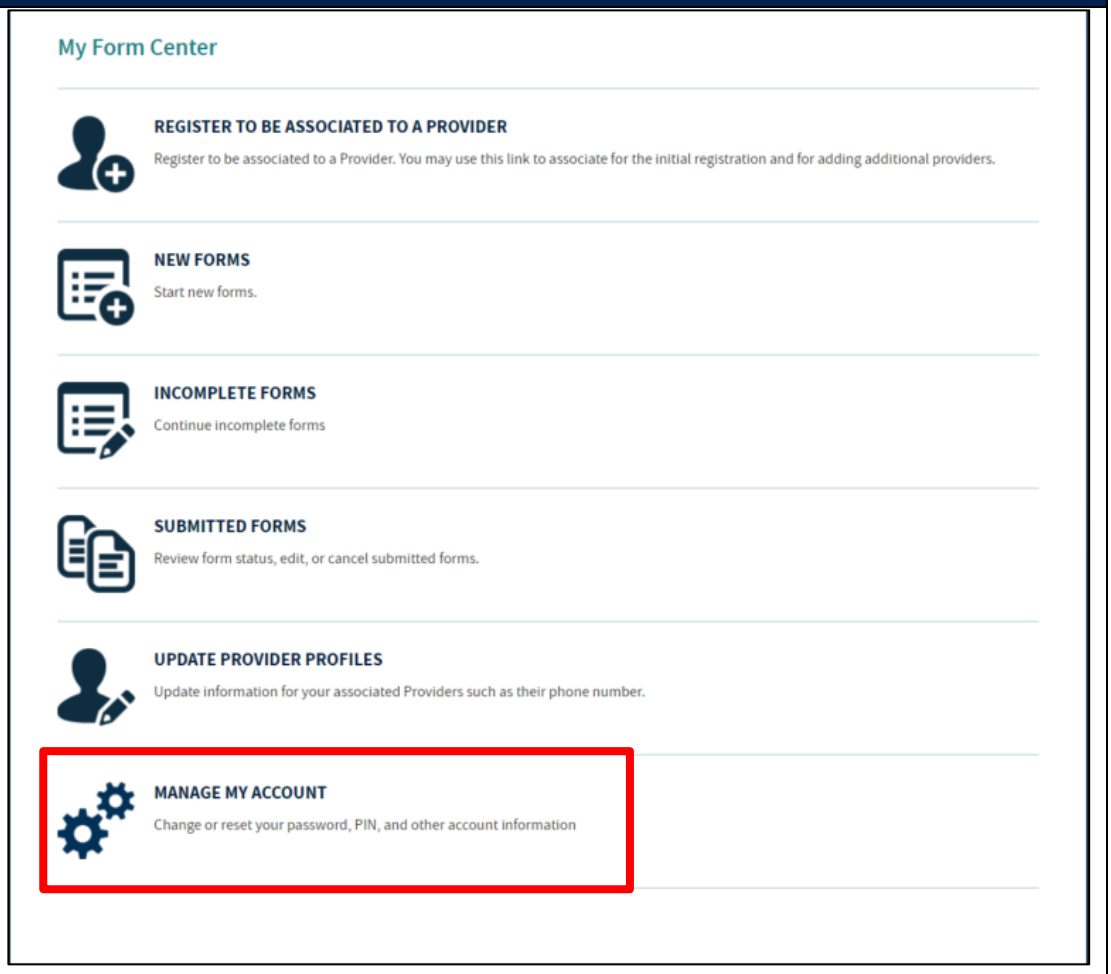
The first time users access the Provider Portal as a representative, they only have access to the **Register to Be Associated to a Provider** and **Manage My Account** functions. In addition to associating more providers to an account, users can manage their personal account information and the information for the existing providers on their account through two functions on the **My Form Center** screen:

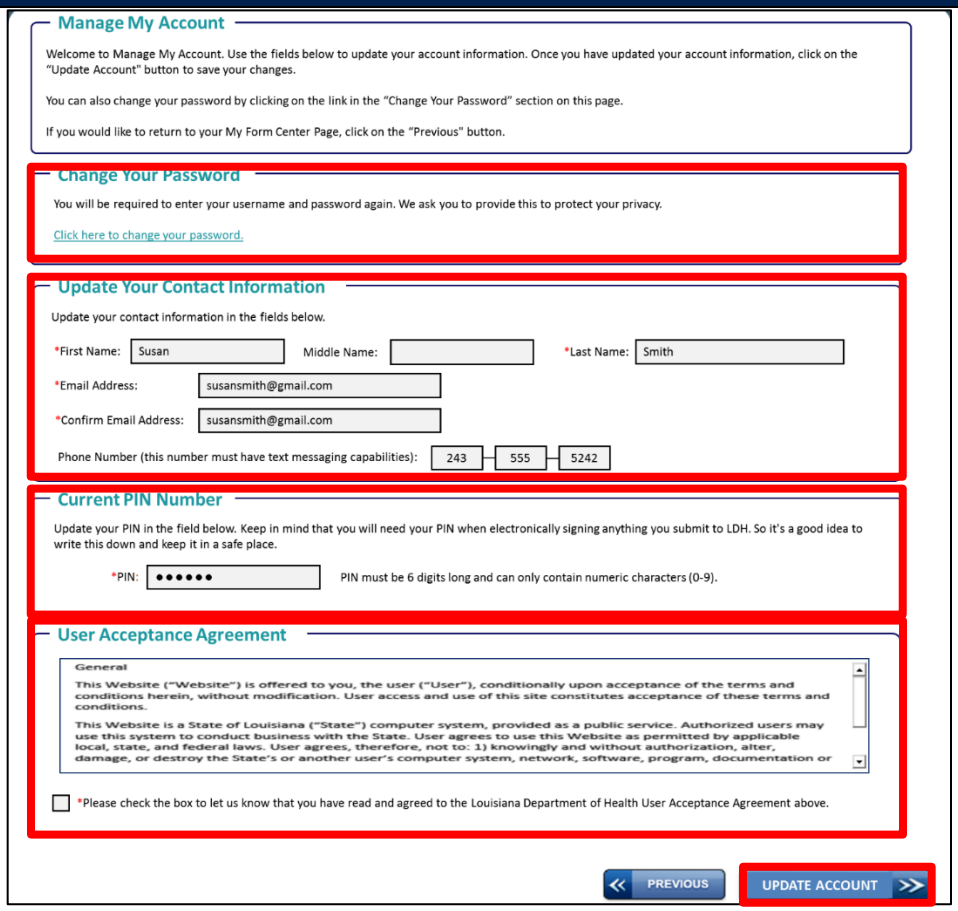
- **Manage My Account**: This allows users to update basic personal information such as name, address, email address, phone number, password, and PIN.
- **Update Provider Profiles**: This allows users to update or remove any provider-related information associated with their account.

This lesson explains how to update basic personal information such as a user's name, address, email address, phone number, password, and PIN. This lesson also explains users how to update or remove any provider-related information associated with their accounts.

Manage My Account

STEPS	INSTRUCTIONS
1.	 From the **Provider Portal User Login & Registration** screen, enter the **User ID** and **Password** associated to the account into the fields and click the **Login** button.

STEPS	INSTRUCTIONS
2.	 **Result:** The **My Form Center** screen displays. Click the **Manage My Account** hyperlink to continue.

STEPS	INSTRUCTIONS
3.	

Note to LDH: This is not a final screen shot.

Result: The **Manage My Account** screen displays.

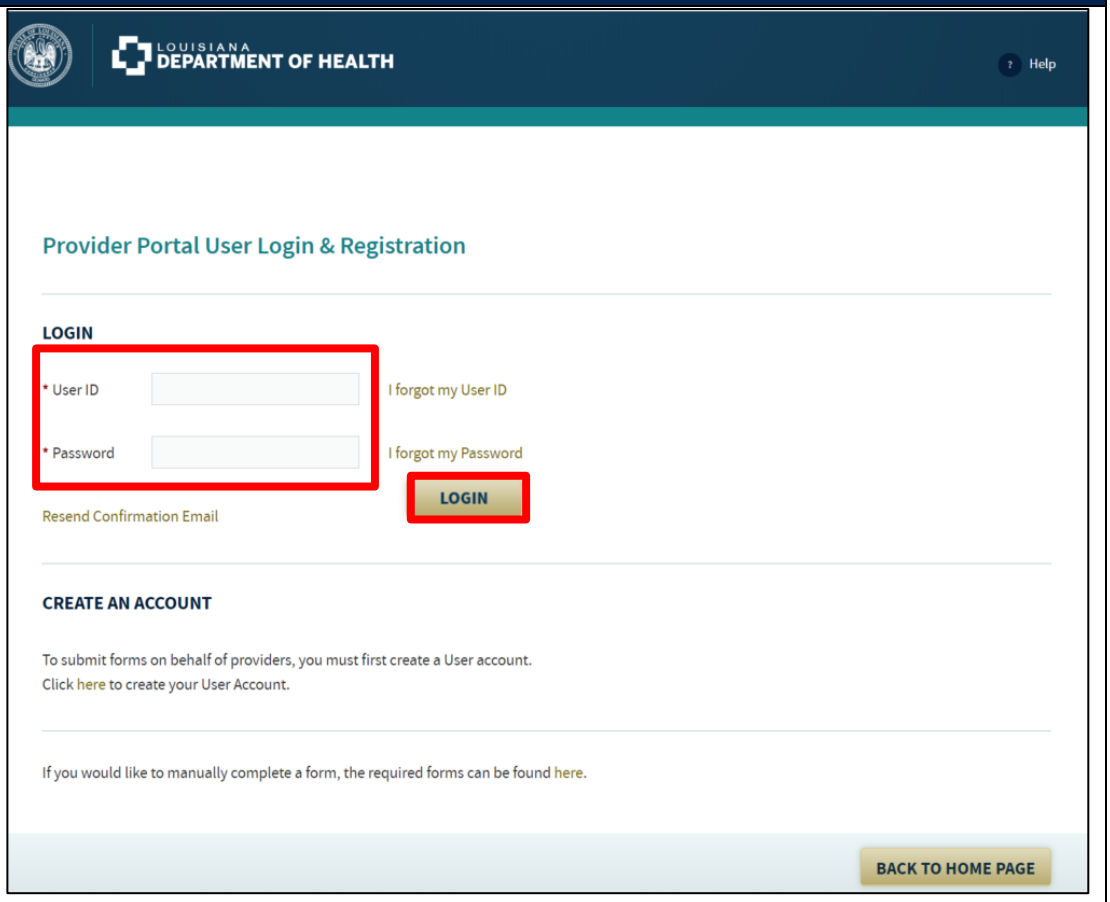
The **Manage My Account** screen has the following sections:

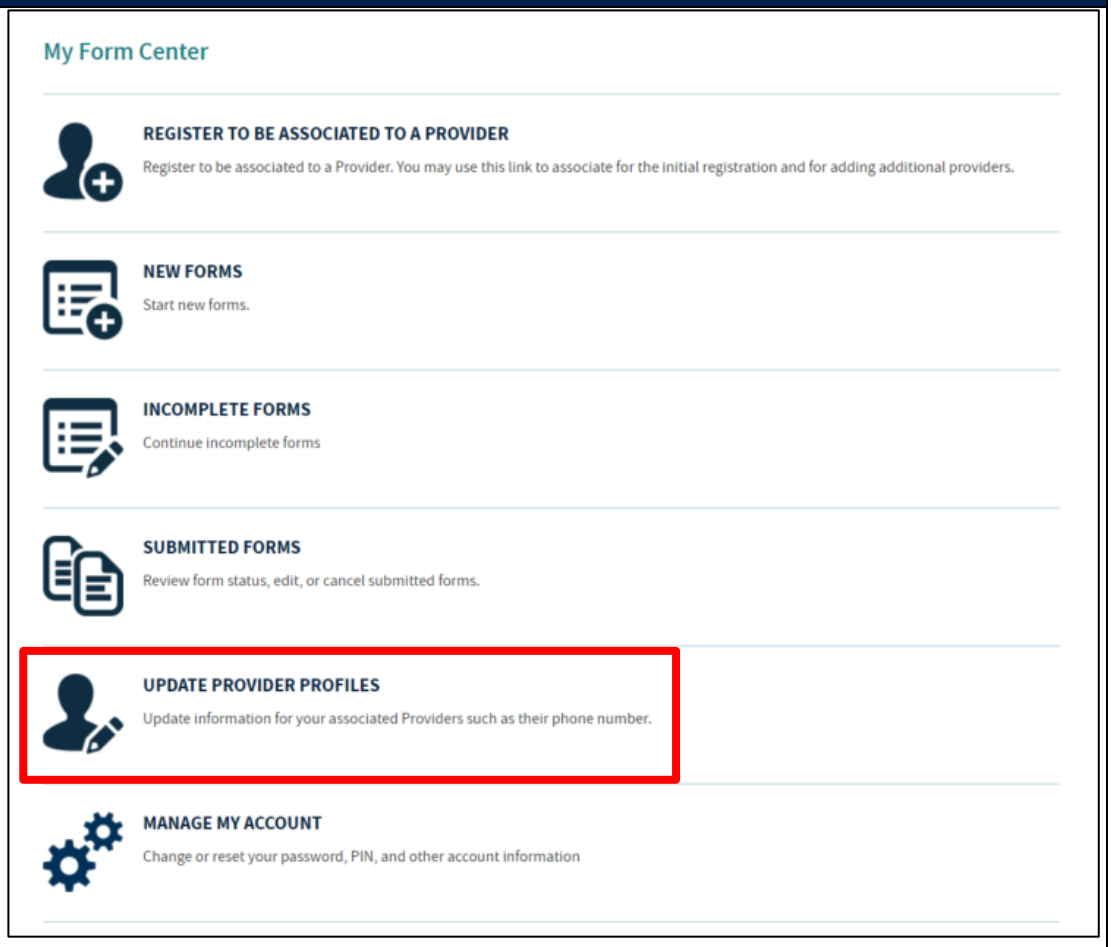
- **Change Your Password:** This section provides a link to change the password associated to the account.
- **Update Your Contact Information:** This section allows user to edit the following information:
  - First Name
  - Last Name
  - Email Address
  - Phone Number
- **Current PIN:** This section allows users to update the PIN associated to the account. The PIN is used to electronically sign forms submitted through the Provider Portal.
- **User Acceptance Agreement:** When making updates to a user's profile, read the User Acceptance Agreement carefully, and then click the checkbox to confirm agreement with the terms.

STEPS	INSTRUCTIONS
	Click the **Update Account** button to save any changes made to the information on this screen.

Update Provider Profiles

The **Update Provider Profiles** function allows users to update information for the providers associated to their account. Users can update information for providers by editing information previously entered, or can completely delete a provider associated to their account. This lesson demonstrates how to update information for a provider.

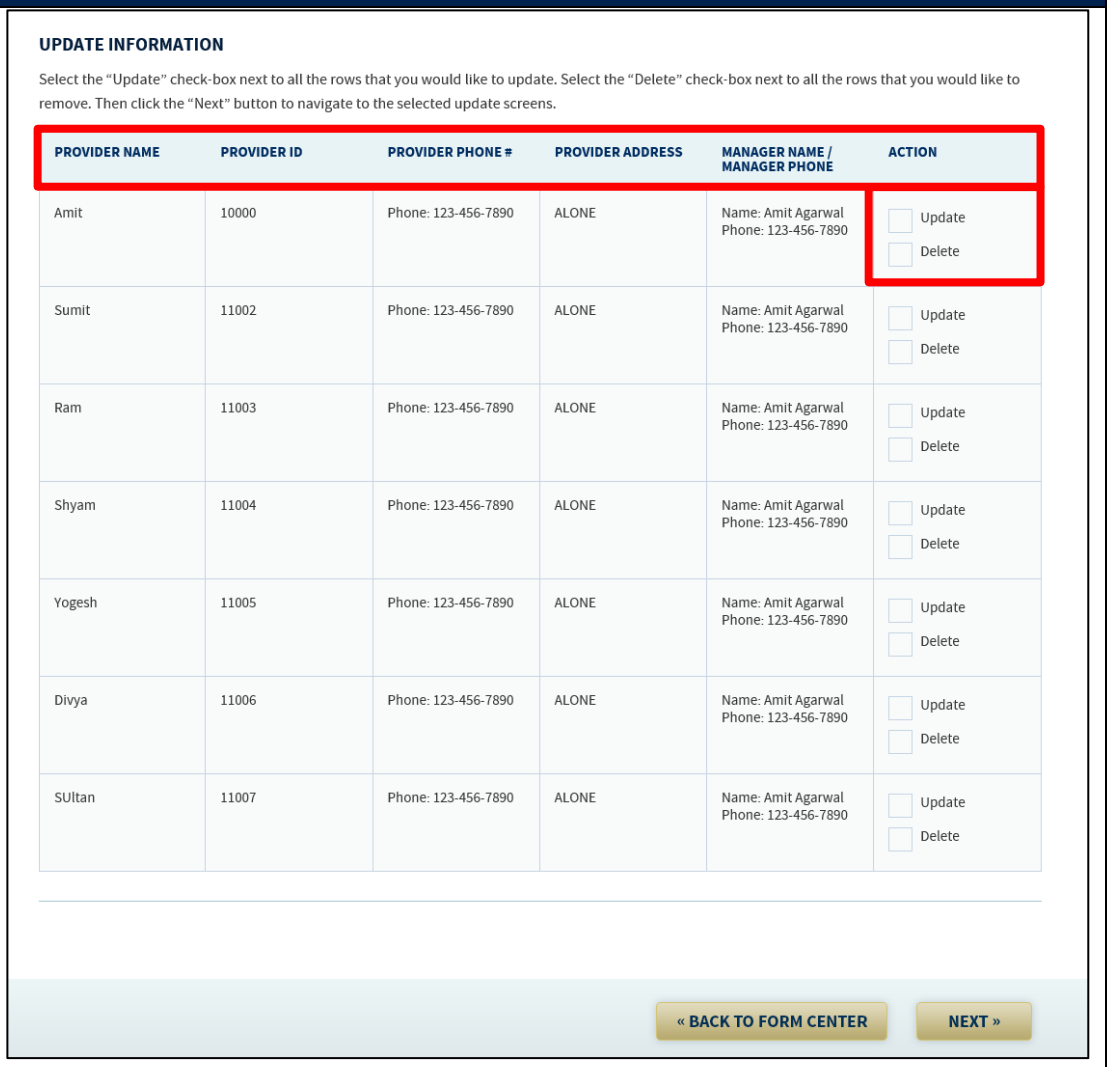
STEPS	INSTRUCTIONS
1.	 From the **Provider Portal User Login & Registration** screen, enter the **User ID** and **Password** associated to the account and click the **Login** button.

STEPS	INSTRUCTIONS
2.	

Result: The **My Form Center** screen displays.

Click the **Update Provider Profiles** hyperlink to continue.

STEPS	INSTRUCTIONS
3.	



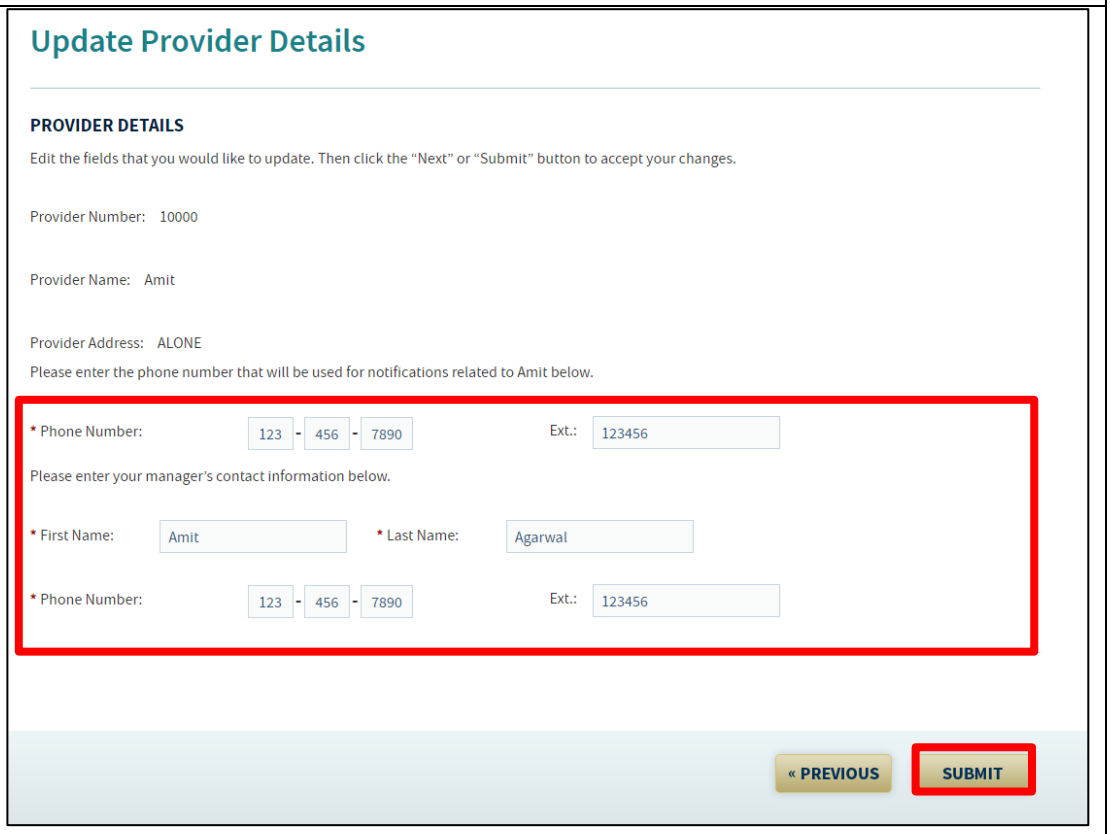
Result: The **Update Information** screen displays.

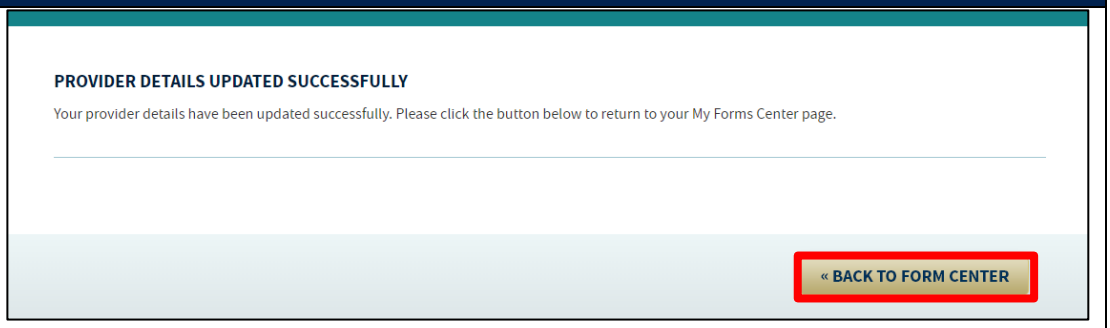
The **Update Information** Summary Table displays the following data for each of the providers to which a user is associated:

- Provider Name
- Provider ID
- Provider Phone Number
- Provider Address
- Manager Name / Manager Phone

In the **Action column**, users select the **Update** or **Delete** checkbox depending on which action they would like to perform for that particular provider.

Selecting the **Delete** checkbox on the **Update Information** screen eliminates the association to the Provider.

STEPS	INSTRUCTIONS
	Multiple providers can be selected at one time.
4.	 **Result:** The **Provider Details** screen displays. The information at the top of the **Provider Details** screen pertains to the provider as an institution, or to the facility itself. This information is read-only and cannot be directly edited. The information for a manager *can* be updated. The information pre-populates with information in the system. Update the phone number associated to the provider. The following information can also be updated for Managers: • Manager's First Name • Manager's Last Name • Manager's Phone Number If multiple providers were selected on the **Update Information** screen, click the **Next** button to update the information for the next provider selected. After reaching the last provider selected, the **Submit** button displays. Click the **Submit** button to save the updates made to the provider information.

STEPS	INSTRUCTIONS
5.	 **Result:** The **Provider Details Updated Successfully** screen displays. Click the **Back to Form Center** button to return to the **My Forms Center** screen.

Lesson 4: Submitting a New Form

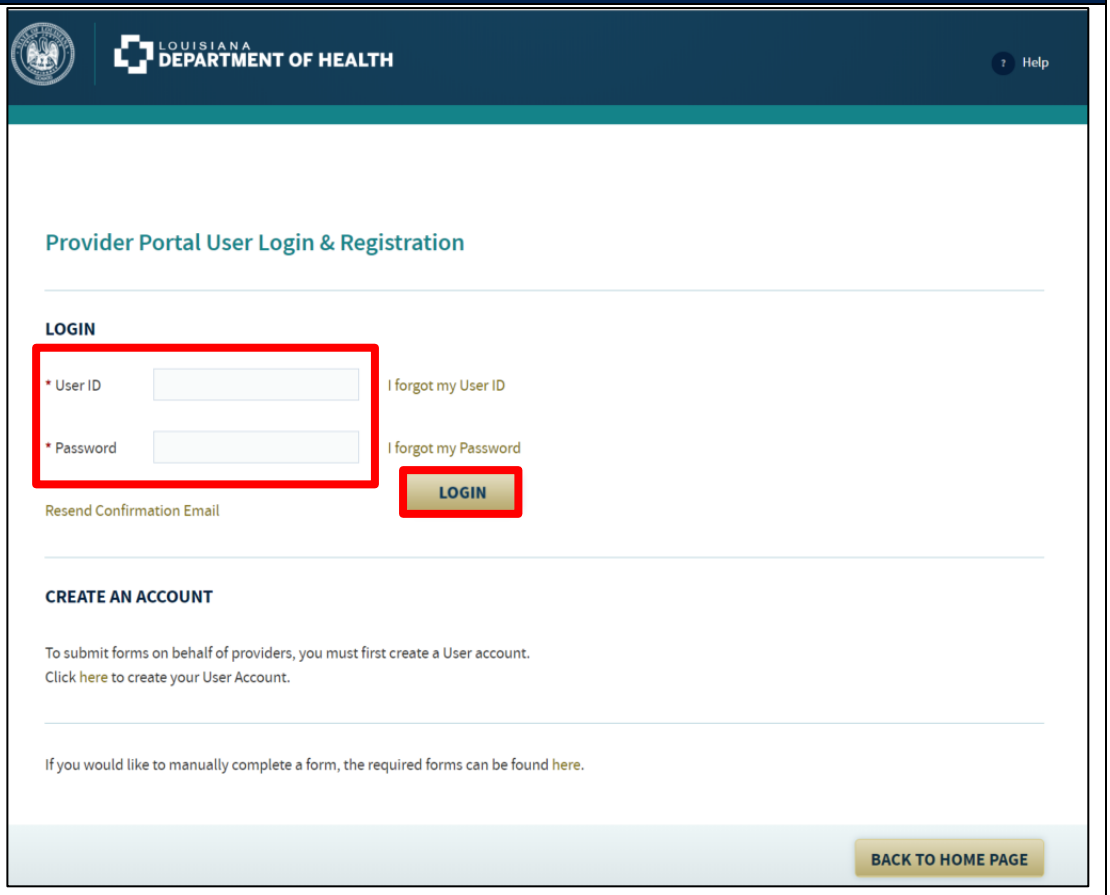
The New Forms screen is where users perform the majority of their work in the Provider Portal. This screen is where Providers submit forms on behalf of applicants, enrollees, or newborns. The New Forms screen has four sections:

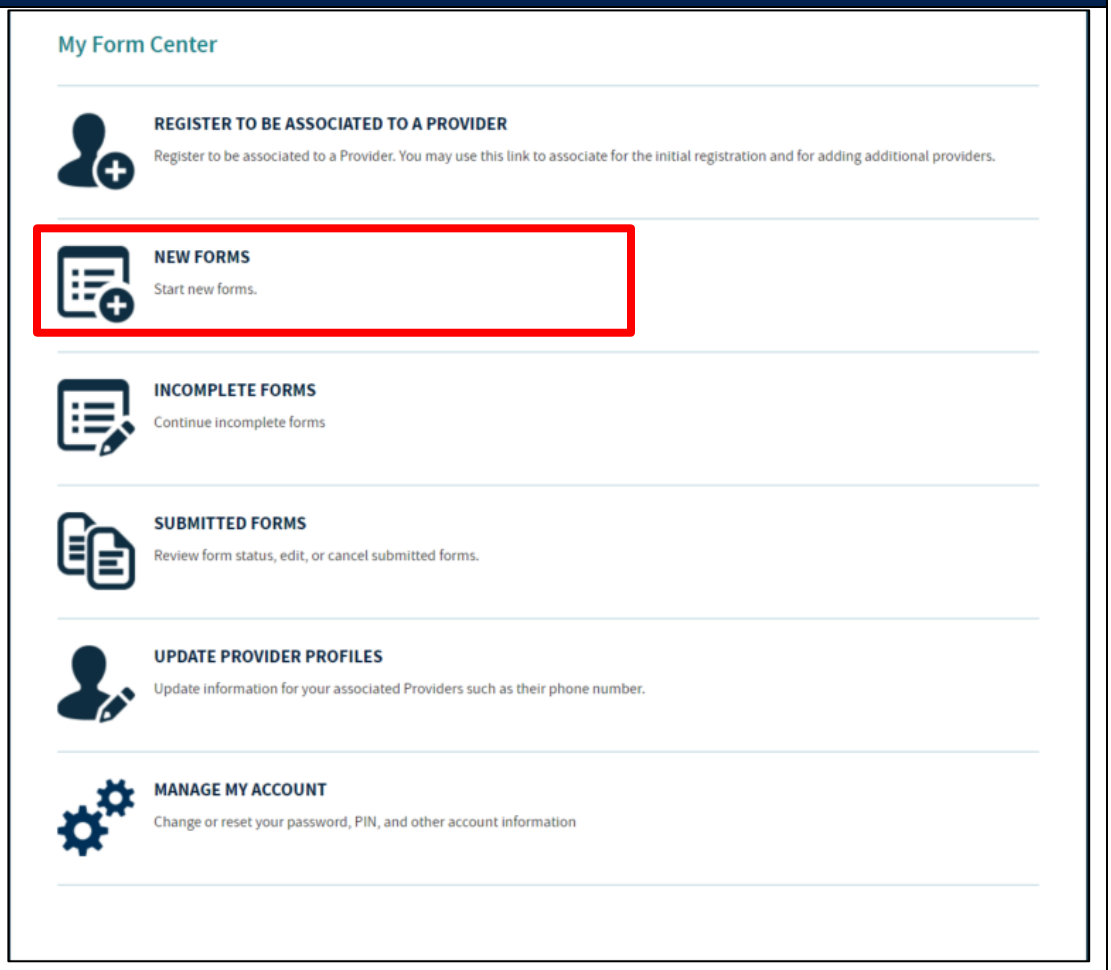
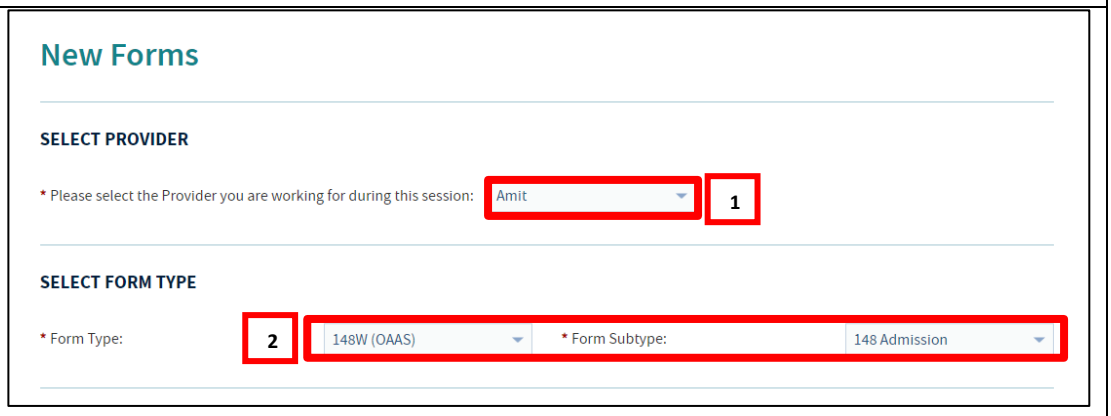
- **Select Provider**
- **Select Form Type**
- **Participant Search**
- **Search Results**

This lesson explains how to submit new forms on behalf of providers. In this lesson we use Form – 148 Admission as an example. For information on how to submit other provider forms, please reference the Appendix. Users can submit the following forms:

- 148W – Linkage
- 148W – Notice of Death
- 148W – Status Change
- 148W – Discharge
- 148W – Withdrawal
- 148 – Admission
- 148 – Transfer
- 148 – Discharge
- 148 – Notice of Death
- 148 – Status Change
- Demographic Change

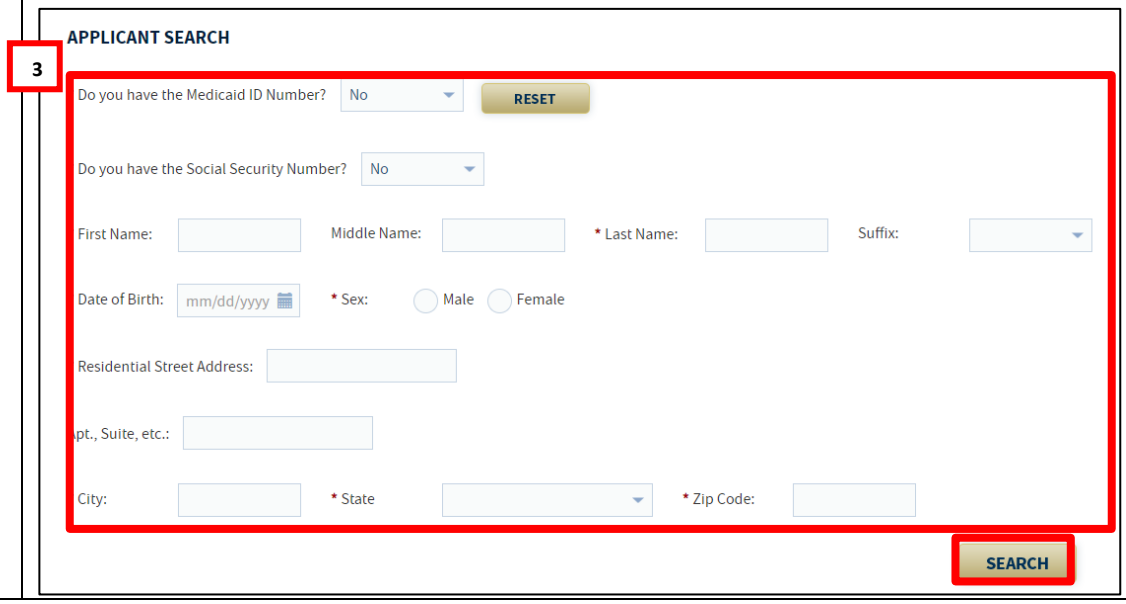
Submitting New Forms

STEPS	INSTRUCTIONS
1.	 From the **Provider Portal User Login & Registration** screen, enter the **User ID** and **Password** associated to the provider account into the fields and click the **Login** button.

STEPS	INSTRUCTIONS
2.	 **Result:** The **My Form Center** screen displays. Select the **New Forms** hyperlink.
3.	 **Result:** The **New Forms** screen displays.

STEPS	INSTRUCTIONS

Section	Description
1 **Select Provider**	Select the provider for whom you are submitting a form. The **Select Provider** drop-down is the only field that displays when the screen first loads. This drop-down lists all approved providers associated to a user's profile. After selecting a provider, the subsequent fields display.
2 **Select Form Type**	Select the desired provider form from the **Form Type** & **Form Subtype** drop-downs. The **Form Type** and **Form Subtype** drop-downs list the provider forms users are permitted to submit based on the type of provider they represent. In the example on the screen, Form 148 Admission was selected.



STEPS	INSTRUCTIONS	
	Section	**Description**
4	**3** **Applicant Search**	The Applicant Search section allows users to select the individual for whom the provider form will be submitted. This section helps representatives determine if an individual already exists in LaMEDS. There are two key questions in the Applicant Search section: *Do you have the Medicaid ID Number?* and *Do you have the Social Security Number?* A few scenarios can occur depending on the answer to these two questions. 1. The first scenario occurs when users know the Medicaid ID Number and the individual displays in the Search Results table with a 100% match. 2. The second scenario occurs when users **do not** have the Medicaid ID number, but do have the Social Security Number. In this scenario, enter as much information as possible for the individual: • First Name • Last Name • Date of Birth • Sex Click the **Search** button to view the Search Results Table. Once the search results for the individual display, click the **Select** checkbox in the **Action** column to select the correct result. 3. The third scenario is when users **do not** have the Medicaid ID number and **do not** have the Social Security Number. In this case, enter all other known information for the individual: • Residential Street Address • City • State • Zip Code Select the **Search** button to view the Search Results Table. Once the search results for the individual display, click the **Select checkbox** in the **Action** column for the correct individual.

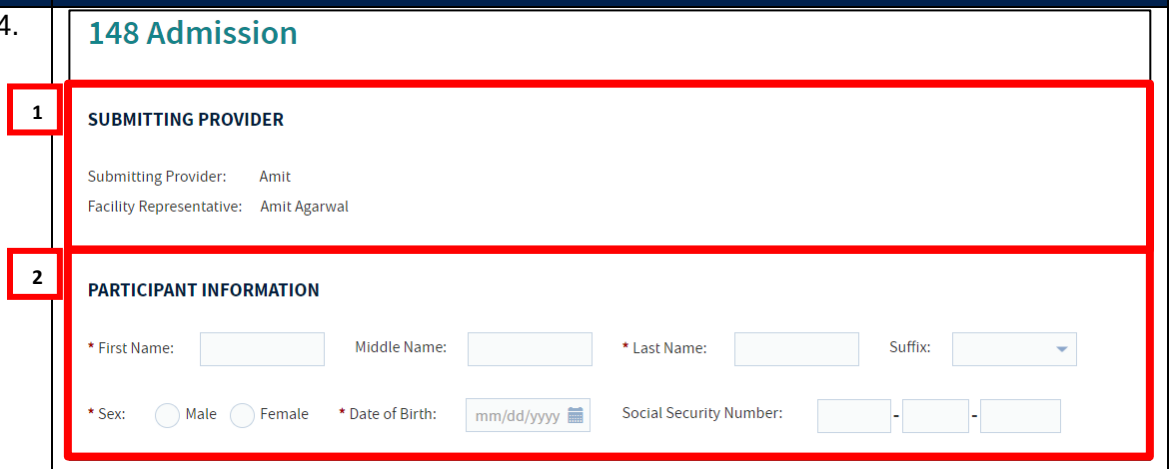
	Process Tip! When users fill out the search parameters on the **New Form** screen, if SSN is not available, they should not enter 999-999-9999. Instead, it is to be left blank. In such a case, street name and zip code become mandatory.

STEPS	INSTRUCTIONS

Section	Description
4 **Search Results**	The Search Results table returns the results from the information entered or selected in the previous three sections. This table highlights the individual's: • Percentage Match • Full Name • Date of Birth • Sex • SSN • Residential Address ○ **Note:** If searches do not result in a match for the individual and users wish to establish a new person, select the **New Person** checkbox in the **Action** column.

Click the **Next** button to proceed to the first screen of the form selected from the **Form Type** drop-down.

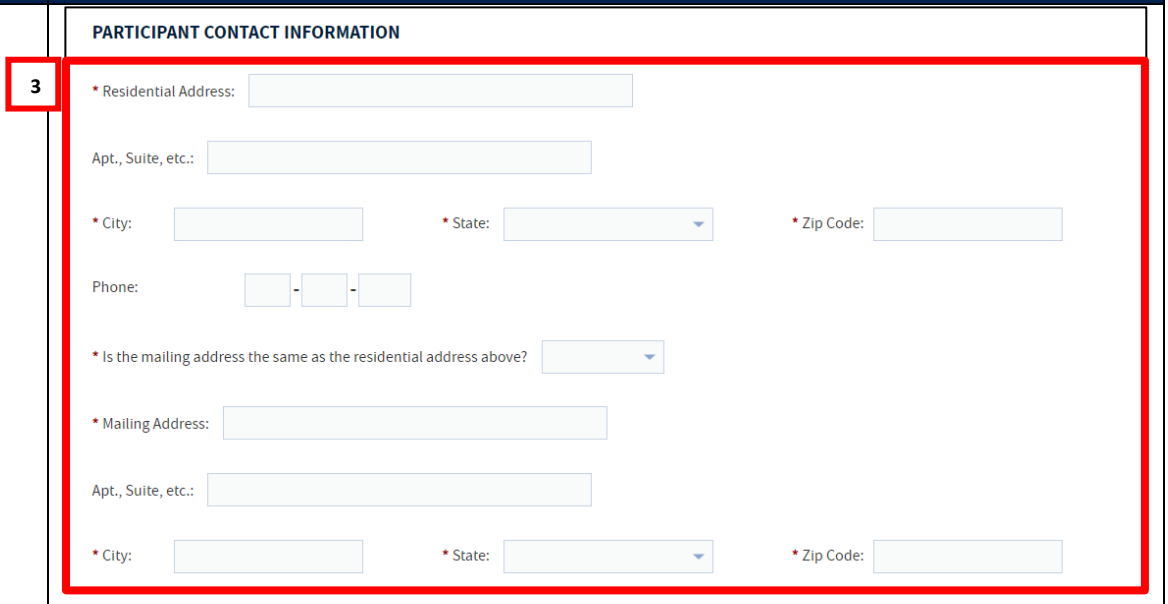
STEPS	INSTRUCTIONS
4.	



Result: The **148 Admission** screen displays.

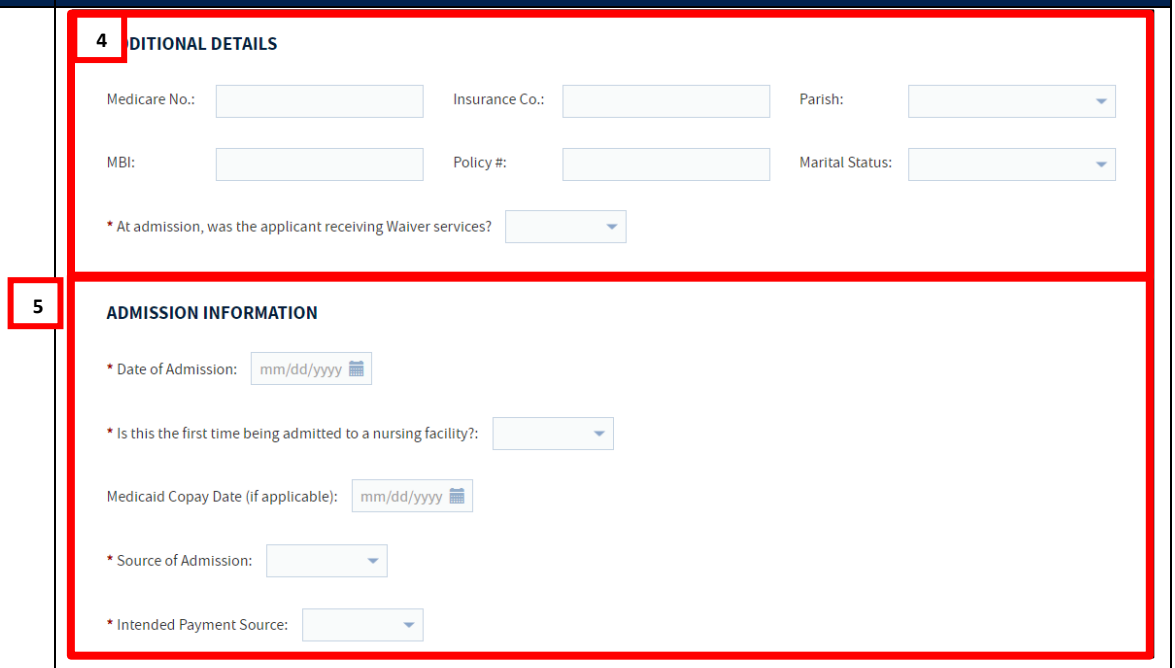
Section	Description
1 **Submitting Provider**	Displays the Provider for whom the form is submitted. The Submitting Provider and Facility Representative fields pre-populate with the information selected on the **New Forms** screen.
2 **Participant Information**	Displays the individual for whom the form is being submitted. If users are able to locate the individual on the **New Forms** screen either by entering his or her Medicaid ID Number or Social Security Number, known fields pre-populate. • First Name • Middle Name • Last Name • Suffix • Sex • Male/Female • Date of Birth • Social Security Number If users need to update any of the information in the **Participant Information** section, select *Yes* from the **Do you need to make an update to the personal information below?** drop-down.

STEPS	INSTRUCTIONS



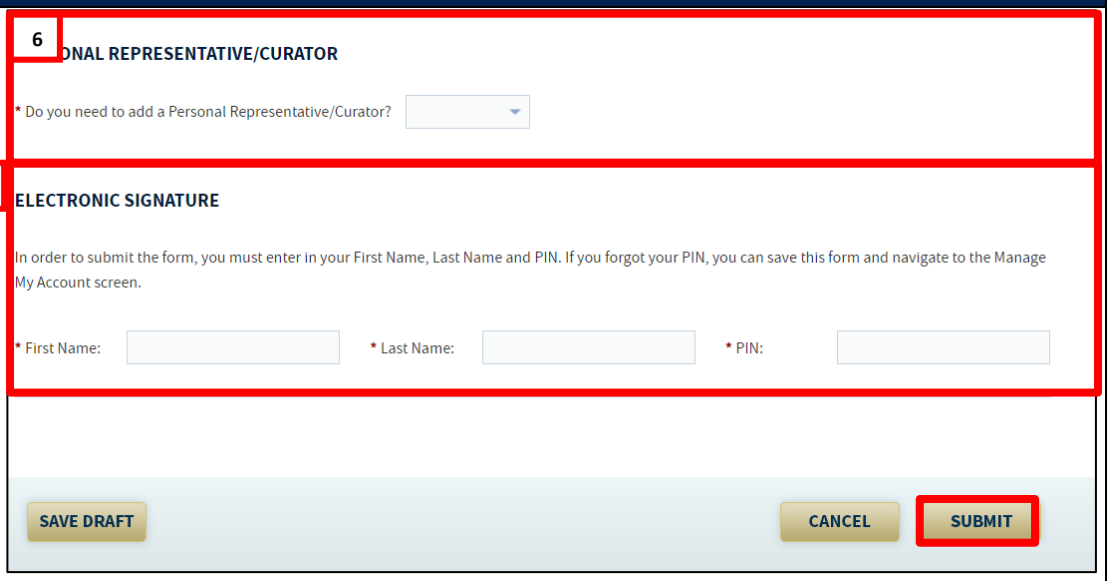
Section	Description
3 **Participant Contact Information**	Similar to the **Participant Information** section, all fields in the **Participant Contact Information** section pre-populate with the individual's information if users were able to locate the individual on the **New Forms** screen. If users need to update any of the contact information that pre-populates for the individual, select *Yes* from the **Do you need to make an update to the address(es) and/or phone number below?** drop-down. If users selected the **New Person** checkbox on the **New Forms** screen, enter the following information for the individual: • Residential Address • Apt., Suite, Etc. • City • State • Zip Code • Phone • *Is the mailing address the same as the residential address above*: User selects *Yes* to this question, the mailing address section pre-populates with the residential address information.

STEPS	INSTRUCTIONS

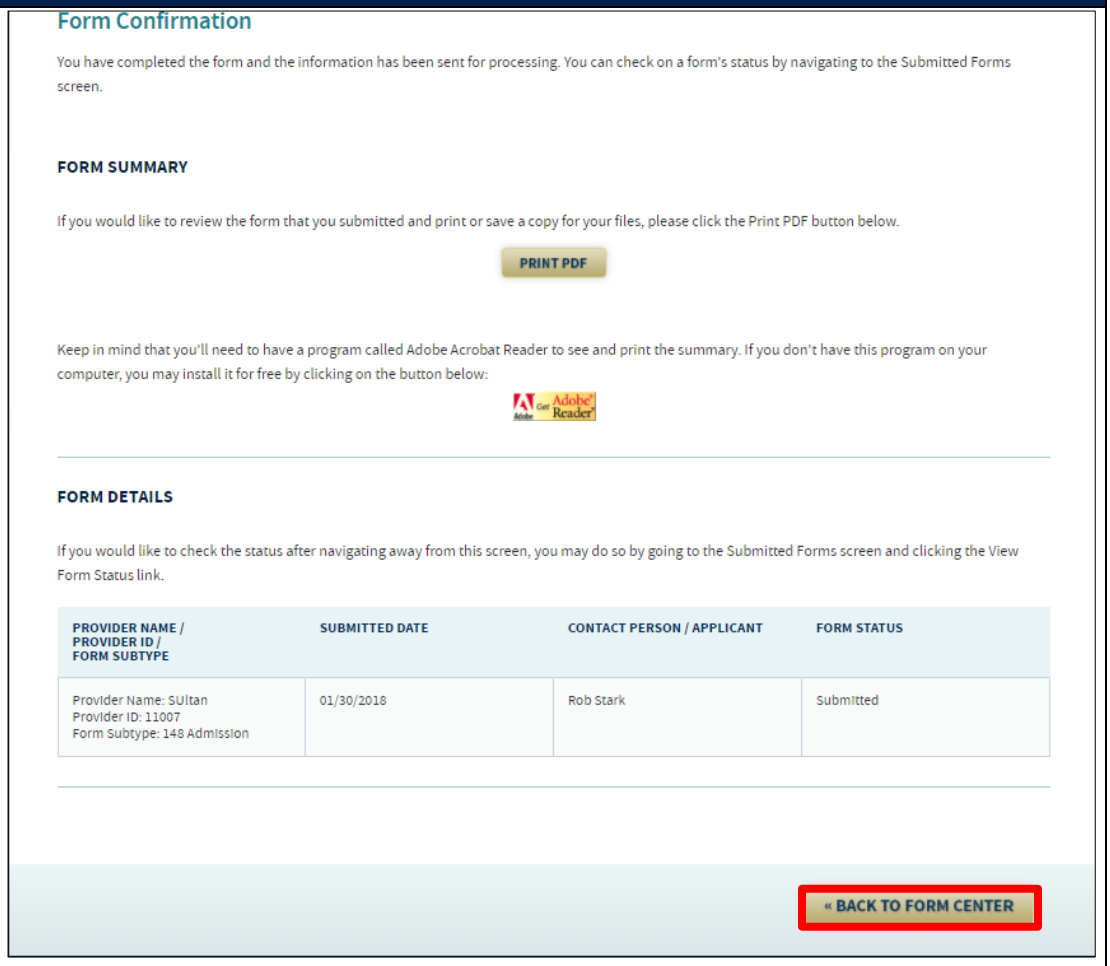


Section	Description
4 **Additional Details**	Enter the following information for the individual: • Medicare No. • Insurance Co. • Parish • Medicare Beneficiary Identifier (MBI) • Policy # • Marital Status • At admission, was the applicant receiving Waiver services?
5 **Admission Information**	Enter the following admission information for the individual: • Date of Admission • Select *Yes* or *No* from the **Is this the first time being admitted to a nursing facility?** drop-down • Medicaid Copay Date (if applicable) • Select the appropriate source from the **Source of Admission** drop-down. • Select the **Intended Payment Source** from the drop-down.

STEPS	INSTRUCTIONS



Section	Description
6 **Personal Representative/Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down.
7 **Electronic Signature**	Enter the following information for the provider representative to electronically sign the form: • First Name • Last Name • PIN Click the **Submit** button. **Note:** If the PIN information is forgotten, save the information on the screen by clicking the **Save Draft** button and navigate to the **Manage My Account** screen to identify the PIN.

STEPS	INSTRUCTIONS
5.	

Result: The **Form Confirmation** screen displays.

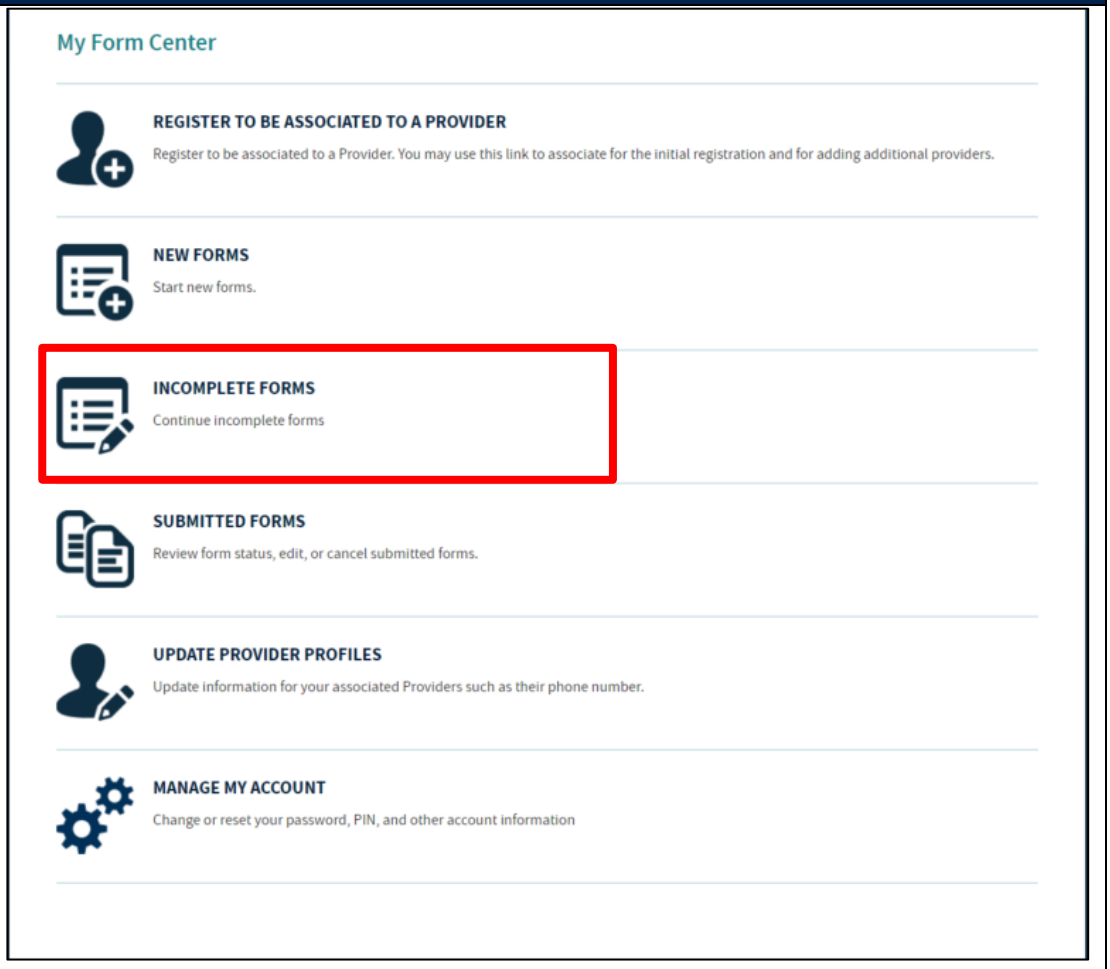
Click the **Back to Form Center** button to navigate back to the **My Form Center** screen.

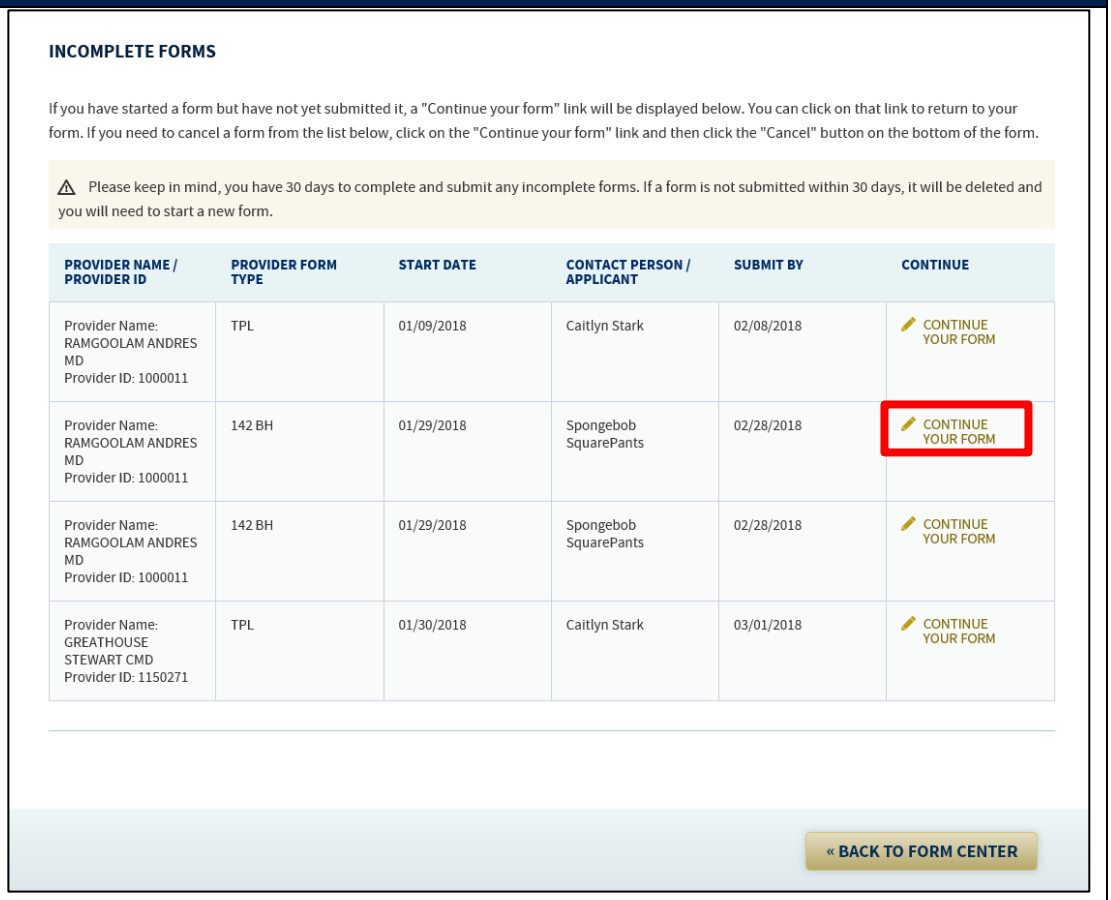
	Process Tip! In case of human error, if form submission causes an individual's certification/segment to be closed, the provider must call LDH to rectify this and manually open the case.

Lesson 5: Incomplete Forms

When users start a provider form but are not able to complete it, users can save the form and return to it later. The **Incomplete Forms** function in the Provider Portal allows users to view all forms that have been started but not submitted.

	Process Tip! After starting a new form, users have 30 days to submit the form. Forms not submitted within 30 days are purged from the Incomplete Forms queue. Additionally, if the provider is inactive, the record of the form shows in the table, but the link to continue the form will be disabled. If a user wants to delete a form that is in *Incomplete* status, they will have to navigate to the form itself and click the **Cancel** button.

STEPS	INSTRUCTIONS
1.	 **Result:** The **My Form Center** screen displays. Click the **Incomplete Forms** hyperlink to continue.

STEPS	INSTRUCTIONS
2.	

Result: The **Incomplete Forms** screen displays.

Incomplete provider forms are organized in a table with the following columns:

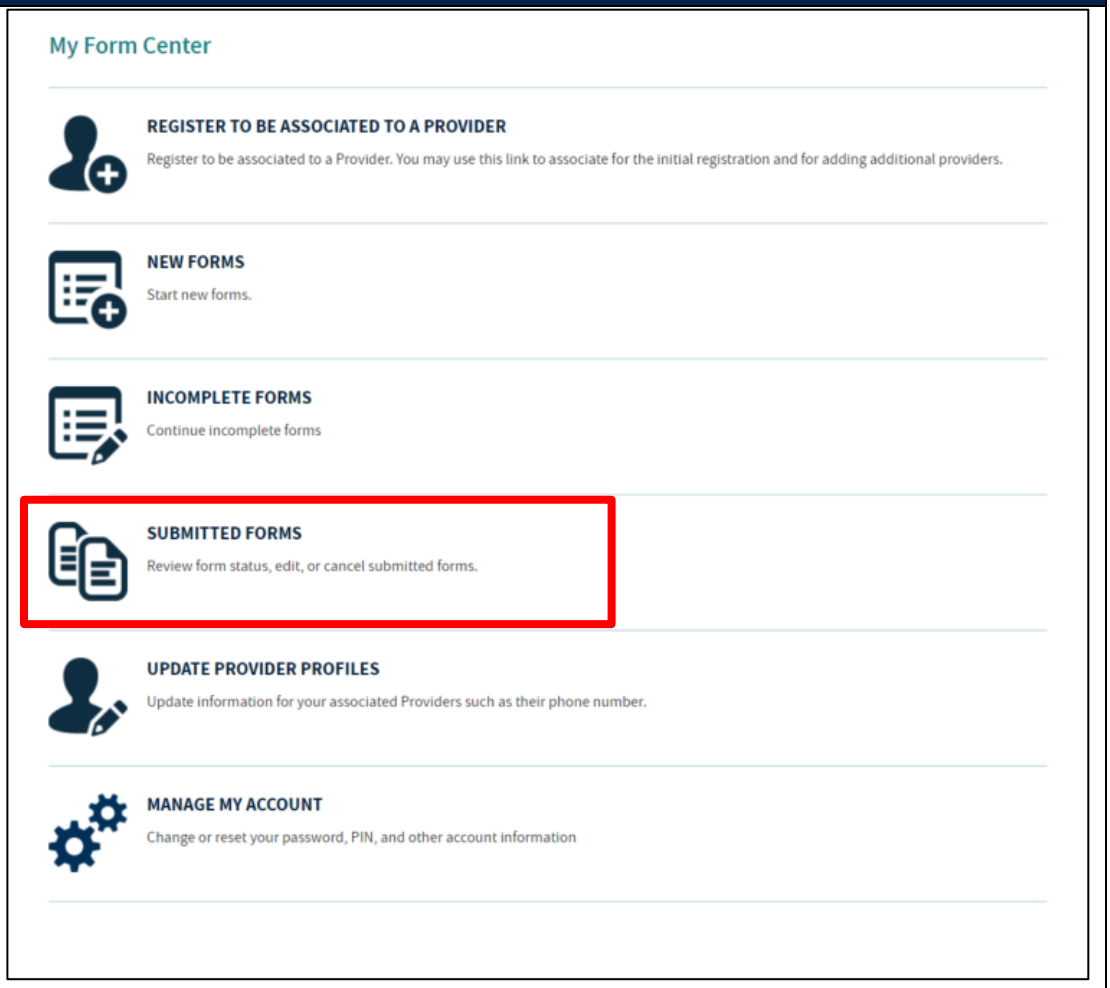
- Provider Name/Provider ID
- Provider Form Type
- Start Date
- Contact Person/Applicant
- Submit By

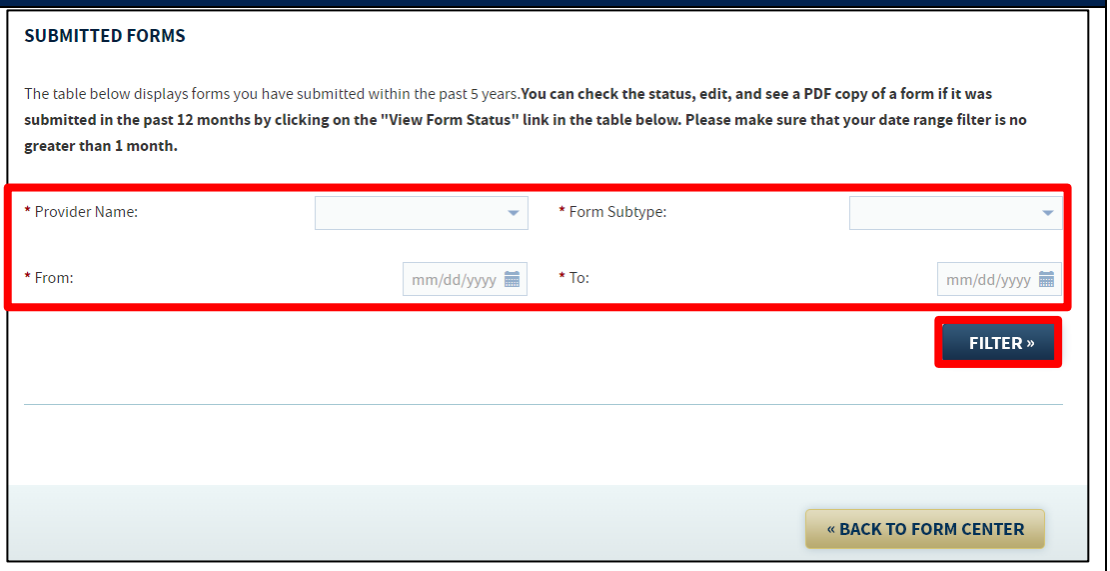
Pay special attention to the **Submit By** column because this is the last date users can submit the form before it is deleted.

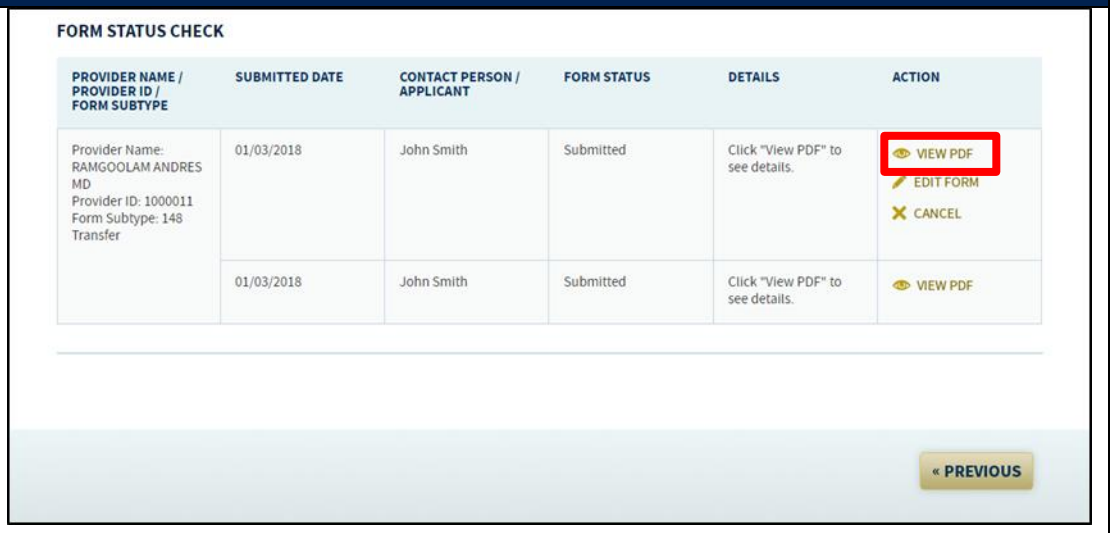
Click the **Continue Your Form** hyperlink to return to the form recently saved. Refer to *Lesson 4: Submitting a New Form* to submit the form.

Lesson 6: Submitted Forms

The **Submitted Forms** function allows users to view forms they have submitted within the past 5 years (from July 2018 onward).

STEPS	INSTRUCTIONS
3.	 **Result:** The **My Form Center** screen displays. Click the **Submitted Forms** hyperlink to continue.

STEPS	INSTRUCTIONS
4.	 **Result:** The **Submitted Forms** screen displays. To view submitted forms enter the following information: • Provider Name • Form Subtype • Date Range fields Click the **Filter** button to view the search results.
5.	 **Result:** The **Submitted Forms** results table displays Click the **View Form Status** hyperlink to continue.

STEPS	INSTRUCTIONS
6.	

Result: The **Form Status Check** screen displays.

The **Form Status Check** table displays the following information for the Provider listed on the form:

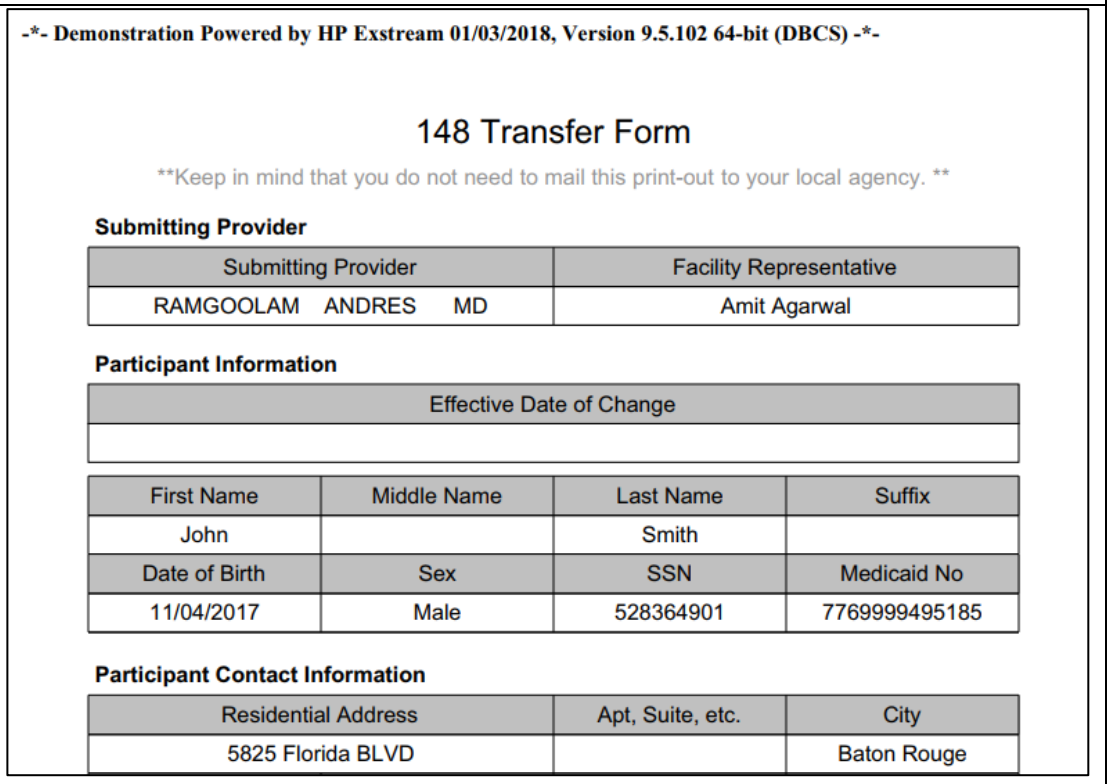
- **Provider Name/Provider ID/Form Subtype**: This column displays the Provider's information and the Form Type
- **Submitted Date**: The **Submitted Date** column shows the date the form was submitted.
- **Contact Person/Applicant**: The **Contact Person/Applicant** column shows the individual for whom the provider form was submitted.
- **Form Status**: The **Form Status** column displays one of the following statuses for the form:
    - *Submitted*
    - *Processed*
    - *Corrected*
    - *Invalid*
    - *Canceled*
- **Details**: The **Details** column lists information about the applicant.

The **Action** column allows users to edit or cancel the form, depending on the form's type and status.

Click the **View PDF** hyperlink to view the status of a form for up to 1 year after the form was submitted.

To cancel a form after submission, click the **Cancel** hyperlink. After the warning message displays, click the **Cancel** hyperlink again to confirm the cancellation.

To edit a form after submission, click the **Edit** hyperlink and navigate back to the form to complete any necessary edits.

STEPS	INSTRUCTIONS
	Process Tip! Forms can be edited or cancelled within 1 year from original submission date.
7.	

-*- Demonstration Powered by HP Exstream 01/03/2018, Version 9.5.102 64-bit (DBCS) -*-

148 Transfer Form

**Keep in mind that you do not need to mail this print-out to your local agency. **

Submitting Provider

Submitting Provider	Facility Representative
RAMGOOLAM ANDRES MD	Amit Agarwal

Participant Information

Effective Date of Change

First Name	Middle Name	Last Name	Suffix
John		Smith	
Date of Birth	**Sex**	**SSN**	**Medicaid No**
11/04/2017	Male	528364901	7769999495185

Participant Contact Information

Residential Address	Apt, Suite, etc.	City
5825 Florida BLVD		Baton Rouge

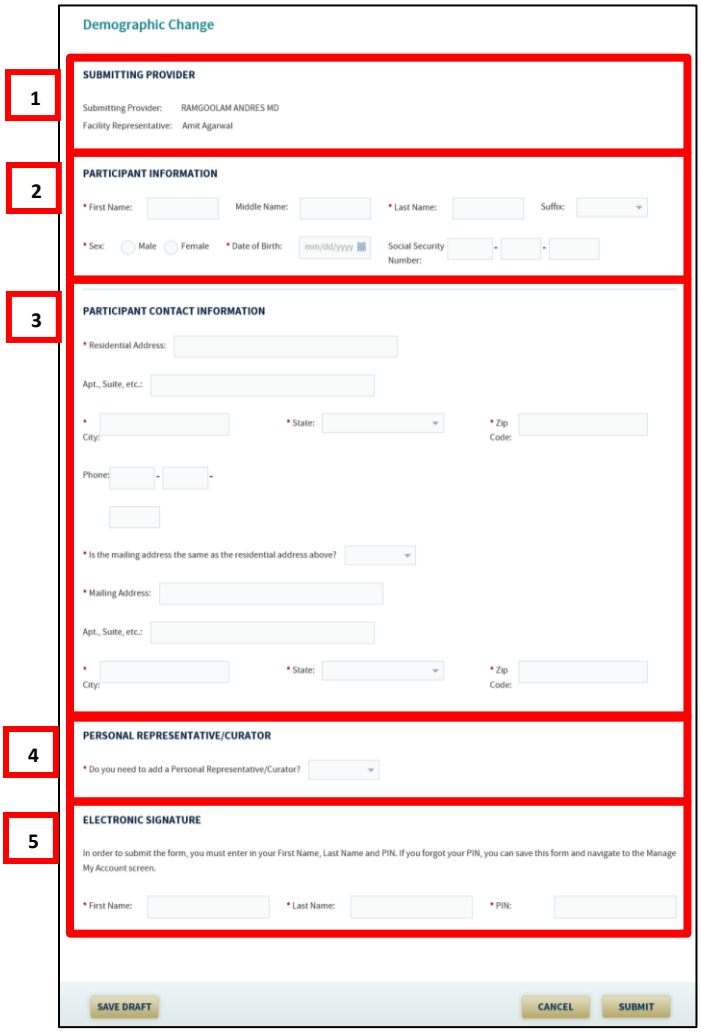
Result: The PDF summary of the submitted form displays when the user selects the **View PDF** hyperlink.

Appendix

Provider Forms support the processing of Long-Term Care applications and cases. The provider for the applicant/enrollee, such as a nursing home or a group home, submits Provider Forms on behalf of the individual to support their initial admission into the facility or waiver program as well as ongoing maintenance of their case in situations such as transfer of facility, discharge from the facility or death. The list of Provider Forms that may arrive from the Provider Portal for an LTC application or case is as follows:

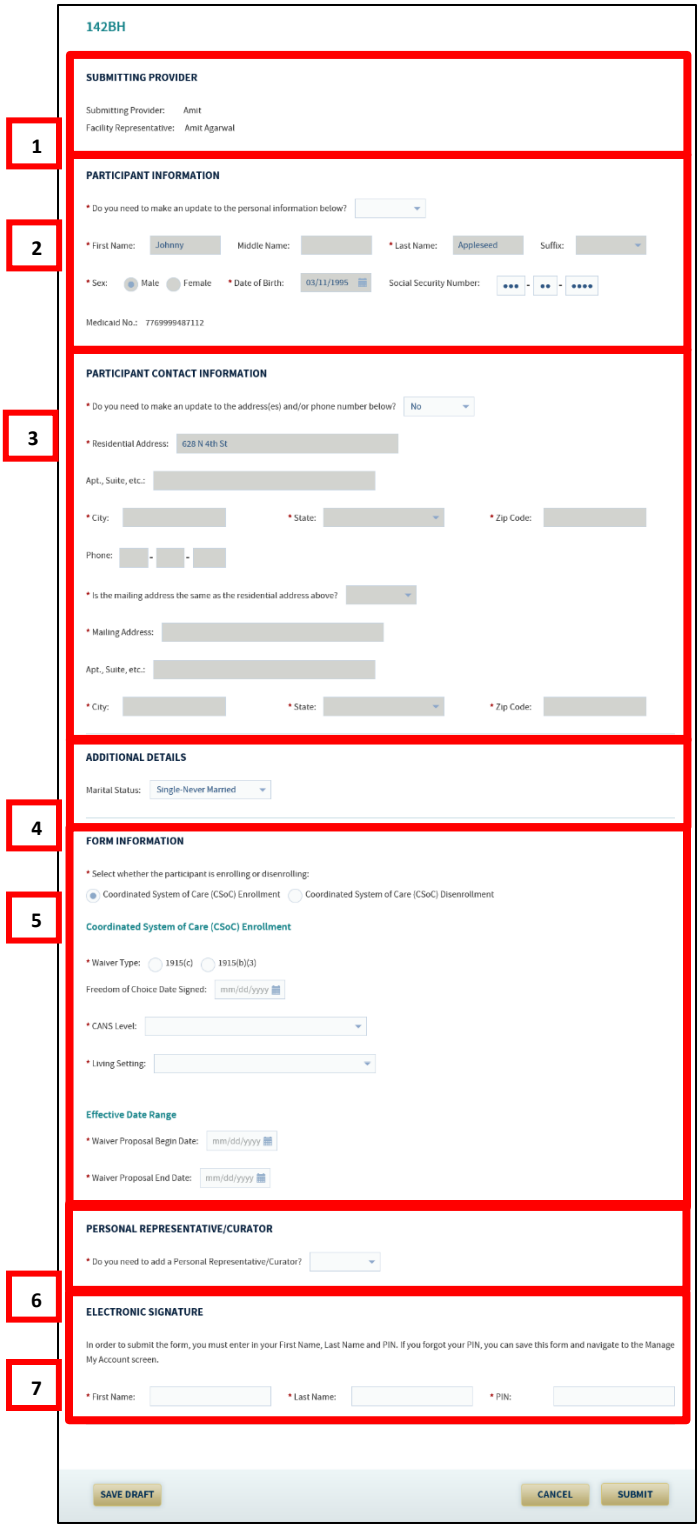
- 148W – Linkage
- 148W – Notice of Death
- 148W – Status Change
- 148W – Discharge
- 148W – Withdrawal
- 148 – Admission
- 148 – Transfer
- 148 – Discharge
- 148 – Notice of Death
- 148 – Status Change
- Demographic Change

Included below are screenshots of the other forms Provider Portal users are able to submit on behalf of a provider.


Demographic Change
1
SUBMITTING PROVIDER
Submitting Provider: RAMGOOLAM ANDRES MD
Facility Representative: Amit Agarwal
2
PARTICIPANT INFORMATION
* First Name:
Middle Name:
* Last Name:
Suffix:
* Sex: Male Female
* Date of Birth: mm/dd/yyyy
Social Security Number:
3
PARTICIPANT CONTACT INFORMATION
* Residential Address:
Apt., Suite, etc.:
* City:
* State:
* Zip Code:
Phone:
* Is the mailing address the same as the residential address above?
* Mailing Address:
Apt., Suite, etc.:
* City:
* State:
* Zip Code:
4
PERSONAL REPRESENTATIVE/CURATOR
* Do you need to add a Personal Representative/Curator?
5
ELECTRONIC SIGNATURE
In order to submit the form, you must enter in your First Name, Last Name and PIN. If you forgot your PIN, you can save this form and navigate to the Manage My Account screen.
* First Name:
* Last Name:
* PIN:
SAVE DRAFT
CANCEL
SUBMIT

Form Demographic Change

Field ID	Field	Description
1	**Submitting Provider**	Displays the following information for the Support Coordinator Agency: • Submitting Provider • Facility Representative
2	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number
3	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • Select *Yes* to the ***Is the mailing address the same as the residential address above?*** to pre-populate the information in this section.
4	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down.
5	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.


142BH
SUBMITTING PROVIDER
Submitting Provider: Amit
Facility Representative: Amit Agarwal
1
PARTICIPANT INFORMATION
* Do you need to make an update to the personal information below?
* First Name: Johnny
Middle Name:
* Last Name: Appleseed
Suffix:
* Sex: Male Female
* Date of Birth: 03/11/1995
Social Security Number:
Medicaid No.: 7769999487112
2
PARTICIPANT CONTACT INFORMATION
* Do you need to make an update to the address(es) and/or phone number below? No
* Residential Address: 628 N 4th St
Apt., Suite, etc.:
* City:
* State:
* Zip Code:
Phone:
* Is the mailing address the same as the residential address above?
* Mailing Address:
Apt., Suite, etc.:
* City:
* State:
* Zip Code:
3
ADDITIONAL DETAILS
Marital Status: Single-Never Married
4
FORM INFORMATION
* Select whether the participant is enrolling or disenrolling:
Coordinated System of Care (CSoC) Enrollment
Coordinated System of Care (CSoC) Disenrollment
5
Coordinated System of Care (CSoC) Enrollment
* Waiver Type: 1915(c) 1915(b)(3)
Freedom of Choice Date Signed: mm/dd/yyyy
* CANS Level:
* Living Setting:
Effective Date Range
* Waiver Proposal Begin Date: mm/dd/yyyy
* Waiver Proposal End Date: mm/dd/yyyy
PERSONAL REPRESENTATIVE/CURATOR
* Do you need to add a Personal Representative/Curator?
6
ELECTRONIC SIGNATURE
In order to submit the form, you must enter in your First Name, Last Name and PIN. If you forgot your PIN, you can save this form and navigate to the Manage My Account screen.
* First Name:
* Last Name:
* PIN:
7
SAVE DRAFT
CANCEL
SUBMIT

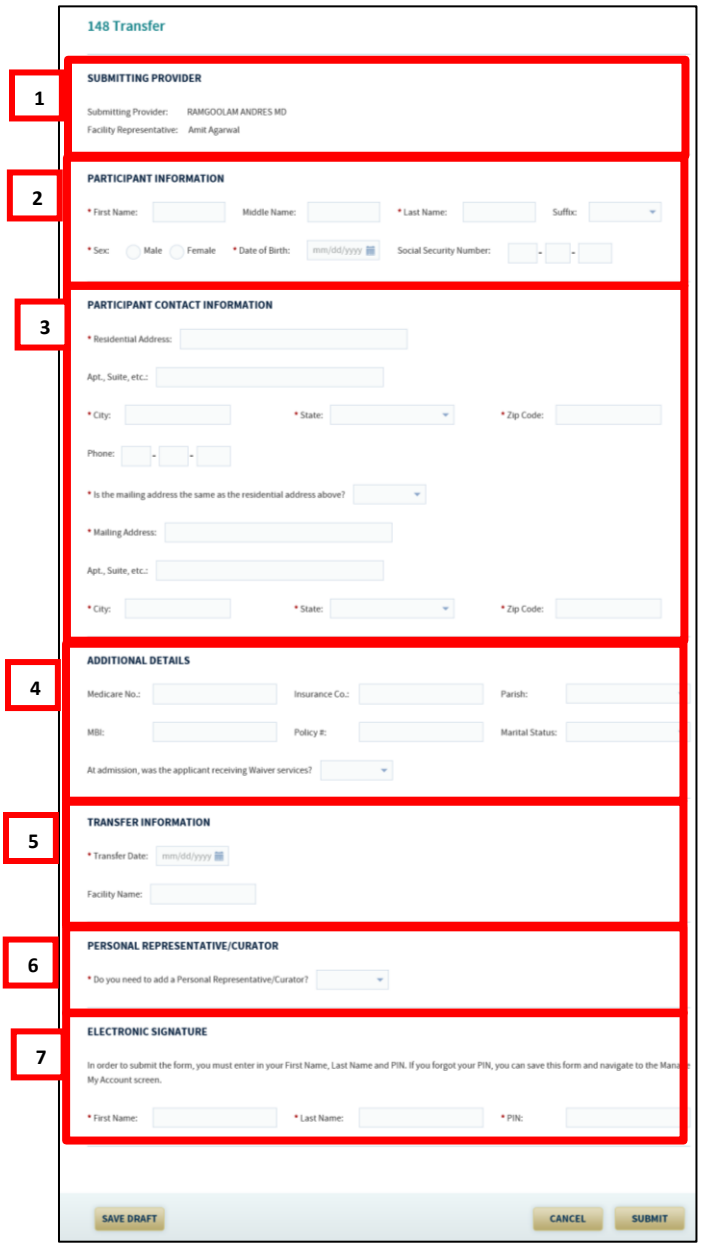
Form 142 BH

Field ID	Field	Description
1	**Submitting Provider**	Displays the following information for the Support Coordinator Agency: • Submitting Provider • Facility Representative
2	**Participant Information**	Displays the following pre-populated information for the applicant: • Do you need to make an update to the personal information below? • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number
3	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Do you need to update the address(es) and/or phone number below? • Residential Address • City • State • Zip Code • Phone Number • Select *Yes* to the ***Is the mailing address the same as the residential address above?*** to pre-populate the information in this section.
4	**Additional Details**	Enter the following information for the individual: • Marital Status

5	**Form Information**	Select whether the participant is enrolling or disenrolling by clicking one of the following radio buttons:
		
		• Coordinated System of Care (CSoC) Enrollment
		• Coordinated System of Care (CSoC) Disenrollment
		
		Note: Additional fields display based on whether the Enrollment or Disenrollment radio button was selected. If Coordinated System of Care (CSoC) Enrollment was chosen, the following fields displays and must be completed.
		
		Coordinated System of Care (CSoC) Enrollment
		
		• Select the radio button for one of the following **Waiver Types:**
		  ○ 1915(c)
		  ○ 1915(b)(3)
		• Select the **Freedom of Choice Date Signed**
		• Select the appropriate value from the **CANS Level** drop-down:
		  ○ Psychiatric Inpatient/5
		  ○ Nursing Facility/3
		  ○ PRTF/4
		  ○ Therapeutic Group Home/2d
		  ○ CSOC Criteria/2
		• Select the correct Living Setting from **the Living Setting** drop-down
		• Effective Date Range
		• Enter the Waiver Proposal Begin Date
		• Enter the Waiver Proposal End Date
		
		Coordinated System of Care (CSoC) Disenrollment
		• If the Coordinated System of Care (CSoC) Disenrollment radio button was chosen, the following fields displays and must be completed.
		
		Enter the Waiver Proposal End Date

6	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down.

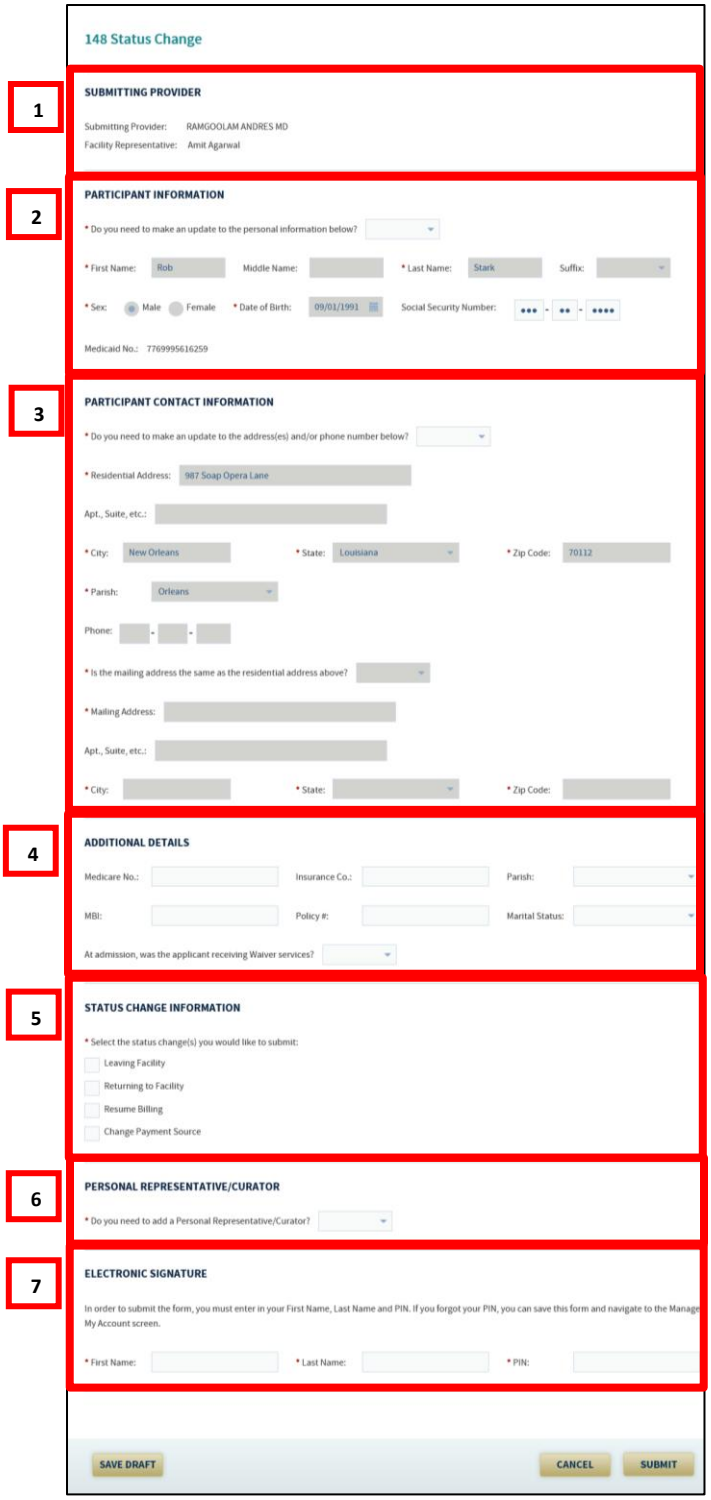
7	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148 Transfer

Field ID	Field	Description
1	**Submitting Provider**	Displays the following information for the Support Coordinator Agency: • Submitting Provider • Facility Representative
2	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number
3	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • Select *Yes* to the ***Is the mailing address the same as the residential address above?*** to pre-populate the information in this section.
4	**Additional Details**	Enter the following information for the individual: • Medicare No. • Insurance Co. • Parish • MBI • Policy # • Marital Status • At admission, was the applicant receiving Waiver services?
5	**Transfer Information**	• Enter the **Transfer Date** • Enter the **Facility Name**
6	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down.

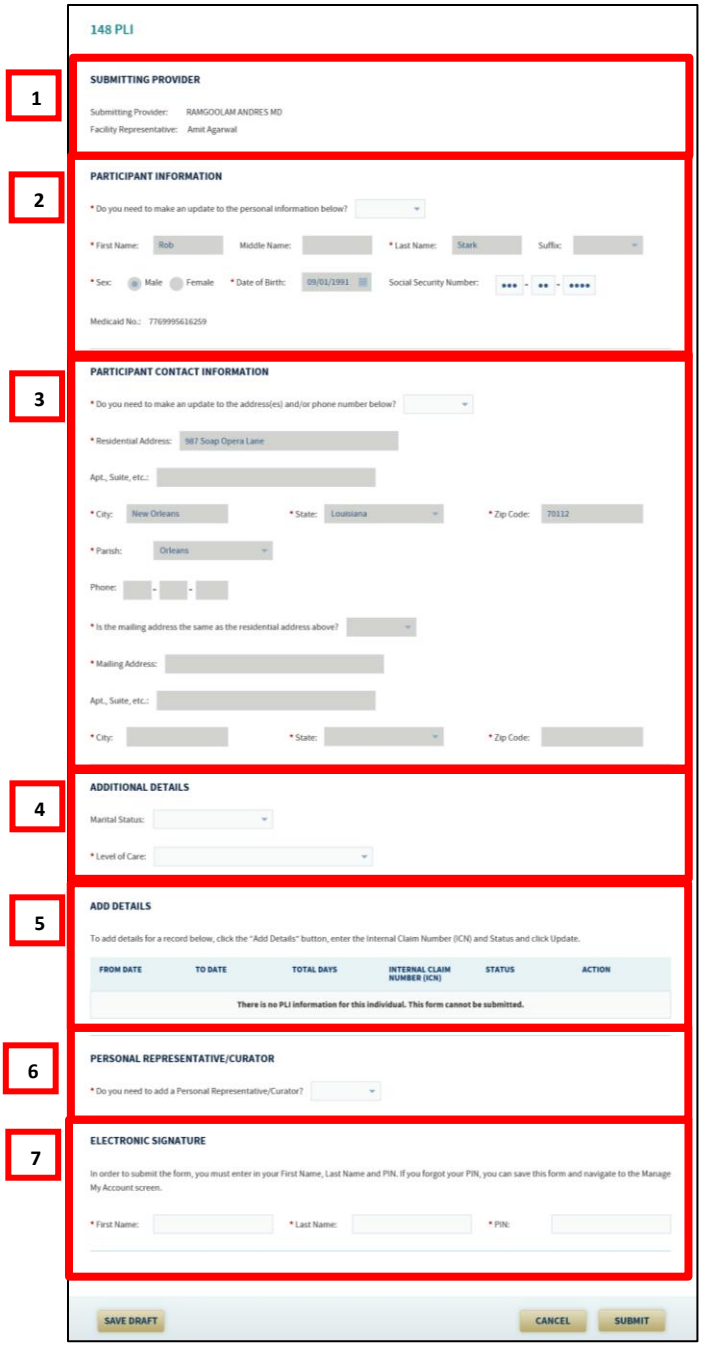
7	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148 Status Change

Field ID	Field	Description
1	**Submitting Provider**	Displays the following information for the Support Coordinator Agency: • Submitting Provider • Facility Representative
2	**Participant Information**	Displays the following pre-populated information for the applicant: • Do you need to make an update to the personal information below? • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number
3	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • Select *Yes* to the ***Is the mailing address the same as the residential address above?*** to pre-populate the information in this section.
4	**Additional Details**	Enter the following information for the individual: • At admission, was the applicant receiving Waiver services? • Medicare No. • Insurance Co. • Parish • MBI • Policy # • Marital Status

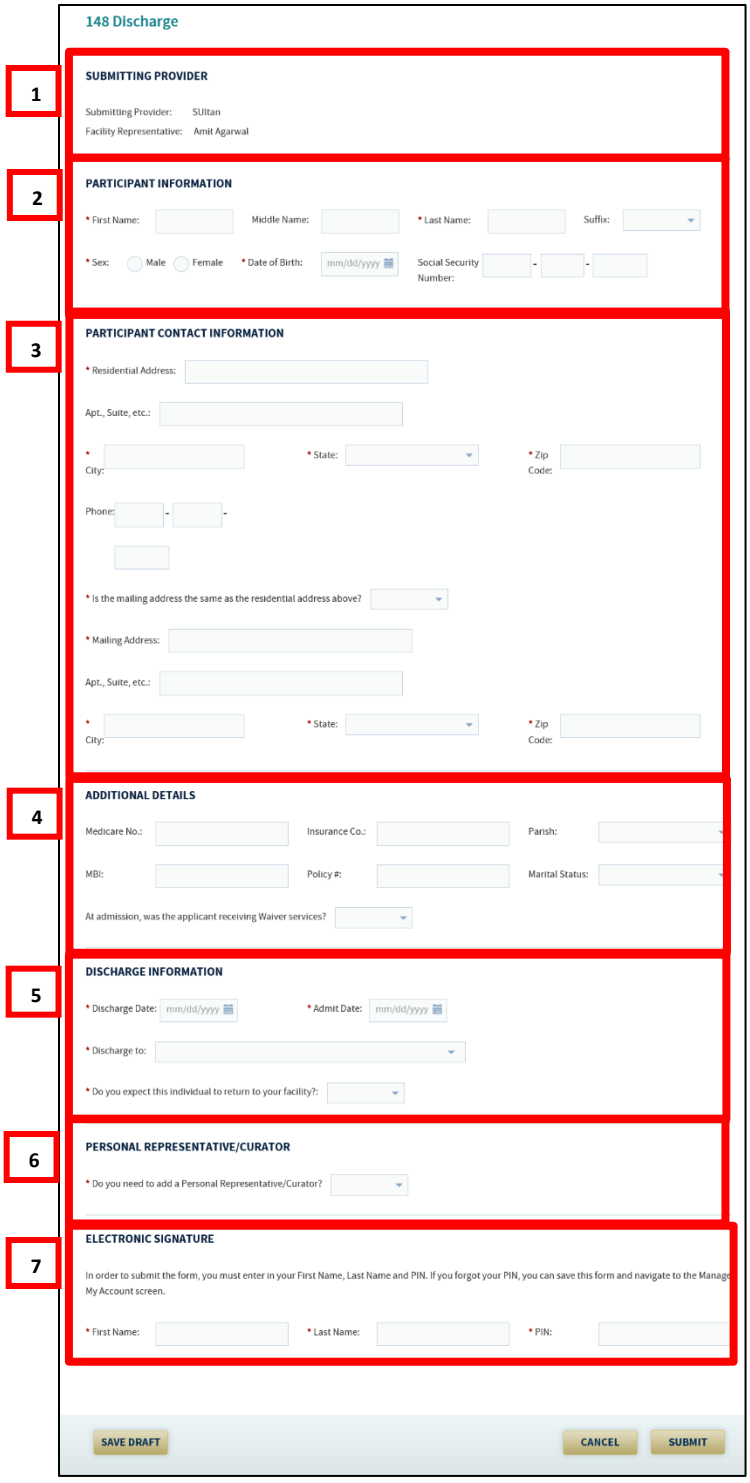
5	**Status Change Information**	• Choose the status change(s) to submit by selecting one of the following checkboxes: ○ Leaving Family ○ Returning to Facility ○ Resume Billing ○ Change Payment Source
6	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down.
7	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.


148 PLI
1
SUBMITTING PROVIDER
Submitting Provider: RAMGOOLAM ANDRES MD
Facility Representative: Amit Agarwal
2
PARTICIPANT INFORMATION
* Do you need to make an update to the personal information below?
* First Name: Rob
Middle Name:
* Last Name: Stark
Suffix:
* Sex: Male Female
* Date of Birth: 09/01/1991
Social Security Number: ••• - •• - ••••
Medicaid No.: 7769995616259
3
PARTICIPANT CONTACT INFORMATION
* Do you need to make an update to the address(es) and/or phone number below?
* Residential Address: 987 Soap Opera Lane
Apt., Suite, etc.:
* City: New Orleans
* State: Louisiana
* Zip Code: 70112
* Parish: Orleans
Phone: - -
* Is the mailing address the same as the residential address above?
* Mailing Address:
Apt., Suite, etc.:
* City:
* State:
* Zip Code:
4
ADDITIONAL DETAILS
Marital Status:
* Level of Care:
5
ADD DETAILS
To add details for a record below, click the "Add Details" button, enter the Internal Claim Number (ICN) and Status and click Update.
FROM DATE
TO DATE
TOTAL DAYS
INTERNAL CLAIM NUMBER (ICN)
STATUS
ACTION
There is no PLI information for this individual. This form cannot be submitted.
6
PERSONAL REPRESENTATIVE/CURATOR
* Do you need to add a Personal Representative/Curator?
7
ELECTRONIC SIGNATURE
In order to submit the form, you must enter in your First Name, Last Name and PIN. If you forgot your PIN, you can save this form and navigate to the Manage My Account screen.
* First Name:
* Last Name:
* PIN:
SAVE DRAFT
CANCEL
SUBMIT

Form 148 PLI

Field ID	Field	Description
1	**Submitting Provider**	Displays the following information for the Support Coordinator Agency: • Submitting Provider • Facility Representative
2	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number
3	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • Select *Yes* to the ***Is the mailing address the same as the residential address above?*** to pre-populate the information in this section.
4	**Additional Details**	Enter the following information for the individual: • Marital Status • Level of Care
5	**Add Details**	• Click the **Add Details** button to enter an **Internal Claim Number** and **Status** • Select the **Update** button in the **Action** column to save the changes.
6	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down.

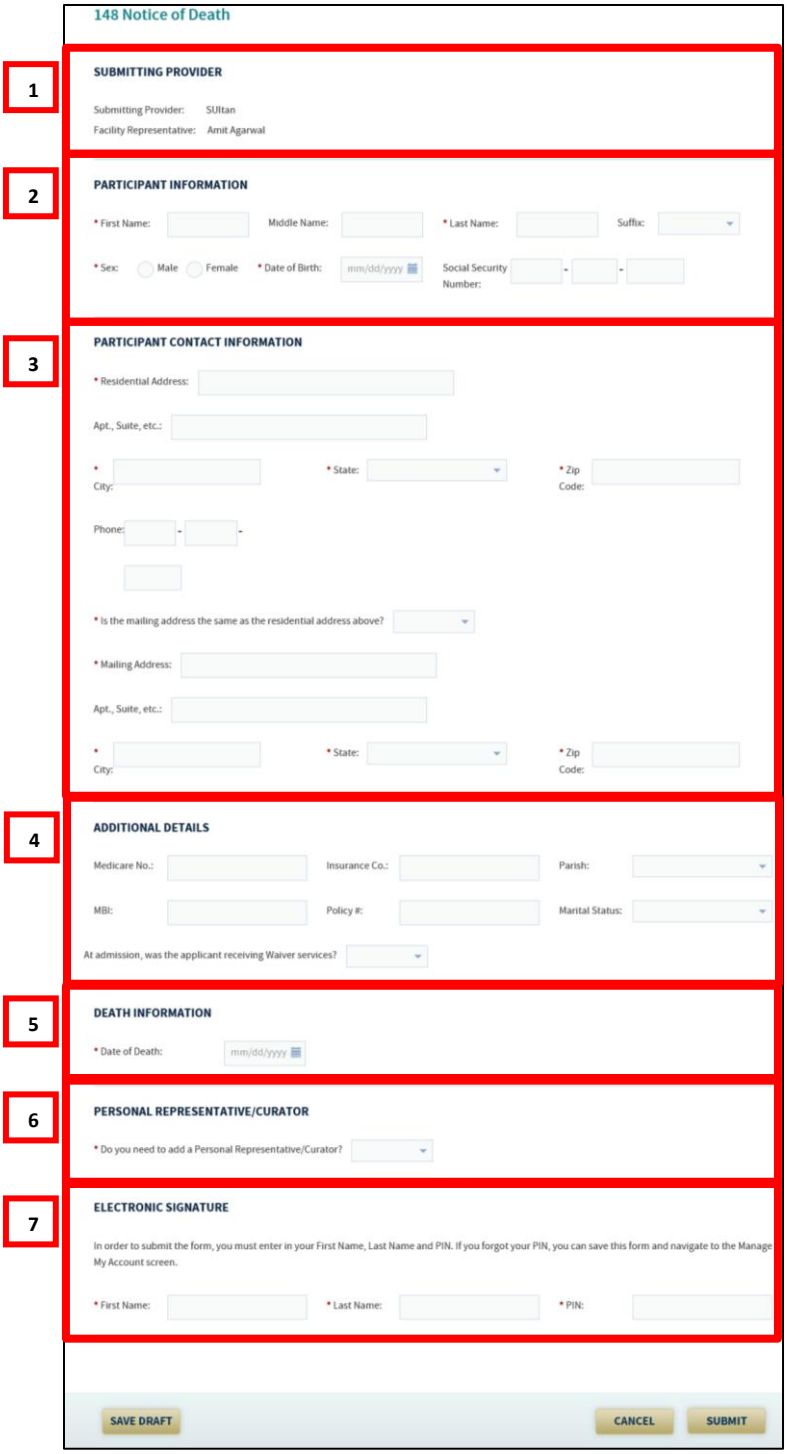
7	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148 Discharge

Field ID	Field	Description
1	**Submitting Provider**	Displays the following information for the Support Coordinator Agency: • Submitting Provider • Facility Representative
2	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number
3	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • Select *Yes* to the ***Is the mailing address the same as the residential address above?*** to pre-populate the information in this section.
4	**Additional Details**	Enter the following information for the individual: • Medicare No. • Insurance Co. • Parish • MBI • Policy # • Marital Status • At admission, was the applicant receiving Waiver services?
5	**Discharge Information**	• Enter the **Discharge Date** • Enter the **Admit Date** • Select the appropriate value from the **Discharge to:** drop-down. • Select *Yes* or *No* from the **Do you expect this individual to return to your facility** drop-down.

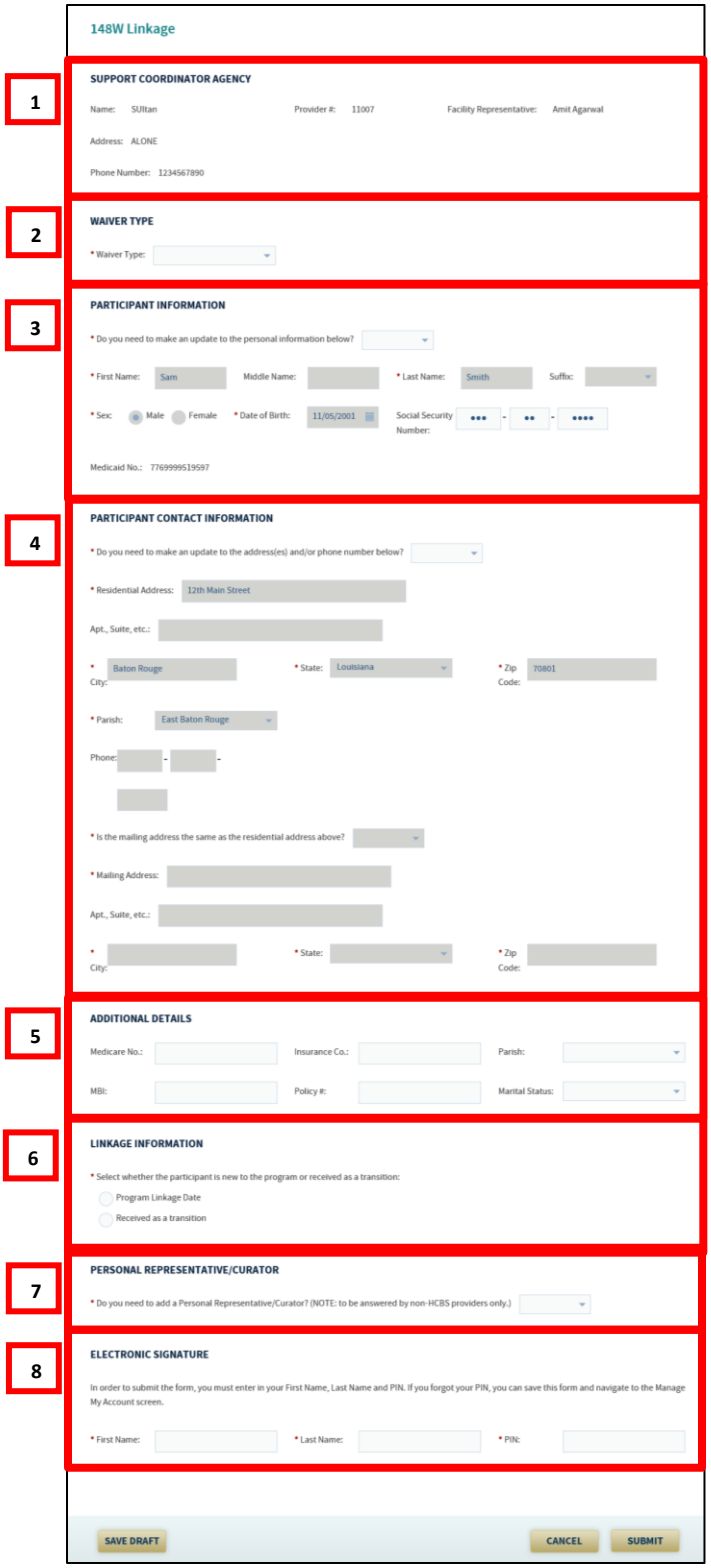
6	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down.
7	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148 Notice of Death

Field ID	Field	Description
1	**Submitting Provider**	Displays the following information for the Support Coordinator Agency: • Submitting Provider • Facility Representative
2	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number
3	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • Select *Yes* to the ***Is the mailing address the same as the residential address above?*** to pre-populate the information in this section.
4	**Additional Details**	Enter the following information for the individual: • Medicare No. • Insurance Co. • Parish • MBI • Policy # • Marital Status
5	**Death Information**	• Enter the **Date of Death** for the individual.
6	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down.

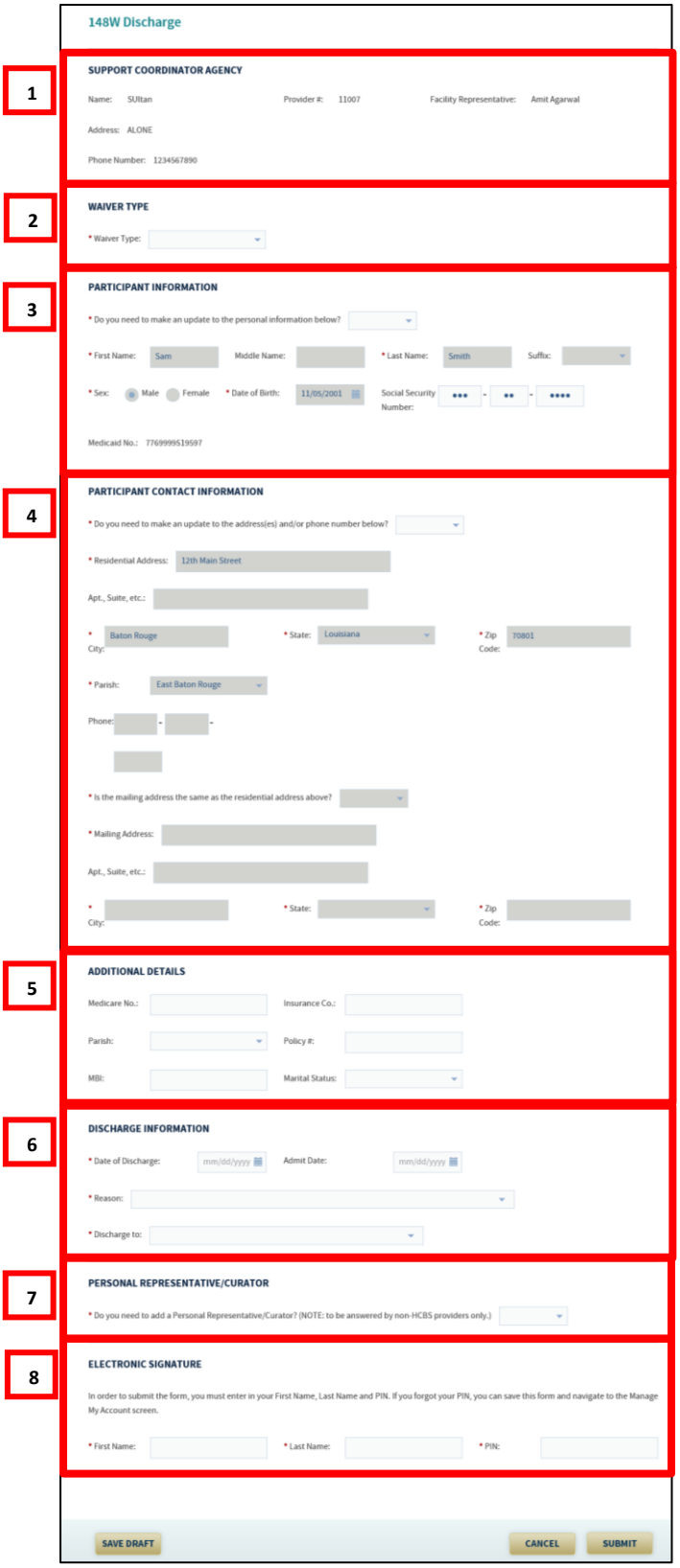
7	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148W Linkage

Field ID	Field	Description
1	**Support Coordinator Agency**	Displays the following information for the Support Coordinator Agency: • Name • Provider ID • Facility Representative • Address • Phone Number
2	**Waiver Type**	Select the appropriate value from the Waiver Type drop-down: • ADHC • Community Choice
3	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number **Note:** If any of the information in the **Participant Information** section needs to be updated, select *Yes* from the **Do you need to make an update to personal information below?** drop-down.
4	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Parish • Phone Number • *Is the mailing address the same as the residential address above?* **Note:** If any of the information in the **Participant Contact Information** section needs to be updated, select *Yes* from the **Do you need to make an update to the address(es) and/or phone number below?** drop-down.

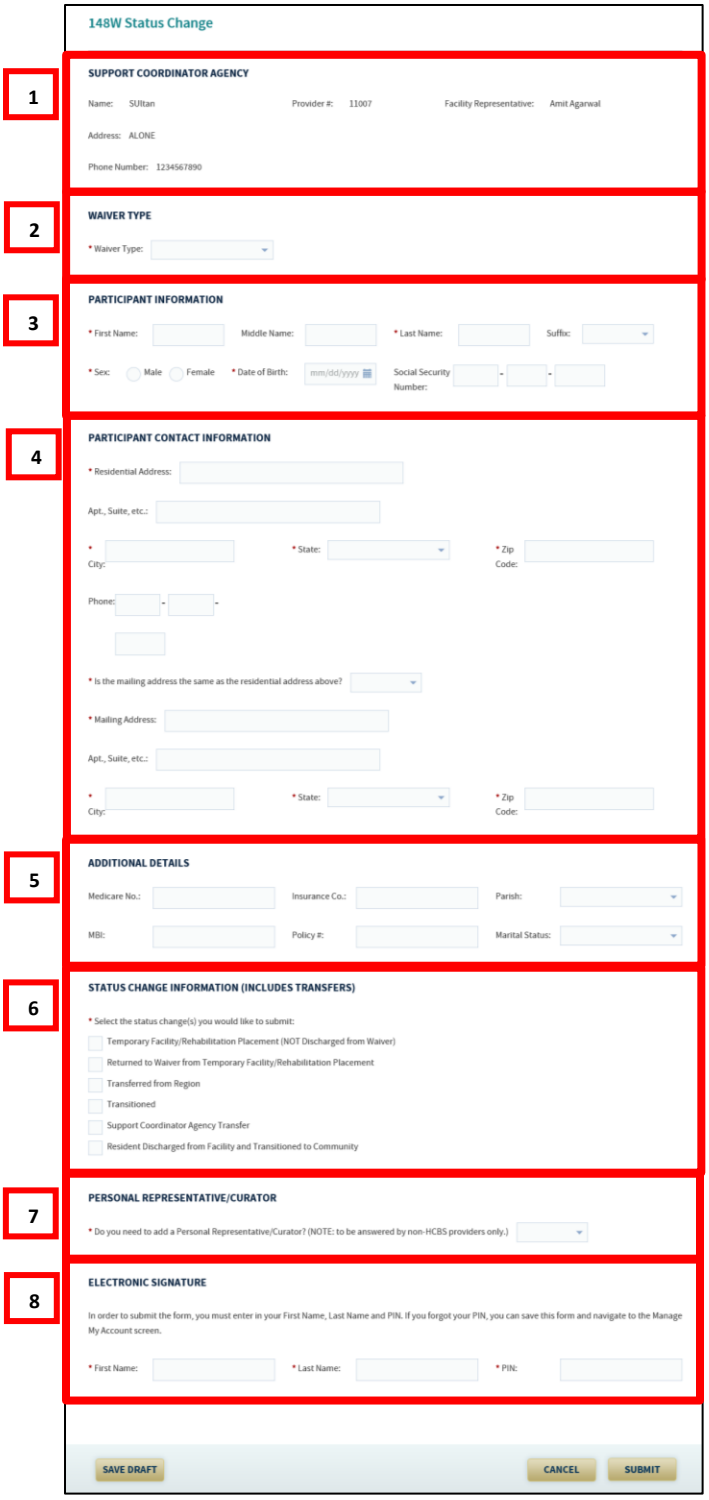
5	**Additional Details**	Enter the following information: • Medicare No. • Parish • MBI • Insurance Co. • Policy # • Marital Status
6	**Linkage Information**	Denote whether the participant is new to the program or received as a transition by selecting one of the following **Linkage Information** radio buttons: • Program Linkage Date • Received as transition
7	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down. **Note:** This field is answered by non-HCBS providers only.
8	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148W Discharge

Field ID	Field	Description
1	**Support Coordinator Agency**	Displays the following information for the Support Coordinator Agency: • Name • Provider ID • Facility Representative • Address • Phone Number
2	**Waiver Type**	Select the appropriate value from the Waiver Type drop-down: • ADHC • Community Choice
3	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number **Note:** If any of the information in the **Participant Information** section needs to be updated, select *Yes* from the **Do you need to make an update to personal information below?** drop-down.
4	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Parish • Phone Number • *Is the mailing address the same as the residential address above?* **Note:** If any of the information in the **Participant Contact Information** section needs to be updated, select *Yes* from the **Do you need to make an update to the address(es) and/or phone number below?** drop-down.

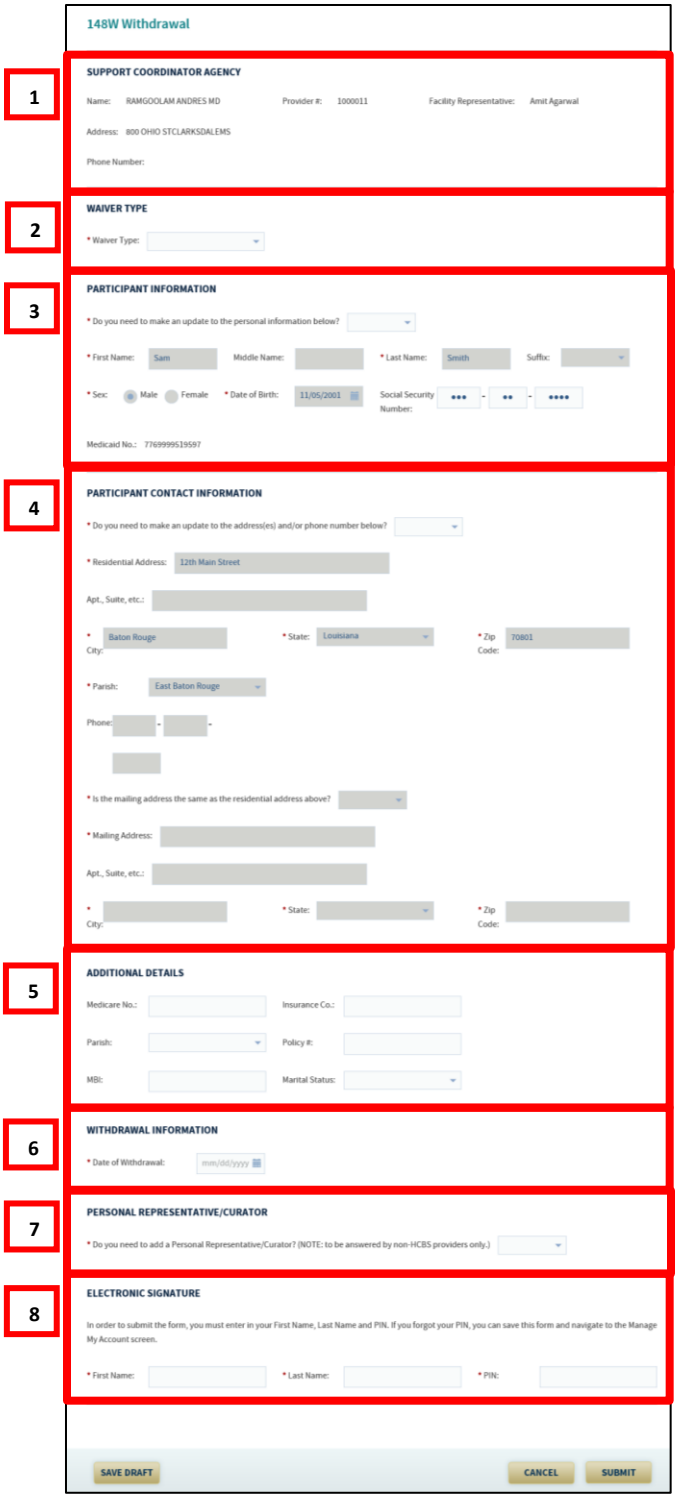
5	**Additional Details**	Enter the following information: • Medicare No. • Parish • MBI • Insurance Co. • Policy # • Marital Status
6	**Discharge Information**	• Enter the **Discharge Date** • Enter the **Admit Date** • Select the appropriate reason for discharge from the **Reason** drop-down. • Select the appropriate value from the **Discharge to:** drop-down.
7	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down. **Note:** This field is answered by non-HCBS providers only.
8	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148W Status Change

Field ID	Field	Description
1	**Support Coordinator Agency**	Displays the following information for the Support Coordinator Agency: • Name • Provider ID • Facility Representative • Address • Phone Number
2	**Waiver Type**	Select the appropriate value from the Waiver Type drop-down: • ADHC • Community Choice
3	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number **Note:** If any of the information in the **Participant Information** section needs to be updated, select *Yes* from the **Do you need to make an update to personal information below?** drop-down.
4	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • *Is the mailing address the same as the residential address above?* **Note:** If any of the information in the **Participant Contact Information** section needs to be updated, select *Yes* from the **Do you need to make an update to the address(es) and/or phone number below?** drop-down.

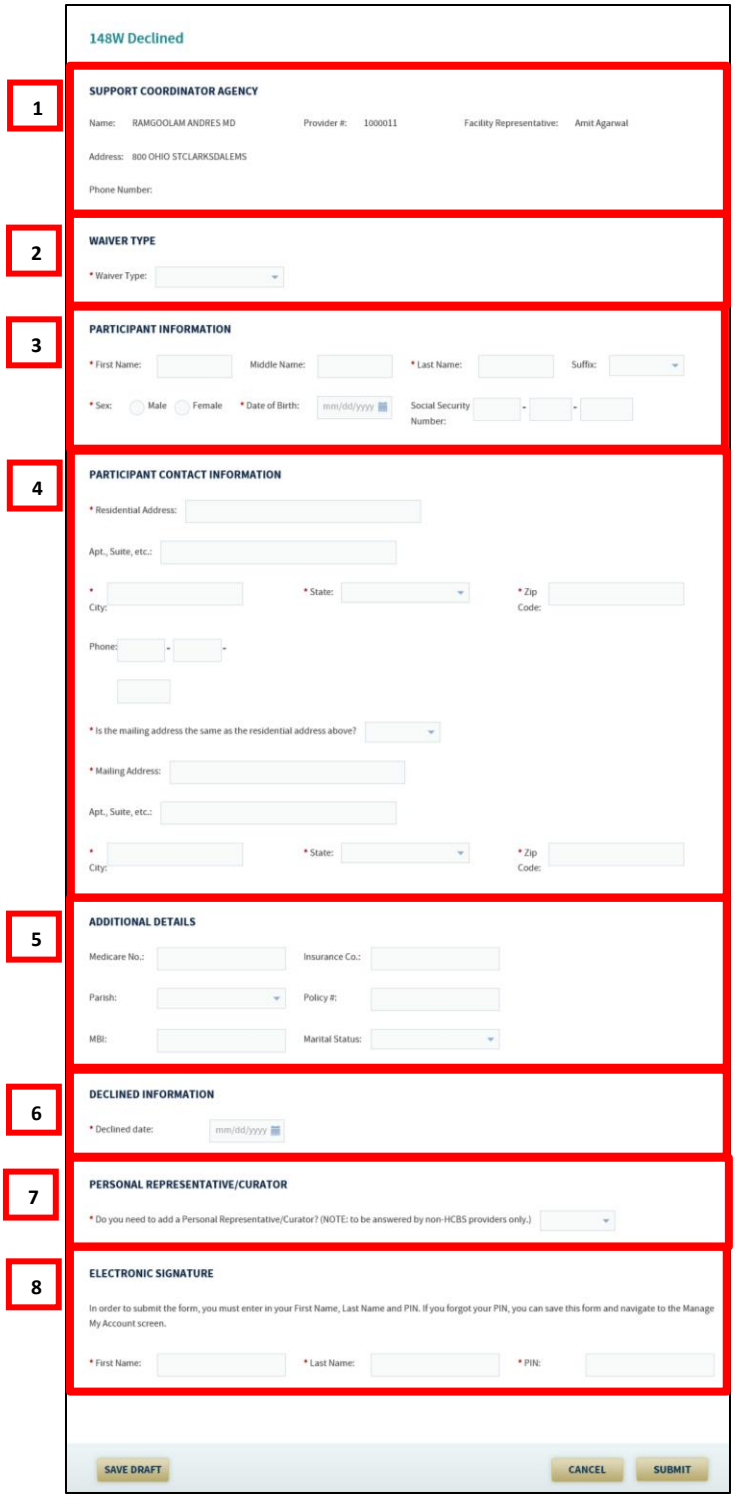
5	**Additional Details**	Enter the following information: • Medicare No. • Parish • MBI • Insurance Co. • Policy # • Marital Status
6	**Status Change Information**	• Choose the status change(s) to submit by selecting one of the following checkboxes: ○ Temporary Facility/Rehabilitation Placement ○ Returned to Waiver from Temporary Facility/Rehabilitation Placement ○ Transferred from Region ○ Transitioned ○ Support Coordinator Agency Transfer ○ Resident Discharged from Facility and Transitioned to Community
7	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down. **Note:** This field is answered by non-HCBS providers only.
8	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148W Withdrawal

Field ID	Field	Description
1	**Support Coordinator Agency**	Displays the following information for the Support Coordinator Agency: • Name • Provider ID • Facility Representative • Address • Phone Number
2	**Waiver Type**	Select the appropriate value from the Waiver Type drop-down: • ADHC • Community Choice
3	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number **Note:** If any of the information in the **Participant Information** section needs to be updated, select *Yes* from the **Do you need to make an update to personal information below?** drop-down.
4	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Parish • Phone Number • *Is the mailing address the same as the residential address above?* **Note:** If any of the information in the **Participant Contact Information** section needs to be updated, select *Yes* from the **Do you need to make an update to the address(es) and/or phone number below?** drop-down.

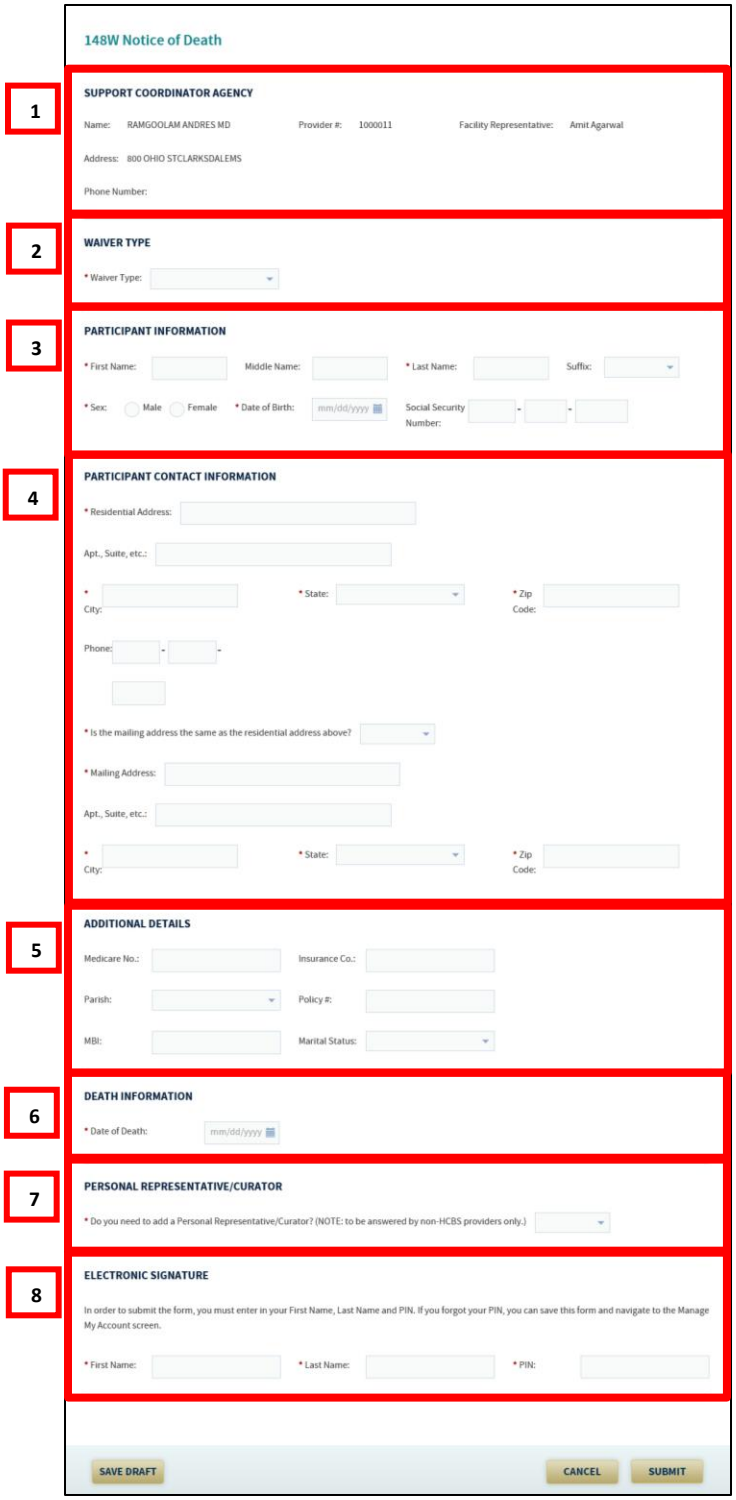
5	**Additional Details**	Enter the following information: • Medicare No. • Parish • MBI • Insurance Co. • Policy # • Marital Status
6	**Withdrawal Information**	• Enter the **Date of Withdrawal**
7	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down. **Note:** This field is answered by non-HCBS providers only.
8	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148W Declined

Field ID	Field	Description
1	**Support Coordinator Agency**	Displays the following information for the Support Coordinator Agency: • Name • Provider ID • Facility Representative • Address • Phone Number
2	**Waiver Type**	Select the appropriate value from the Waiver Type drop-down: • ADHC • Community Choice
3	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number **Note:** If any of the information in the **Participant Information** section needs to be updated, select *Yes* from the **Do you need to make an update to personal information below?** drop-down.
4	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • *Is the mailing address the same as the residential address above?* **Note:** If any of the information in the **Participant Contact Information** section needs to be updated, select *Yes* from the **Do you need to make an update to the address(es) and/or phone number below?** drop-down.

5	**Additional Details**	Enter the following information: • Medicare No. • Parish • MBI • Insurance Co. • Policy # • Marital Status
6	**Declined Information**	• Enter the Declined Information
7	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down. **Note:** This field is answered by non-HCBS providers only.
8	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.



Form 148W Notice of Death

Field ID	Field	Description
1	**Support Coordinator Agency**	Displays the following information for the Support Coordinator Agency: • Name • Provider ID • Facility Representative • Address • Phone Number
2	**Waiver Type**	Select the appropriate value from the Waiver Type drop-down: • ADHC • Community Choice
3	**Participant Information**	Displays the following pre-populated information for the applicant: • First Name • Middle Name • Last Name • Suffix • Sex • Date of Birth • Social Security Number • Medicaid Number **Note:** If any of the information in the **Participant Information** section needs to be updated, select *Yes* from the **Do you need to make an update to personal information below?** drop-down.
4	**Participant Contact Information**	Displays the following pre-populated information for the applicant: • Residential Address • City • State • Zip Code • Phone Number • *Is the mailing address the same as the residential address above?* **Note:** If any of the information in the **Participant Contact Information** section needs to be updated, select *Yes* from the **Do you need to make an update to the address(es) and/or phone number below?** drop-down.

5	**Additional Details**	Enter the following information: • Medicare No. • Parish • MBI • Insurance Co. • Policy # • Marital Status
6	**Death Information**	• Enter the **Date of Death** for the individual.
7	**Personal Representative/ Curator**	Select *Yes* or *No* from the **Do you need to add a Personal Representative/Curator?** drop-down. **Note:** This field is answered by non-HCBS providers only.
8	**Electronic Signature**	Enter the following information to electronically sign and submit the form: • First Name • Last Name • PIN **Note:** If the PIN information is forgotten, save the information on the screen and navigate to the **Manage My Account** screen to identify the PIN.