

# **Quick Reference Guide**

## **Provider Portal for Trusted Users**

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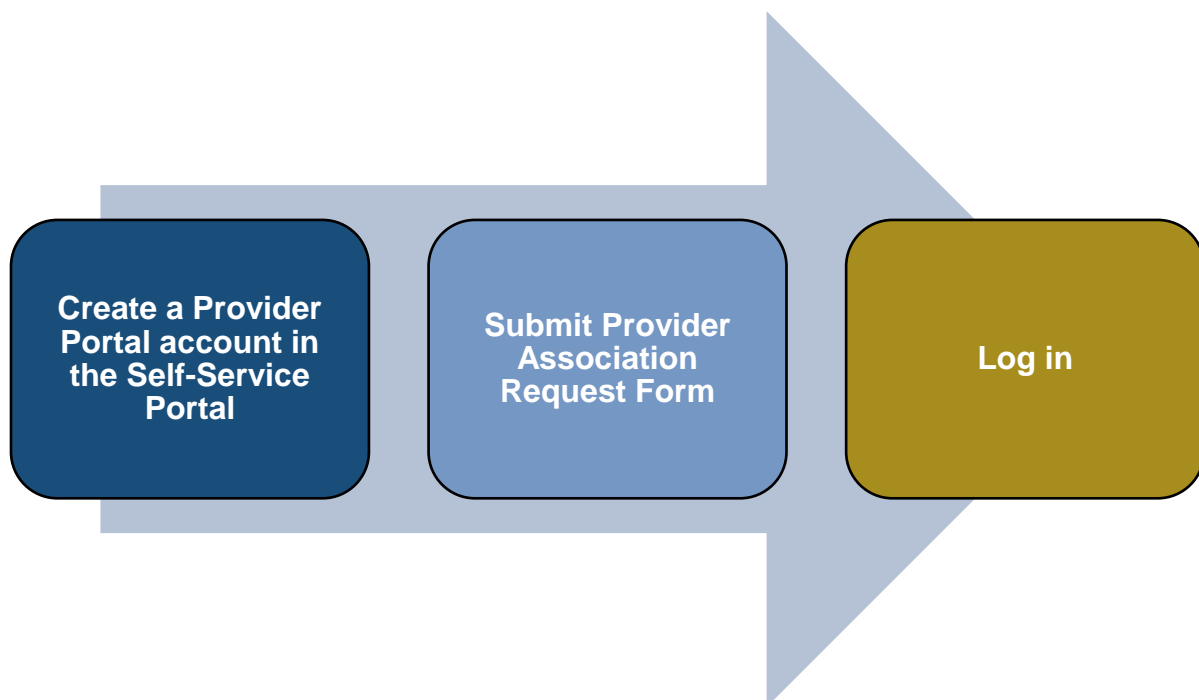
## Introduction

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:

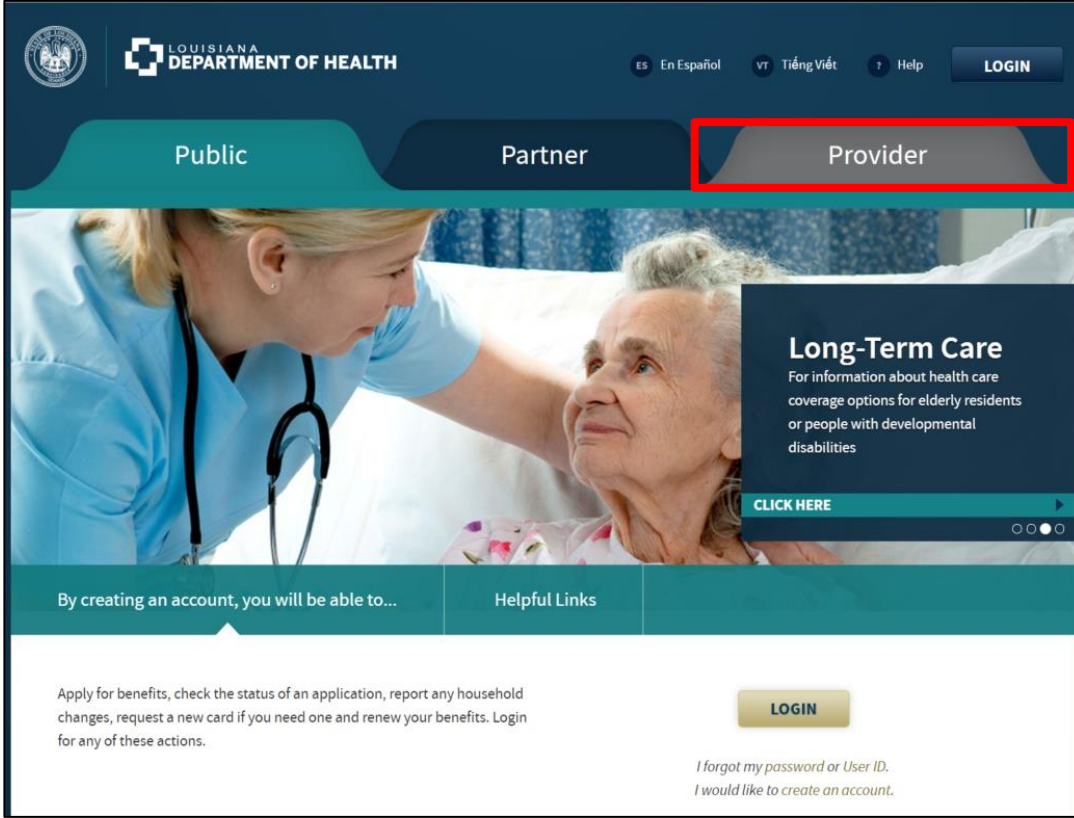
- **Register to be Associated to a Provider:** This allows users to submit provider registration forms or add additional provider associations to an account.
- **Manage My Account:** This allows users to update basic personal information such as name, address, email address, phone number, and PIN.

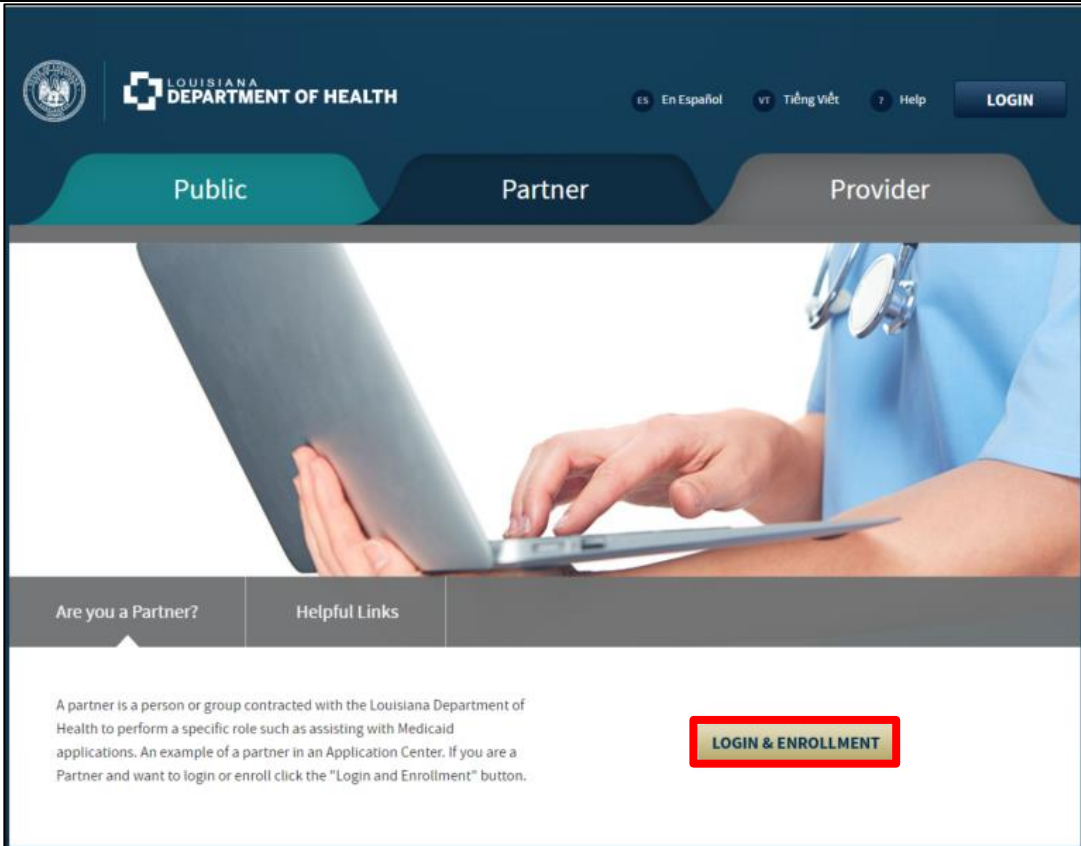
- **New Forms:** This allows users to submit specific forms (based on the provider type) on behalf of providers to whom users are associated.
- **Incomplete Forms:** This allows users to return to forms that were initiated by the user but that have not been submitted.
- **Submitted Forms:** This allows 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.

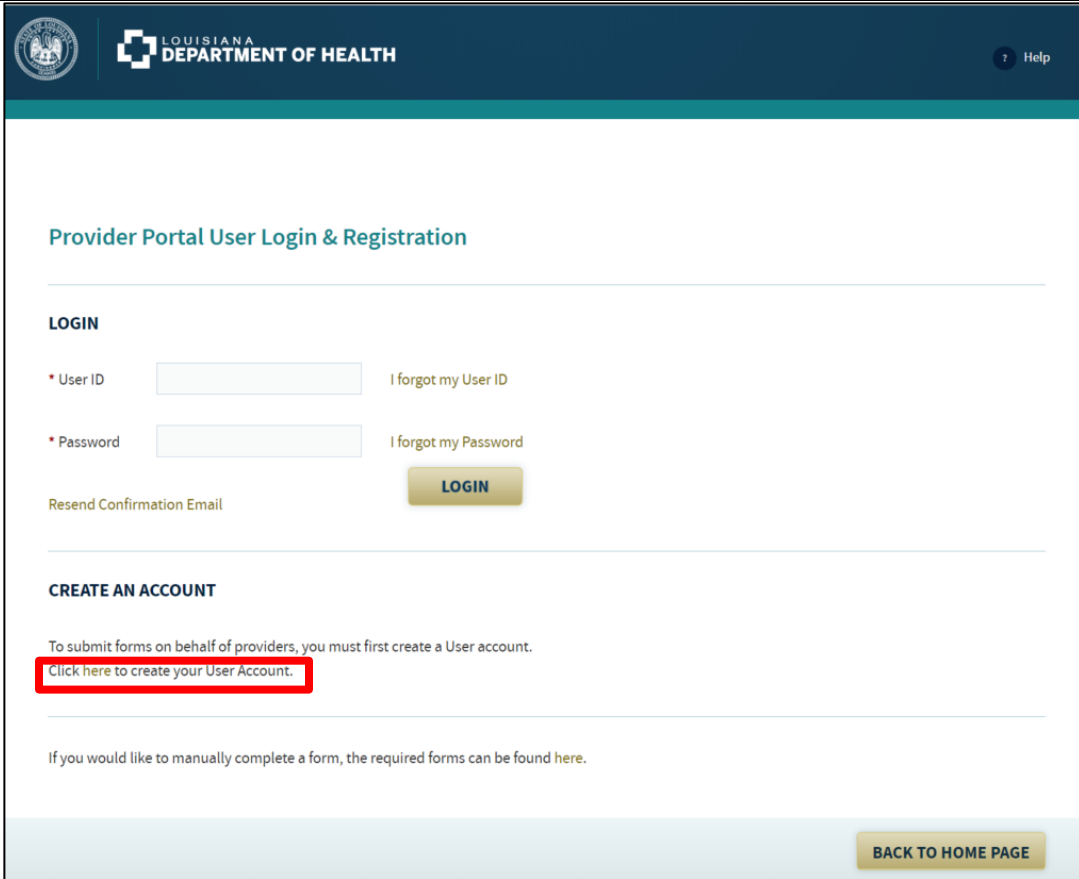
This QRG introduces the basics of accessing the Self-Service Portal (SSP) for Provider Portal Trusted Users and explains how to perform all functions in the Provider Portal.

## 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.	 <p>From the <b>Self-Service Portal</b> home screen, click the <b>Provider</b> tab.</p>



STEPS	INSTRUCTIONS
2.	 <p>The screenshot shows the Louisiana Department of Health website. The 'Public' tab is selected, and the 'Provider' tab is highlighted. Below the tabs, there is a banner image of a healthcare professional using a laptop. Underneath the banner, there are links for 'Are you a Partner?' and 'Helpful Links'. A text block explains the role of a partner and provides instructions on how to login or enroll. A red box highlights the 'LOGIN &amp; ENROLLMENT' button.</p> <p><b>Result:</b> The <b>Provider</b> tab displays.</p> <p>From the <b>Provider</b> tab, click the <b>Login &amp; Enrollment</b> button.</p>

STEPS	INSTRUCTIONS
3.	<div data-bbox="337 226 1409 1100">  <p><b>Provider Portal User Login &amp; Registration</b></p> <p><b>LOGIN</b></p> <p>* User ID <input type="text"/> <a href="#">I forgot my User ID</a></p> <p>* Password <input type="password"/> <a href="#">I forgot my Password</a></p> <p><a href="#">Resend Confirmation Email</a> <input type="button" value="LOGIN"/></p> <p><b>CREATE AN ACCOUNT</b></p> <p>To submit forms on behalf of providers, you must first create a User account.</p> <p><a href="#">Click here to create your User Account.</a></p> <p>If you would like to manually complete a form, the required forms can be found <a href="#">here</a>.</p> <p><input type="button" value="BACK TO HOME PAGE"/></p> </div> <p><b>Result:</b> The <b>Provider Portal User Login &amp; Registration</b> screen displays.</p> <p>Click the <b><u>Click here to create your User Account</u></b> hyperlink in the <b>Create an Account</b> section.</p>

STEPS	INSTRUCTIONS										
4.	<p><b>CREATE A PROVIDER PORTAL TRUSTED USER ACCOUNT</b></p> <hr/> <p><b>SETTING UP YOUR ACCOUNT</b></p> <p>There are four steps to setting up a secure account. After completing the four steps on this page, you will be able to login to your new account. Keep in mind that this is a secure website run by the Louisiana Department of Health. By law, we must keep your information private and secure. If you already have an online account, <a href="#">click here to log in to your account.</a></p> <p>If you have questions about setting up your account, please email the Medicaid Eligibility Systems Section at <a href="mailto:EligibilitySystemsSection@la.gov">EligibilitySystemsSection@la.gov</a>.</p> <p>Some items have an asterisk (*) next to them. You must fill these items in before you can create your account.</p> <hr/> <p><b>STEP 1: YOUR CONTACT INFORMATION</b></p> <div style="border: 2px solid red; padding: 10px;"> <p>Please fill in your name and email address below.</p> <p>* First Name: <input type="text"/> Middle Name: <input type="text"/> * Last Name: <input type="text"/></p> <p>In order to setup an account, you are required to enter an email address.</p> <p>* Email Address: <input type="text"/></p> <p>* Confirm Email Address: <input type="text"/></p> <p>Phone Number (this number must have text messaging capabilities): <input type="text"/> - <input type="text"/> - <input type="text"/></p> </div>										
	<p><b>Result:</b> The <b>Create A Provider Portal Trusted User Account</b> screen displays.</p> <p><i>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.</i></p> <p>There are four steps to create a Trusted User account:</p> <table border="1"> <thead> <tr> <th>Section</th><th>Description</th></tr> </thead> <tbody> <tr> <td><b>Step 1:</b> Your Contact Information</td><td>Enter <b>First Name, Middle Name, Last Name, Email Address, and Phone Number</b></td></tr> <tr> <td><b>Step 2:</b> Account Credentials</td><td>Create a User ID, Password, and PIN</td></tr> <tr> <td><b>Step 3:</b> Security Check</td><td>Enter the characters from the CAPTCHA image exactly as they display in the text field provided</td></tr> <tr> <td><b>Step 4:</b> Confirm Your Email Address</td><td>Confirm the email address associated to the account by clicking the hyperlink in the confirmation email.</td></tr> </tbody> </table>	Section	Description	<b>Step 1:</b> Your Contact Information	Enter <b>First Name, Middle Name, Last Name, Email Address, and Phone Number</b>	<b>Step 2:</b> Account Credentials	Create a User ID, Password, and PIN	<b>Step 3:</b> Security Check	Enter the characters from the CAPTCHA image exactly as they display in the text field provided	<b>Step 4:</b> Confirm Your Email Address	Confirm the email address associated to the account by clicking the hyperlink in the confirmation email.
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STEPS	INSTRUCTIONS
5.	<p><b>STEP 2: ACCOUNT CREDENTIALS</b></p> <p>To create an account, you will need to create a user ID, password, and PIN. For all of these, you should choose something that's easy for you to remember but hard for other people to guess. <b>Keep in mind that you will need your PIN when electronically signing anything you submit to LDH.</b></p> <div data-bbox="365 373 1372 703" style="border: 2px solid red; padding: 10px;"> <p>User IDs must have a minimum of 8 characters and a maximum of 64 characters. User IDs must contain at least 1 letter, and can contain numbers and the following special characters: " _ , ' @ , - , . " (underscore, at symbol, hyphen, and period). User IDs cannot contain two consecutive allowable special characters.</p> <p>* User ID: <input type="text"/></p> <p>Password must have a minimum of 8 characters and contain at least 2 of the following 3 categories: Numeric Character (0-9), English Uppercase (A-Z), and special characters ( ! @ # \$ % ^ &amp; * ( ) _ + [ = \   ; : ' " , &lt; &gt; )</p> <p>* Password: <input type="password"/></p> <p>* Retype Password: <input type="password"/></p> <p>PINs must consist of a combination of 6 base digits (0-9).</p> <p>* PIN: <input type="text"/></p> </div> <p>Create a <b>User ID, Password, and PIN</b> in the <b>Step 2: Account Credentials</b> section.</p>
6.	<p><b>STEP 3: SECURITY CHECK</b></p> <p>Please enter the letters and/or numbers you see below. If you cannot tell what letter or numbers are being displayed, click on the "Refresh" button and the system will display new letters and/or numbers. If you are using screen reader software or cannot tell what the letter and/or numbers are, you can click on the "Listen" button and the system will read them to you (please note: your computer must be able to play sound and your volume must be on for this to work).</p> <div data-bbox="381 1018 706 1081">  <div> <input type="button" value="Refresh"/> <input type="button" value="Listen"/> </div> </div> <p>* Enter the letters and/or numbers you see above: <input style="border: 2px solid red;" type="text"/></p> <div data-bbox="998 1291 1356 1333"> <input type="button" value="« PREVIOUS"/> <input style="border: 2px solid red;" type="button" value="CREATE ACCOUNT »"/> </div> <p>Enter the characters from the CAPTCHA image exactly as they display in the text field provided in the <b>Step 3: Security Check</b> section.</p> <p>Click the <b>Create Account</b> button.</p>
7.	<p><b>CONFIRM YOUR EMAIL ADDRESS</b></p> <div data-bbox="365 1638 1380 1701" style="border: 2px solid red; padding: 5px;"> <p>Please confirm that you have access to the email address you provided. <b>An email with a hyperlink has been sent to your email account.</b> Please check your email to click on the hyperlink inside of it to confirm your email address. It may take up to 10 minutes to receive the email.</p> </div> <div data-bbox="1242 1827 1364 1869" style="border: 2px solid red; text-align: center;"> <p>EXIT</p> </div>

STEPS	INSTRUCTIONS
	<p><b>Result:</b> The <b>Confirm Your Email Address</b> screen displays.</p> <p>Click the <b>Exit</b> button after reviewing the text on the screen.</p>
8.	<div data-bbox="337 436 1412 688">  </div> <p>The user checks their email for a unique link to confirm their email address. The user clicks that link.</p> <p><b>Result:</b> The <b>Account Update Successfully</b> screen displays. The user has created a trusted user account and can now log in to the Provider Portal.</p> <p>There is one final step. Users have to be associated to a provider, which is covered in Lesson 2.</p> <p>Click the <b>Next</b> button.</p> <div data-bbox="337 1092 1412 1234"> <div data-bbox="358 1125 435 1199">  </div> <div data-bbox="461 1092 1398 1234"> <p><b>Process Tip!</b></p> <p>For questions about setting up an account reach out to the Medicaid Eligibility Systems Section via email- <a href="mailto:medicaideligibilitysystems@la.gov">medicaideligibilitysystems@la.gov</a>.</p> </div> </div>

## STEPS

9.

## INSTRUCTIONS

**Provider Portal User Login & Registration**

**LOGIN**

\* User ID  [I forgot my User ID](#)

\* Password  [I forgot my Password](#)

[Resend Confirmation Email](#)

**LOGIN**

**CREATE AN ACCOUNT**

To submit forms on behalf of providers, you must first create a User account.  
Click [here](#) to create your User Account.

If you would like to manually complete a form, the required forms can be found [here](#).

[BACK TO HOME PAGE](#)

**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.	<div data-bbox="337 226 1411 1171"> <p><b>My Form Center</b></p> <hr/> <div data-bbox="386 323 464 407"></div> <div data-bbox="483 323 1321 382"> <p><b>REGISTER TO BE ASSOCIATED TO A PROVIDER</b>  Register to be associated to a Provider. You may use this link to associate for the initial registration and for adding additional providers.</p> </div> <hr/> <div data-bbox="386 457 464 541"></div> <div data-bbox="483 457 587 516"> <p><b>NEW FORMS</b>  Start new forms.</p> </div> <hr/> <div data-bbox="386 592 464 676"></div> <div data-bbox="483 592 656 646"> <p><b>INCOMPLETE FORMS</b>  Continue incomplete forms</p> </div> <hr/> <div data-bbox="386 726 464 810"></div> <div data-bbox="483 726 808 781"> <p><b>SUBMITTED FORMS</b>  Review form status, edit, or cancel submitted forms.</p> </div> <hr/> <div data-bbox="386 856 464 940"></div> <div data-bbox="483 856 974 915"> <p><b>UPDATE PROVIDER PROFILES</b>  Update information for your associated Providers such as their phone number.</p> </div> <hr/> <div data-bbox="386 991 464 1075"></div> <div data-bbox="483 991 906 1045"> <p><b>MANAGE MY ACCOUNT</b>  Change or reset your password, PIN, and other account information</p> </div> <hr/> </div> <p><b>Result:</b> The <b>My Form Center</b> screen displays.</p> <p>The first time a user accesses the Provider Portal as a representative, only the <b>Register to Be Associated to a Provider</b> and <b>Manage My Account</b> functions display.</p> <div data-bbox="337 1407 1398 1644"> <div data-bbox="358 1444 436 1528"></div> <div data-bbox="461 1407 1360 1612"> <p><b>Process Tip!</b>  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 <b>MUST</b> register to be associated to a provider. This is covered in Lesson 2.</p> </div> </div>

## 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 <i>Lesson 1: Accessing the Self-Service Portal for Providers</i> to navigate to the <b>My Form Center</b> screen.
2.	<div><p><b>My Form Center</b></p><div><b>REGISTER TO BE ASSOCIATED TO A PROVIDER</b> Register to be associated to a Provider. You may use this link to associate for the initial registration and for adding additional providers.</div><div><b>NEW FORMS</b> Start new forms.</div><div><b>INCOMPLETE FORMS</b> Continue incomplete forms</div><div><b>SUBMITTED FORMS</b> Review form status, edit, or cancel submitted forms.</div><div><b>UPDATE PROVIDER PROFILES</b> Update information for your associated Providers such as their phone number.</div><div><b>MANAGE MY ACCOUNT</b> Change or reset your password, PIN, and other account information</div></div> <p><b>Result:</b> The <b>My Form Center</b> screen displays.</p> <p>Click the <b><u>Register to be Associated to a Provider</u></b> hyperlink.</p>

STEPS	INSTRUCTIONS
3.	<div data-bbox="386 268 776 310"> <h2>Provider Portal Registration</h2> </div> <div data-bbox="386 363 506 384"> <p><b>INSTRUCTIONS</b></p> </div> <div data-bbox="386 420 1347 489"> <p>In order to associate with a provider(s) or associate to additional providers, you will need to fill out the form below and accept the terms of the Confidentiality Responsibilities Agreement. When you created your account, you were required to add a PIN. A PIN is a 6 digit code used when submitting this form. If you have forgotten your PIN, you may navigate to your Manage My Account screen to update this number.</p> </div> <div data-bbox="305 525 324 546">1</div> <div data-bbox="386 552 626 573"> <p><b>YOUR CONTACT INFORMATION</b></p> </div> <div data-bbox="386 606 1050 630"> <p>If you would like to edit the information displayed below, please navigate to the <a href="#">Manage My Account</a> page</p> </div> <div data-bbox="386 665 1047 812"> <p>First Name Middle Name Last Name</p> <p>Email Address</p> <p>Phone Number:</p> </div> <div data-bbox="305 844 324 865">2</div> <div data-bbox="386 850 579 871"> <p><b>PROVIDER ASSOCIATION</b></p> </div> <div data-bbox="386 905 912 926"> <p>Please enter the exact Provider Number in the box below and hit the Search button.</p> </div> <div data-bbox="386 966 833 1001"> <p>* Provider Number: <input type="text"/> <input type="button" value="SEARCH"/></p> </div> <div data-bbox="386 1066 781 1087"> <p><b>CONFIDENTIALITY RESPONSIBILITIES AGREEMENT</b></p> </div> <div data-bbox="386 1148 1320 1218"> <p>Federal Medicaid regulations, 42 CFR 431.300 et seq., and Louisiana law, R.S. 46:56, restrict the use or disclosure of information concerning applicants/enrollees to purposes directly connected with the administration of Medicaid. Federal regulations at 45 CFR Parts 160 and 164 govern the privacy and security of individually identifiable health information (HIPAA Privacy and Security Rules.)</p> </div> <div data-bbox="386 1257 779 1278"> <p>Purposes directly related to the Medicaid program include:</p> </div> <div data-bbox="386 1281 1364 1302"> <p>&lt; &gt;</p> </div> <div data-bbox="386 1335 1234 1358"> <p><input type="checkbox"/> *Please check the box to let us know that you have read and agreed to the Confidentiality Responsibilities Agreement above.</p> </div> <div data-bbox="386 1398 1364 1423"> <p>* First Name: <input type="text"/> * Last Name: <input type="text"/> * User PIN: <input type="text"/></p> </div> <div data-bbox="1117 1562 1364 1593"> <p><input type="button" value="« PREVIOUS"/> <input type="button" value="SUBMIT"/></p> </div> <div data-bbox="336 1654 1104 1690"> <p><b>Result:</b> The <b>Provider Portal Registration</b> screen displays.</p> </div>

STEPS	INSTRUCTIONS	
	Section	Description
	<p style="text-align: center;"><b>1</b></p> <p style="text-align: center;"><b>Your Contact Information</b></p>	<p>The <b>Your Contact Information</b> section pre-populates the following information from the information entered when creating a Provider Portal account:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Email Address</li> <li>• Phone Number</li> </ul>
	<p style="text-align: center;"><b>2</b></p> <p style="text-align: center;"><b>Provider Association</b></p>	<p>Enter the <b>Provider Number</b> that will be associated to the account, then click the <b>Search</b> button.</p> <p><b>Note:</b> LaMEDS pre-populates the following information associated with the Provider Number entered:</p> <ul style="list-style-type: none"> <li>• <b>Provider Name</b></li> <li>• <b>Provider Address</b></li> <li>• <b>Provider Type Code</b></li> </ul> <p>After this information pre-populates, enter the following information for the provider:</p> <ul style="list-style-type: none"> <li>• <b>Manager's First Name</b></li> <li>• <b>Manager's Last Name</b></li> <li>• <b>Manager's Phone Number</b></li> </ul> <p>To associate additional Providers, click the <b>Add</b> button.</p> <p>To remove a provider, click the <b>Delete</b> icon next to the <b>Search</b> button. Please note that association to at least one provider is required.</p>
	<p style="text-align: center;"><b>3</b></p> <p style="text-align: center;"><b>Confidentiality Responsibilities Agreement</b></p>	<p>Read the <b>Confidentiality Responsibilities Agreement</b> carefully and check the box next to the following statement: <b>"Please check the box to let us know that you have read and agreed to the Confidentiality Responsibilities Agreement above"</b>.</p> <p>Sign the form by entering your <b>First Name</b>, <b>Last Name</b>, and <b>PIN</b> into the appropriate fields.</p>
	Click the <b>Submit</b> button to continue.	

STEPS

INSTRUCTIONS

4.

Registration Confirmation

You have completed the form and the information has been sent for processing. You can check on a form's status by navigating to the Submitted Forms screen.

FORM SUMMARY

If you would like to review the form that you submitted and print or save a copy for your files, please click the Print PDF button below.

PRINT PDF

Keep in mind that you'll need to have a program called Adobe Acrobat Reader to see and print the summary. If you don't have this program on your computer, you may install it for free by clicking on the button below:

FORM DETAILS

If you would like to check the status after navigating away from this screen, you may do so by going to the Submitted Forms screen and clicking the [View Form Status](#) link.

PROVIDER NAME / PROVIDER ID / FORM SUBTYPE	SUBMITTED DATE	CONTACT PERSON / APPLICANT	FORM STATUS
No data found.			

« BACK TO FORM CENTER

**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.



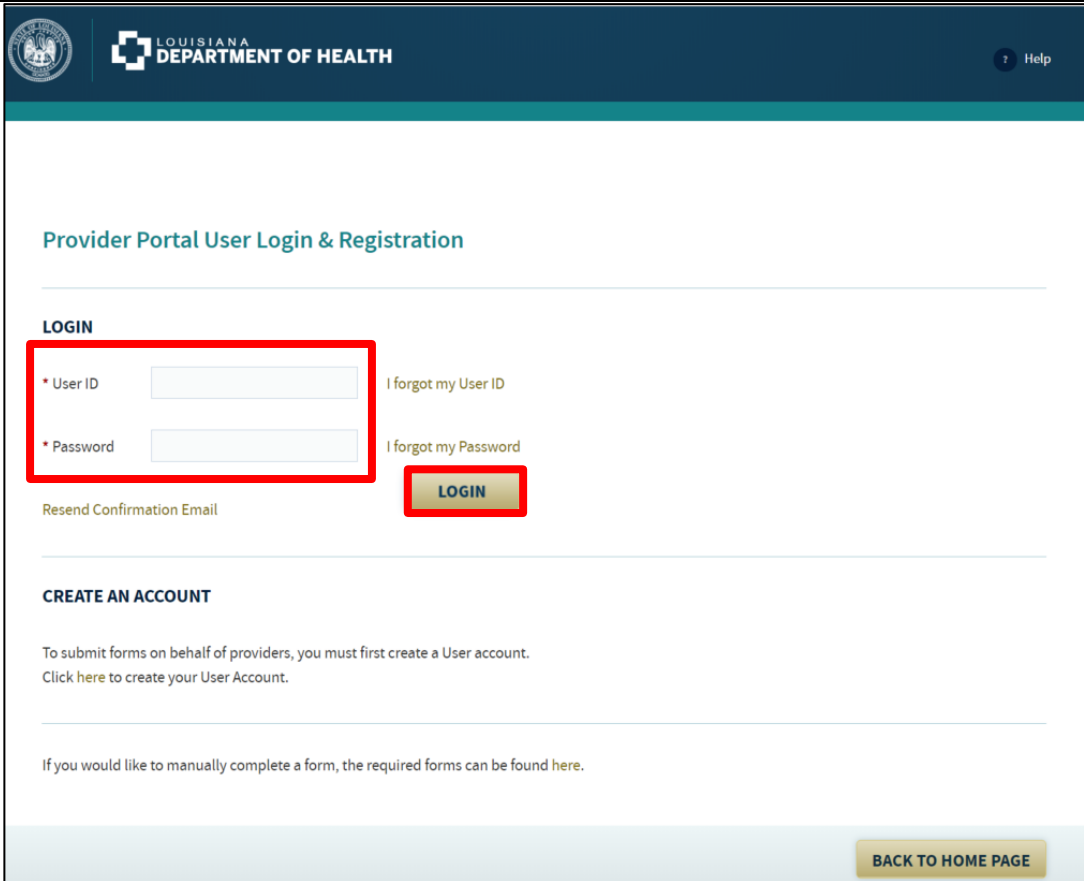
## Lesson 3: Account Management

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.	<div><p>The screenshot displays the 'Provider Portal User Login &amp; Registration' page. At the top, there is a header with the Louisiana Department of Health logo and a 'Help' link. The main content area is titled 'Provider Portal User Login &amp; Registration'. Under the 'LOGIN' section, there are two input fields: '* User ID' and '* Password'. To the right of each field is a link: 'I forgot my User ID' and 'I forgot my Password'. Below the password field is a 'Resend Confirmation Email' link. A prominent 'LOGIN' button is located to the right of the password field. Below the login section is a 'CREATE AN ACCOUNT' section with instructions: 'To submit forms on behalf of providers, you must first create a User account. Click <a href="#">here</a> to create your User Account.' At the bottom of the page, there is a link: 'If you would like to manually complete a form, the required forms can be found <a href="#">here</a>.' A 'BACK TO HOME PAGE' button is located at the bottom right of the page.</p></div> <p>From the <b>Provider Portal User Login &amp; Registration</b> screen, enter the <b>User ID</b> and <b>Password</b> associated to the account into the fields and click the <b>Login</b> button.</p>

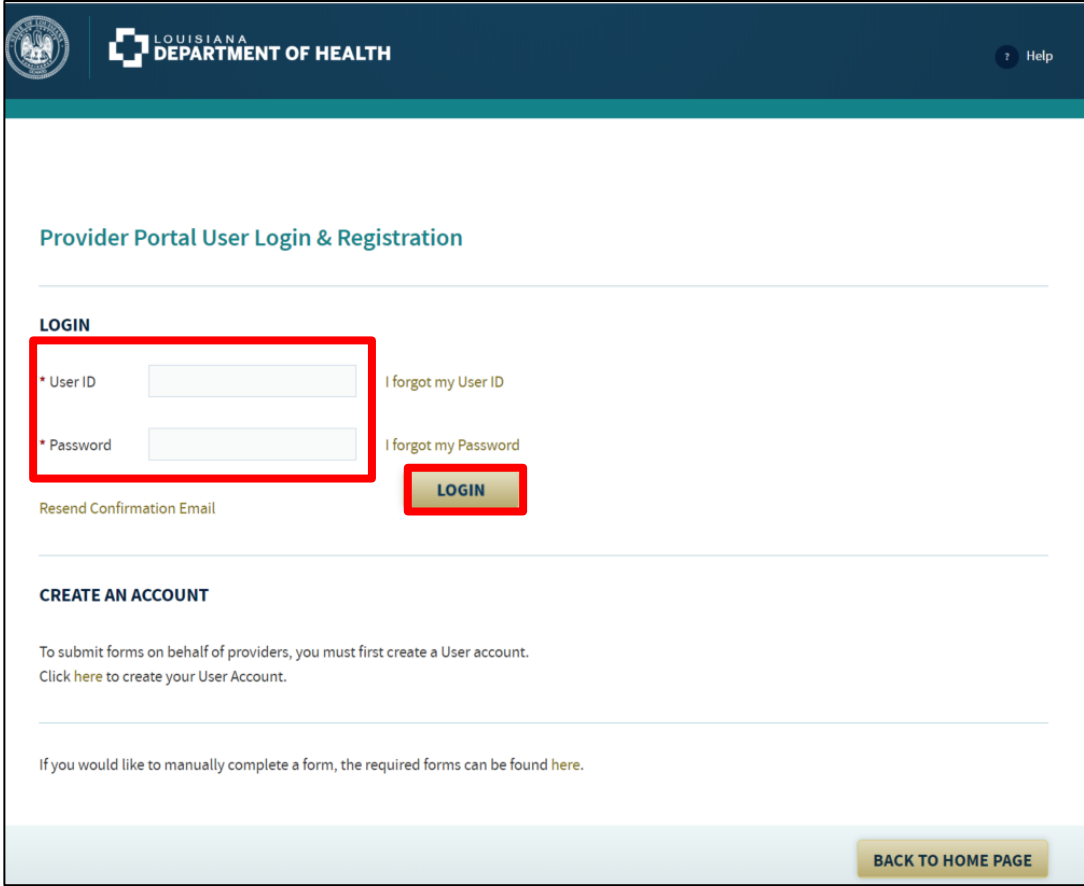
STEPS	INSTRUCTIONS
2.	<div data-bbox="386 247 548 279">My Form Center</div> <div data-bbox="386 331 467 415"></div> <div data-bbox="483 331 836 357"><b>REGISTER TO BE ASSOCIATED TO A PROVIDER</b></div> <div data-bbox="483 363 1323 388">Register to be associated to a Provider. You may use this link to associate for the initial registration and for adding additional providers.</div> <div data-bbox="386 468 467 552"></div> <div data-bbox="483 468 581 493"><b>NEW FORMS</b></div> <div data-bbox="483 499 587 525">Start new forms.</div> <div data-bbox="386 604 467 688"></div> <div data-bbox="483 604 646 627"><b>INCOMPLETE FORMS</b></div> <div data-bbox="483 634 657 659">Continue incomplete forms</div> <div data-bbox="386 739 467 823"></div> <div data-bbox="483 739 636 762"><b>SUBMITTED FORMS</b></div> <div data-bbox="483 768 808 793">Review form status, edit, or cancel submitted forms.</div> <div data-bbox="386 865 467 949"></div> <div data-bbox="483 865 711 890"><b>UPDATE PROVIDER PROFILES</b></div> <div data-bbox="483 896 974 921">Update information for your associated Providers such as their phone number.</div> <div data-bbox="386 1001 467 1085"></div> <div data-bbox="483 1001 657 1026"><b>MANAGE MY ACCOUNT</b></div> <div data-bbox="483 1033 906 1058">Change or reset your password, PIN, and other account information</div>
	<p><b>Result:</b> The <b>My Form Center</b> screen displays.</p> <p>Click the <b><u>Manage My Account</u></b> hyperlink to continue.</p>

STEPS	INSTRUCTIONS
3.	<div data-bbox="407 226 1346 1119"> <div> <b>Manage My Account</b> <p>Welcome to Manage My Account. Use the fields below to update your account information. Once you have updated your account information, click on the "Update Account" button to save your changes.</p> <p>You can also change your password by clicking on the link in the "Change Your Password" section on this page.</p> <p>If you would like to return to your My Form Center Page, click on the "Previous" button.</p> </div> <div> <b>Change Your Password</b> <p>You will be required to enter your username and password again. We ask you to provide this to protect your privacy.</p> <p><a href="#">Click here to change your password.</a></p> </div> <div> <b>Update Your Contact Information</b> <p>Update your contact information in the fields below.</p> <p>*First Name: <input type="text" value="Susan"/> Middle Name: <input type="text"/> *Last Name: <input type="text" value="Smith"/></p> <p>*Email Address: <input type="text" value="susansmith@gmail.com"/></p> <p>*Confirm Email Address: <input type="text" value="susansmith@gmail.com"/></p> <p>Phone Number (this number must have text messaging capabilities): <input type="text" value="243"/> <input type="text" value="555"/> <input type="text" value="5242"/></p> </div> <div> <b>Current PIN Number</b> <p>Update your PIN in the field below. Keep in mind that you will need your PIN when electronically signing anything you submit to LDH. So it's a good idea to write this down and keep it in a safe place.</p> <p>*PIN: <input type="text" value="*****"/> PIN must be 6 digits long and can only contain numeric characters (0-9).</p> </div> <div> <b>User Acceptance Agreement</b> <div> <p>General</p> <p>This Website ("Website") is offered to you, the user ("User"), conditionally upon acceptance of the terms and conditions herein, without modification. User access and use of this site constitutes acceptance of these terms and conditions.</p> <p>This Website is a State of Louisiana ("State") computer system, provided as a public service. Authorized users may use this system to conduct business with the State. User agrees, therefore, not to: 1) knowingly and without authorization, alter, damage, or destroy the State's or another user's computer system, network, software, program, documentation or</p> </div> <p><input type="checkbox"/> *Please check the box to let us know that you have read and agreed to the Louisiana Department of Health User Acceptance Agreement above.</p> </div> <div> <div>PREVIOUS</div> <div>UPDATE ACCOUNT</div> </div> </div> <p><b>Note to LDH:</b> This is not a final screen shot.</p> <p><b>Result:</b> The <b>Manage My Account</b> screen displays.</p> <p>The <b>Manage My Account</b> screen has the following sections:</p> <ul style="list-style-type: none"> <li>• <b>Change Your Password:</b> This section provides a link to change the password associated to the account.</li> <li>• <b>Update Your Contact Information:</b> This section allows user to edit the following information: <ul style="list-style-type: none"> <li>○ First Name</li> <li>○ Last Name</li> <li>○ Email Address</li> <li>○ Phone Number</li> </ul> </li> <li>• <b>Current PIN:</b> 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.</li> <li>• <b>User Acceptance Agreement:</b> 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.</li> </ul>

STEPS	INSTRUCTIONS
	Click the <b>Update Account</b> 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.	<div data-bbox="337 485 1414 1365"></div> <p>From the <b>Provider Portal User Login &amp; Registration</b> screen, enter the <b>User ID</b> and <b>Password</b> associated to the account and click the <b>Login</b> button.</p>

STEPS	INSTRUCTIONS
2.	<div data-bbox="341 241 1421 1150"> <p><b>My Form Center</b></p> <hr/> <div data-bbox="370 338 456 422"></div> <div data-bbox="467 338 839 363"><b>REGISTER TO BE ASSOCIATED TO A PROVIDER</b></div> <div data-bbox="467 371 1341 396">Register to be associated to a Provider. You may use this link to associate for the initial registration and for adding additional providers.</div> <hr/> <div data-bbox="370 478 456 562"></div> <div data-bbox="467 478 573 499"><b>NEW FORMS</b></div> <div data-bbox="467 510 579 531">Start new forms.</div> <hr/> <div data-bbox="370 613 456 697"></div> <div data-bbox="467 613 643 636"><b>INCOMPLETE FORMS</b></div> <div data-bbox="467 646 651 669">Continue incomplete forms</div> <hr/> <div data-bbox="370 751 456 835"></div> <div data-bbox="467 751 631 774"><b>SUBMITTED FORMS</b></div> <div data-bbox="467 783 808 806">Review form status, edit, or cancel submitted forms.</div> <hr/> <div data-bbox="370 888 456 972"></div> <div data-bbox="467 888 711 911"><b>UPDATE PROVIDER PROFILES</b></div> <div data-bbox="467 919 980 945">Update information for your associated Providers such as their phone number.</div> <hr/> <div data-bbox="370 1026 456 1110"></div> <div data-bbox="467 1026 652 1050"><b>MANAGE MY ACCOUNT</b></div> <div data-bbox="467 1058 909 1081">Change or reset your password, PIN, and other account information</div> <hr/> </div> <p><b>Result:</b> The <b>My Form Center</b> screen displays.</p> <p>Click the <b><u>Update Provider Profiles</u></b> hyperlink to continue.</p>

## STEPS

3.

## INSTRUCTIONS

### UPDATE INFORMATION

Select the "Update" check-box next to all the rows that you would like to update. Select the "Delete" check-box next to all the rows that you would like to remove. Then click the "Next" button to navigate to the selected update screens.

PROVIDER NAME	PROVIDER ID	PROVIDER PHONE #	PROVIDER ADDRESS	MANAGER NAME / MANAGER PHONE	ACTION
Amit	11000	Phone: 123-456-7890	ALONE	Name: Amit Agarwal Phone: 123-456-7890	<input type="checkbox"/> Update <input type="checkbox"/> Delete
Sumit	11002	Phone: 123-456-7890	ALONE	Name: Amit Agarwal Phone: 123-456-7890	<input type="checkbox"/> Update <input type="checkbox"/> Delete
Ram	11003	Phone: 123-456-7890	ALONE	Name: Amit Agarwal Phone: 123-456-7890	<input type="checkbox"/> Update <input type="checkbox"/> Delete
Shyam	11004	Phone: 123-456-7890	ALONE	Name: Amit Agarwal Phone: 123-456-7890	<input type="checkbox"/> Update <input type="checkbox"/> Delete
Yogesh	11005	Phone: 123-456-7890	ALONE	Name: Amit Agarwal Phone: 123-456-7890	<input type="checkbox"/> Update <input type="checkbox"/> Delete
Divya	11006	Phone: 123-456-7890	ALONE	Name: Amit Agarwal Phone: 123-456-7890	<input type="checkbox"/> Update <input type="checkbox"/> Delete
SULTan	11007	Phone: 123-456-7890	ALONE	Name: Amit Agarwal Phone: 123-456-7890	<input type="checkbox"/> Update <input type="checkbox"/> Delete

« BACK TO FORM CENTER

NEXT »

**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.	<div data-bbox="345 300 1396 1108"> <h3>Update Provider Details</h3> <hr/> <p><b>PROVIDER DETAILS</b></p> <p>Edit the fields that you would like to update. Then click the "Next" or "Submit" button to accept your changes.</p> <p>Provider Number: 10000</p> <p>Provider Name: Amit</p> <p>Provider Address: ALONE</p> <p>Please enter the phone number that will be used for notifications related to Amit below.</p> <div style="border: 2px solid red; padding: 10px;"> <p>* Phone Number: <input type="text" value="123"/> - <input type="text" value="456"/> - <input type="text" value="7890"/> Ext.: <input type="text" value="123456"/></p> <p>Please enter your manager's contact information below.</p> <p>* First Name: <input type="text" value="Amit"/> * Last Name: <input type="text" value="Agarwal"/></p> <p>* Phone Number: <input type="text" value="123"/> - <input type="text" value="456"/> - <input type="text" value="7890"/> Ext.: <input type="text" value="123456"/></p> </div> <div style="text-align: right; margin-top: 20px;"> <input type="button" value="« PREVIOUS"/> <input style="border: 2px solid red;" type="button" value="SUBMIT"/> </div> </div> <p><b>Result:</b> The <b>Provider Details</b> screen displays.</p> <p>The information at the top of the <b>Provider Details</b> 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 <i>can</i> be updated.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Manager's First Name</li> <li>• Manager's Last Name</li> <li>• Manager's Phone Number</li> </ul> <p>If multiple providers were selected on the <b>Update Information</b> screen, click the <b>Next</b> button to update the information for the next provider selected. After reaching the last provider selected, the <b>Submit</b> button displays.</p> <p>Click the <b>Submit</b> button to save the updates made to the provider information.</p>



STEPS	INSTRUCTIONS
5.	<div data-bbox="337 226 1416 537"><p data-bbox="386 289 737 310"><b>PROVIDER DETAILS UPDATED SUCCESSFULLY</b></p><p data-bbox="386 321 1162 342">Your provider details have been updated successfully. Please click the button below to return to your My Forms Center page.</p><hr data-bbox="386 373 1370 378"/><div data-bbox="1122 470 1365 520"><a data-bbox="1146 485 1341 506" href="#">« BACK TO FORM CENTER</a></div></div> <p data-bbox="337 575 1252 609"><b>Result:</b> The <b>Provider Details Updated Successfully</b> screen displays.</p> <p data-bbox="337 640 1382 674">Click the <b>Back to Form Center</b> button to return to the <b>My Forms Center</b> screen.</p>

## Lesson 4: Submitting a New Form

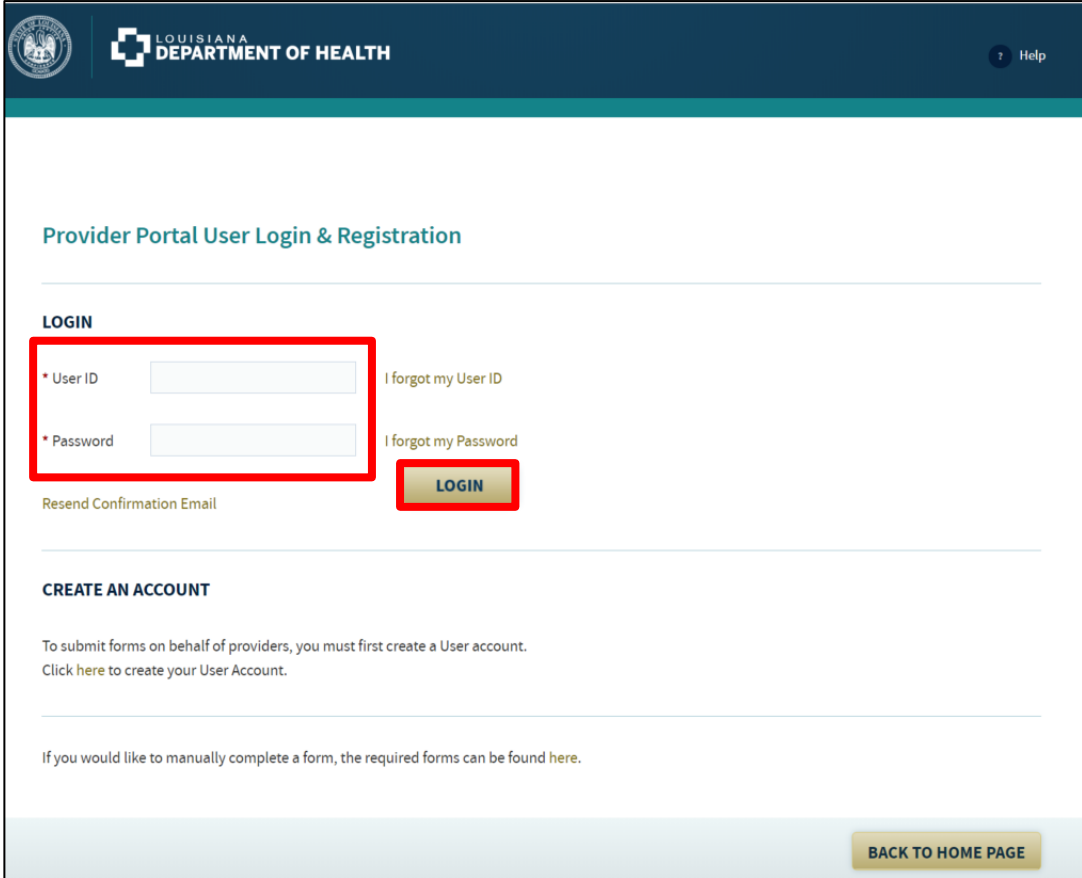
The New Forms screen is where users perform the majority of their work in the Provider Portal. This screen is where Providers submit forms on behalf of applicants, enrollees, or newborns. The New Forms screen has four sections:







- **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.	<div data-bbox="337 367 1412 1239"></div> <p>From the <b>Provider Portal User Login &amp; Registration</b> screen, enter the <b>User ID</b> and <b>Password</b> associated to the provider account into the fields and click the <b>Login</b> button.</p>

STEPS	INSTRUCTIONS
2.	<div data-bbox="337 233 1409 1171"> <h3>My Form Center</h3> <hr/> <div>  <b>REGISTER TO BE ASSOCIATED TO A PROVIDER</b>            Register to be associated to a Provider. You may use this link to associate for the initial registration and for adding additional providers.         </div> <hr/> <div>  <b>NEW FORMS</b>            Start new forms.         </div> <hr/> <div>  <b>INCOMPLETE FORMS</b>            Continue incomplete forms         </div> <hr/> <div>  <b>SUBMITTED FORMS</b>            Review form status, edit, or cancel submitted forms.         </div> <hr/> <div>  <b>UPDATE PROVIDER PROFILES</b>            Update information for your associated Providers such as their phone number.         </div> <hr/> <div>  <b>MANAGE MY ACCOUNT</b>            Change or reset your password, PIN, and other account information         </div> <hr/> </div> <p><b>Result:</b> The <b>My Form Center</b> screen displays.</p> <p>Select the <b><u>New Forms</u></b> hyperlink.</p>
3.	<div data-bbox="337 1352 1409 1738"> <h3>New Forms</h3> <hr/> <p><b>SELECT PROVIDER</b></p> <p>* Please select the Provider you are working for during this session: <span>Amit</span> <span>1</span></p> <hr/> <p><b>SELECT FORM TYPE</b></p> <p>* Form Type: <span>2</span> <span>148W (OAAS)</span> * Form Subtype: <span>148 Admission</span></p> </div> <p><b>Result:</b> The <b>New Forms</b> screen displays.</p>

STEPS		INSTRUCTIONS							
		<table border="1"> <thead> <tr> <th>Section</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td> <p><b>1</b></p> <p><b>Select Provider</b></p> </td> <td> <p>Select the provider for whom you are submitting a form. The <b>Select Provider</b> drop-down is the only field that displays when the screen first loads.</p> <p>This drop-down lists all approved providers associated to a user's profile. After selecting a provider, the subsequent fields display.</p> </td> </tr> <tr> <td> <p><b>2</b></p> <p><b>Select Form Type</b></p> </td> <td> <p>Select the desired provider form from the <b>Form Type &amp; Form Subtype</b> drop-downs.</p> <p>The <b>Form Type</b> and <b>Form Subtype</b> 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.</p> </td> </tr> </tbody> </table>	Section	Description	<p><b>1</b></p> <p><b>Select Provider</b></p>	<p>Select the provider for whom you are submitting a form. The <b>Select Provider</b> drop-down is the only field that displays when the screen first loads.</p> <p>This drop-down lists all approved providers associated to a user's profile. After selecting a provider, the subsequent fields display.</p>	<p><b>2</b></p> <p><b>Select Form Type</b></p>	<p>Select the desired provider form from the <b>Form Type &amp; Form Subtype</b> drop-downs.</p> <p>The <b>Form Type</b> and <b>Form Subtype</b> 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.</p>	
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		<div> <div> <b>3</b> </div> <div> <p><b>APPLICANT SEARCH</b></p> <p>Do you have the Medicaid ID Number? <input type="text" value="No"/> <input type="button" value="RESET"/></p> <p>Do you have the Social Security Number? <input type="text" value="No"/></p> <p>First Name: <input type="text"/> Middle Name: <input type="text"/> * Last Name: <input type="text"/> Suffix: <input type="text"/></p> <p>Date of Birth: <input type="text" value="mm/dd/yyyy"/> * Sex: <input type="radio"/> Male <input type="radio"/> Female</p> <p>Residential Street Address: <input type="text"/></p> <p>pt., Suite, etc.: <input type="text"/></p> <p>City: <input type="text"/> * State: <input type="text"/> * Zip Code: <input type="text"/></p> <p><input type="button" value="SEARCH"/></p> </div> </div>							

STEPS	INSTRUCTIONS	
	Section	Description
4	<p>3</p> <p><b>Applicant Search</b></p>	<p>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.</p> <p>There are two key questions in the Applicant Search section: <i>Do you have the Medicaid ID Number?</i> and <i>Do you have the Social Security Number?</i> A few scenarios can occur depending on the answer to these two questions.</p> <ol style="list-style-type: none"> <li>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.</li> <li>2. The second scenario occurs when users <b>do not</b> have the Medicaid ID number, but do have the Social Security Number. In this scenario, enter as much information as possible for the individual: <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• Date of Birth</li> <li>• Sex</li> </ul> <p>Click the <b>Search</b> button to view the Search Results Table. Once the search results for the individual display, click the <b>Select</b> checkbox in the <b>Action</b> column to select the correct result.</p> </li> <li>3. The third scenario is when users <b>do not</b> have the Medicaid ID number and <b>do not</b> have the Social Security Number. In this case, enter all other known information for the individual: <ul style="list-style-type: none"> <li>• Residential Street Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> </ul> <p>Select the <b>Search</b> button to view the Search Results Table. Once the search results for the individual display, click the <b>Select checkbox</b> in the <b>Action</b> column for the correct individual.</p> </li> </ol>
	<div>  <p><b>Process Tip!</b> When users fill out the search parameters on the <b>New Form</b> 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.</p> </div>	

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STEPS	INSTRUCTIONS						
4.	<div>148 Admission</div> <div> <div>1</div> <div>SUBMITTING PROVIDER</div> <div> Submitting Provider: Amit  Facility Representative: Amit Agarwal </div> </div> <div> <div>2</div> <div>PARTICIPANT INFORMATION</div> <div> <div> * First Name: <input type="text"/> Middle Name: <input type="text"/> * Last Name: <input type="text"/> Suffix: <input type="text"/> </div> <div> * Sex: <input type="radio"/> Male <input type="radio"/> Female * Date of Birth: <input type="text"/> mm/dd/yyyy Social Security Number: <input type="text"/> - <input type="text"/> - <input type="text"/> </div> </div> </div> <p><b>Result:</b> The <b>148 Admission</b> screen displays.</p> <table> <tr> <th>Section</th><th>Description</th></tr> <tr> <td>1 <b>Submitting Provider</b></td><td>Displays the Provider for whom the form is submitted. The Submitting Provider and Facility Representative fields pre-populate with the information selected on the <b>New Forms</b> screen.</td></tr> <tr> <td>2 <b>Participant Information</b></td><td> <p>Displays the individual for whom the form is being submitted. If users are able to locate the individual on the <b>New Forms</b> screen either by entering his or her Medicaid ID Number or Social Security Number, known fields pre-populate.</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Male/Female</li> <li>• Date of Birth</li> <li>• Social Security Number</li> </ul> <p>If users need to update any of the information in the <b>Participant Information</b> section, select Yes from the <b>Do you need to make an update to the personal information below?</b> drop-down.</p> </td></tr> </table>	Section	Description	1 <b>Submitting Provider</b>	Displays the Provider for whom the form is submitted. The Submitting Provider and Facility Representative fields pre-populate with the information selected on the <b>New Forms</b> screen.	2 <b>Participant Information</b>	<p>Displays the individual for whom the form is being submitted. If users are able to locate the individual on the <b>New Forms</b> screen either by entering his or her Medicaid ID Number or Social Security Number, known fields pre-populate.</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Male/Female</li> <li>• Date of Birth</li> <li>• Social Security Number</li> </ul> <p>If users need to update any of the information in the <b>Participant Information</b> section, select Yes from the <b>Do you need to make an update to the personal information below?</b> drop-down.</p>
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STEPS	INSTRUCTIONS				
	<div> <div> <div>3</div> <div> <p><b>PARTICIPANT CONTACT INFORMATION</b></p> <p>* Residential Address: <input type="text"/></p> <p>Apt., Suite, etc.: <input type="text"/></p> <p>* City: <input type="text"/> * State: <input type="text"/> * Zip Code: <input type="text"/></p> <p>Phone: <input type="text"/> - <input type="text"/> - <input type="text"/></p> <p>* Is the mailing address the same as the residential address above? <input type="text"/></p> <p>* Mailing Address: <input type="text"/></p> <p>Apt., Suite, etc.: <input type="text"/></p> <p>* City: <input type="text"/> * State: <input type="text"/> * Zip Code: <input type="text"/></p> </div> </div> </div> <table> <tr> <th>Section</th><th>Description</th></tr> <tr> <td> <p>3</p> <p><b>Participant Contact Information</b></p> </td><td> <p>Similar to the <b>Participant Information</b> section, all fields in the <b>Participant Contact Information</b> section pre-populate with the individual's information if users were able to locate the individual on the <b>New Forms</b> screen.</p> <p>If users need to update any of the contact information that pre-populates for the individual, select <b>Yes</b> from the <b>Do you need to make an update to the address(es) and/or phone number below?</b> drop-down.</p> <p>If users selected the <b>New Person</b> checkbox on the <b>New Forms</b> screen, enter the following information for the individual:</p> <ul style="list-style-type: none"> <li>Residential Address</li> <li>Apt., Suite, Etc.</li> <li>City</li> <li>State</li> <li>Zip Code</li> <li>Phone</li> <li><i>Is the mailing address the same as the residential address above:</i> User selects <b>Yes</b> to this question, the mailing address section pre-populates with the residential address information.</li> </ul> </td></tr> </table>	Section	Description	<p>3</p> <p><b>Participant Contact Information</b></p>	<p>Similar to the <b>Participant Information</b> section, all fields in the <b>Participant Contact Information</b> section pre-populate with the individual's information if users were able to locate the individual on the <b>New Forms</b> screen.</p> <p>If users need to update any of the contact information that pre-populates for the individual, select <b>Yes</b> from the <b>Do you need to make an update to the address(es) and/or phone number below?</b> drop-down.</p> <p>If users selected the <b>New Person</b> checkbox on the <b>New Forms</b> screen, enter the following information for the individual:</p> <ul style="list-style-type: none"> <li>Residential Address</li> <li>Apt., Suite, Etc.</li> <li>City</li> <li>State</li> <li>Zip Code</li> <li>Phone</li> <li><i>Is the mailing address the same as the residential address above:</i> User selects <b>Yes</b> to this question, the mailing address section pre-populates with the residential address information.</li> </ul>
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STEPS	INSTRUCTIONS						
	<div> <div>4</div> <div>ADDITIONAL DETAILS</div> <div> Medicare No.: <input type="text"/> Insurance Co.: <input type="text"/> Parish: <input type="text"/> </div> <div> MBI: <input type="text"/> Policy #: <input type="text"/> Marital Status: <input type="text"/> </div> <div> * At admission, was the applicant receiving Waiver services? <input type="text"/> </div> </div>						
5	<div> <div>5</div> <div>ADMISSION INFORMATION</div> <div> * Date of Admission: <input type="text"/> </div> <div> * Is this the first time being admitted to a nursing facility?: <input type="text"/> </div> <div> Medicaid Copay Date (if applicable): <input type="text"/> </div> <div> * Source of Admission: <input type="text"/> </div> <div> * Intended Payment Source: <input type="text"/> </div> </div>						
	<table border="1"> <thead> <tr> <th>Section</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td> <div>4</div> <div>Additional Details</div> </td> <td> Enter the following information for the individual: <ul style="list-style-type: none"> <li>Medicare No.</li> <li>Insurance Co.</li> <li>Parish</li> <li>Medicare Beneficiary Identifier (MBI)</li> <li>Policy #</li> <li>Marital Status</li> <li>At admission, was the applicant receiving Waiver services?</li> </ul> </td> </tr> <tr> <td> <div>5</div> <div>Admission Information</div> </td> <td> Enter the following admission information for the individual: <ul style="list-style-type: none"> <li>Date of Admission</li> <li>Select <b>Yes</b> or <b>No</b> from the <b>Is this the first time being admitted to a nursing facility?</b> drop-down</li> <li>Medicaid Copay Date (if applicable)</li> <li>Select the appropriate source from the <b>Source of Admission</b> drop-down.</li> <li>Select the <b>Intended Payment Source</b> from the drop-down.</li> </ul> </td> </tr> </tbody> </table>	Section	Description	<div>4</div> <div>Additional Details</div>	Enter the following information for the individual: <ul style="list-style-type: none"> <li>Medicare No.</li> <li>Insurance Co.</li> <li>Parish</li> <li>Medicare Beneficiary Identifier (MBI)</li> <li>Policy #</li> <li>Marital Status</li> <li>At admission, was the applicant receiving Waiver services?</li> </ul>	<div>5</div> <div>Admission Information</div>	Enter the following admission information for the individual: <ul style="list-style-type: none"> <li>Date of Admission</li> <li>Select <b>Yes</b> or <b>No</b> from the <b>Is this the first time being admitted to a nursing facility?</b> drop-down</li> <li>Medicaid Copay Date (if applicable)</li> <li>Select the appropriate source from the <b>Source of Admission</b> drop-down.</li> <li>Select the <b>Intended Payment Source</b> from the drop-down.</li> </ul>
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STEPS	INSTRUCTIONS						
	<div> <div>6</div> <div>PERSONAL REPRESENTATIVE/CURATOR</div> <div>           * Do you need to add a Personal Representative/Curator? <input type="text"/> </div> </div> <div> <div>7</div> <div>ELECTRONIC SIGNATURE</div> <div>           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.         </div> <div>           * First Name: <input type="text"/>           * Last Name: <input type="text"/>           * PIN: <input type="text"/> </div> <div> <div>SAVE DRAFT</div> <div>CANCEL</div> <div>SUBMIT</div> </div> </div> <table> <tr> <th>Section</th><th>Description</th></tr> <tr> <td>6 Personal Representative/Curator</td><td>Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.</td></tr> <tr> <td>7 Electronic Signature</td><td>           Enter the following information for the provider representative to electronically sign the form:           <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul>           Click the <b>Submit</b> button.           <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen by clicking the <b>Save Draft</b> button and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p> </td></tr> </table>	Section	Description	6 Personal Representative/Curator	Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.	7 Electronic Signature	Enter the following information for the provider representative to electronically sign the form: <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul> Click the <b>Submit</b> button. <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen by clicking the <b>Save Draft</b> button and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>
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STEPS	INSTRUCTIONS								
5.	<div><h3>Form Confirmation</h3><p>You have completed the form and the information has been sent for processing. You can check on a form's status by navigating to the Submitted Forms screen.</p><h4>FORM SUMMARY</h4><p>If you would like to review the form that you submitted and print or save a copy for your files, please click the Print PDF button below.</p><div>PRINT PDF</div><p>Keep in mind that you'll need to have a program called Adobe Acrobat Reader to see and print the summary. If you don't have this program on your computer, you may install it for free by clicking on the button below:</p><div></div><hr/><h4>FORM DETAILS</h4><p>If you would like to check the status after navigating away from this screen, you may do so by going to the Submitted Forms screen and clicking the View Form Status link.</p><table><tr><th>PROVIDER NAME / PROVIDER ID / FORM SUBTYPE</th><th>SUBMITTED DATE</th><th>CONTACT PERSON / APPLICANT</th><th>FORM STATUS</th></tr><tr><td>Provider Name: Sultan Provider ID: 11007 Form Subtype: 148 Admission</td><td>01/30/2018</td><td>Rob Stark</td><td>Submitted</td></tr></table><hr/><div>« BACK TO FORM CENTER</div></div>	PROVIDER NAME / PROVIDER ID / FORM SUBTYPE	SUBMITTED DATE	CONTACT PERSON / APPLICANT	FORM STATUS	Provider Name: Sultan Provider ID: 11007 Form Subtype: 148 Admission	01/30/2018	Rob Stark	Submitted
PROVIDER NAME / PROVIDER ID / FORM SUBTYPE	SUBMITTED DATE	CONTACT PERSON / APPLICANT	FORM STATUS						
Provider Name: Sultan Provider ID: 11007 Form Subtype: 148 Admission	01/30/2018	Rob Stark	Submitted						

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

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




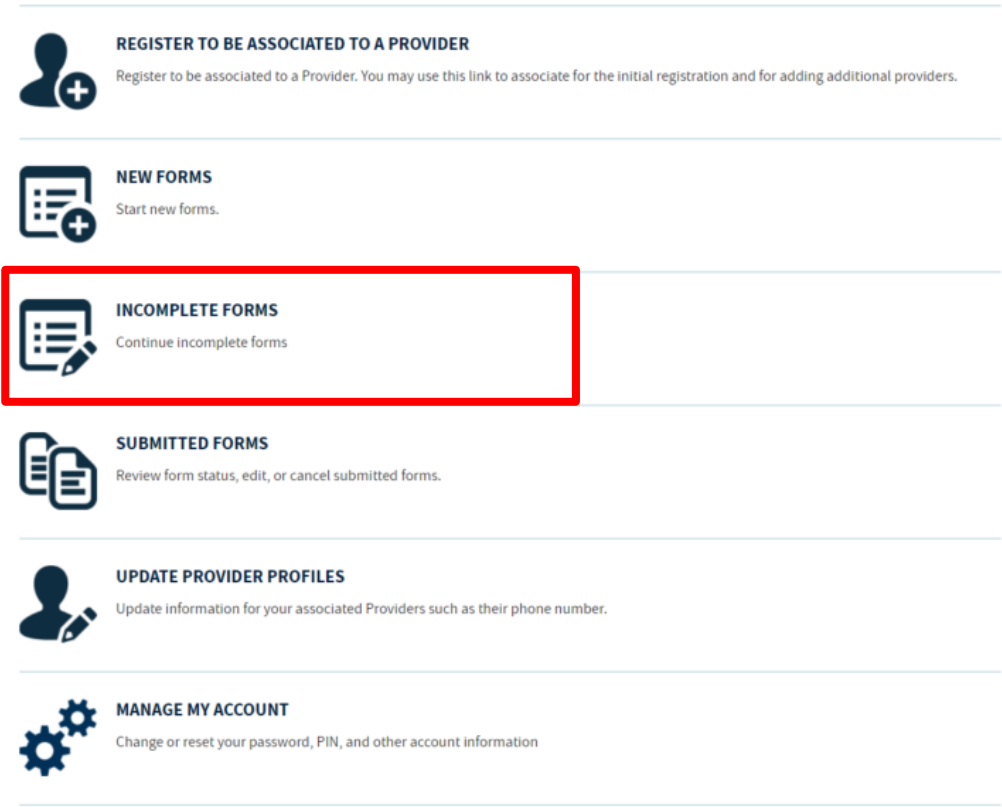
**Process Tip!**

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.

	<p><b>Process Tip!</b></p> <p>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.</p> <p>If a user wants to delete a form that is in <i>Incomplete</i> status, they will have to navigate to the form itself and click the <b>Cancel</b> button.</p>
---	---

STEPS	INSTRUCTIONS
1.	<div><p><b>My Form Center</b></p><p>The screenshot shows the 'My Form Center' interface with several options: 'REGISTER TO BE ASSOCIATED TO A PROVIDER', 'NEW FORMS', 'INCOMPLETE FORMS' (highlighted with a red box), 'SUBMITTED FORMS', 'UPDATE PROVIDER PROFILES', and 'MANAGE MY ACCOUNT'. Each option includes an icon and a brief description.</p></div> <p><b>Result:</b> The <b>My Form Center</b> screen displays.</p> <p>Click the <b>Incomplete Forms</b> hyperlink to continue.</p>


STEPS

2.





INSTRUCTIONS

INCOMPLETE FORMS

If you have started a form but have not yet submitted it, a "Continue your form" link will be displayed below. You can click on that link to return to your form. If you need to cancel a form from the list below, click on the "Continue your form" link and then click the "Cancel" button on the bottom of the form.



Please keep in mind, you have 30 days to complete and submit any incomplete forms. If a form is not submitted within 30 days, it will be deleted and you will need to start a new form.

PROVIDER NAME / PROVIDER ID	PROVIDER FORM TYPE	START DATE	CONTACT PERSON / APPLICANT	SUBMIT BY	CONTINUE
Provider Name: RAMGOOLAM ANDRES MD Provider ID: 1000011	TPL	01/09/2018	Caitlyn Stark	02/08/2018	 CONTINUE YOUR FORM
Provider Name: RAMGOOLAM ANDRES MD Provider ID: 1000011	142 BH	01/29/2018	Spongebob SquarePants	02/28/2018	 CONTINUE YOUR FORM
Provider Name: RAMGOOLAM ANDRES MD Provider ID: 1000011	142 BH	01/29/2018	Spongebob SquarePants	02/28/2018	 CONTINUE YOUR FORM
Provider Name: GREATHOUSE STEWART CMD Provider ID: 1150271	TPL	01/30/2018	Caitlyn Stark	03/01/2018	 CONTINUE YOUR FORM

« BACK TO FORM CENTER

**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.	<div data-bbox="341 388 1412 1354"><p><b>My Form Center</b></p><hr/><div data-bbox="373 483 1380 577"><b>REGISTER TO BE ASSOCIATED TO A PROVIDER</b> Register to be associated to a Provider. You may use this link to associate for the initial registration and for adding additional providers.</div><hr/><div data-bbox="373 619 1380 714"><b>NEW FORMS</b> Start new forms.</div><hr/><div data-bbox="373 756 1380 850"><b>INCOMPLETE FORMS</b> Continue incomplete forms</div><hr/><div data-bbox="349 871 941 997"><b>SUBMITTED FORMS</b> Review form status, edit, or cancel submitted forms.</div><hr/><div data-bbox="373 1029 1380 1123"><b>UPDATE PROVIDER PROFILES</b> Update information for your associated Providers such as their phone number.</div><hr/><div data-bbox="373 1165 1380 1260"><b>MANAGE MY ACCOUNT</b> Change or reset your password, PIN, and other account information</div><hr/></div> <p><b>Result:</b> The <b>My Form Center</b> screen displays.</p> <p>Click the <b><u>Submitted Forms</u></b> hyperlink to continue.</p>

STEPS

INSTRUCTIONS

4.

SUBMITTED FORMS

The table below displays forms you have submitted within the past 5 years. You can check the status, edit, and see a PDF copy of a form if it was submitted in the past 12 months by clicking on the "View Form Status" link in the table below. Please make sure that your date range filter is no greater than 1 month.

\* Provider Name:

\* Form Subtype:

\* From:

mm/dd/yyyy

\* To:

mm/dd/yyyy

FILTER »

« BACK TO FORM CENTER

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.

\* Provider Name:

RAMGOOLAM ANDRES MD

\* Form Subtype:

148 Transfer




\* From:

01/01/2018

\* To:

02/01/2018

FILTER »

PROVIDER NAME / PROVIDER ID	FORM SUBTYPE	SUBMITTED DATE	CONTACT PERSON / APPLICANT	ACTION
Provider Name: RAMGOOLAM ANDRES MD Provider ID: 1000011	148 Transfer	01/03/2018	John Smith	 VIEW FORM STATUS
Provider Name: RAMGOOLAM ANDRES MD Provider ID: 1000011	148 Transfer	01/24/2018	John Smith	 VIEW FORM STATUS
Provider Name: RAMGOOLAM ANDRES MD Provider ID: 1000011	148 Transfer	01/10/2018	CaseLTC Notes	 VIEW FORM STATUS

Result: The Submitted Forms results table displays

Click the View Form Status hyperlink to continue.



STEPS	INSTRUCTIONS																	
6.	<div><div>FORM STATUS CHECK</div><table><tr><th>PROVIDER NAME / PROVIDER ID / FORM SUBTYPE</th><th>SUBMITTED DATE</th><th>CONTACT PERSON / APPLICANT</th><th>FORM STATUS</th><th>DETAILS</th><th>ACTION</th></tr><tr><td rowspan="2">Provider Name: RAMGOOLAM ANDRES MD Provider ID: 1000011 Form Subtype: 148 Transfer</td><td>01/03/2018</td><td>John Smith</td><td>Submitted</td><td>Click "View PDF" to see details.</td><td><div>VIEW PDF</div><div>EDIT FORM</div><div>CANCEL</div></td></tr><tr><td>01/03/2018</td><td>John Smith</td><td>Submitted</td><td>Click "View PDF" to see details.</td><td><div>VIEW PDF</div></td></tr></table><div>« PREVIOUS</div></div>	PROVIDER NAME / PROVIDER ID / FORM SUBTYPE	SUBMITTED DATE	CONTACT PERSON / APPLICANT	FORM STATUS	DETAILS	ACTION	Provider Name: RAMGOOLAM ANDRES MD Provider ID: 1000011 Form Subtype: 148 Transfer	01/03/2018	John Smith	Submitted	Click "View PDF" to see details.	<div>VIEW PDF</div> <div>EDIT FORM</div> <div>CANCEL</div>	01/03/2018	John Smith	Submitted	Click "View PDF" to see details.	<div>VIEW PDF</div>
PROVIDER NAME / PROVIDER ID / FORM SUBTYPE	SUBMITTED DATE	CONTACT PERSON / APPLICANT	FORM STATUS	DETAILS	ACTION													
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	01/03/2018	John Smith	Submitted	Click "View PDF" to see details.	<div>VIEW PDF</div>													

**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.



## 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.

1

2

3

4

5

Demographic Change

SUBMITTING PROVIDER

Submitting Provider: RAMGOOLAM ANDRES MD

Facility Representative: Amit Aganwal

PARTICIPANT INFORMATION

\* First Name:  Middle Name:  \* Last Name:  Suffix:

\* Sex: ☐ Male ☐ Female \* Date of Birth:  Social Security Number:

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:

PERSONAL REPRESENTATIVE/CURATOR

\* Do you need to add a Personal Representative/Curator?

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

Page 44 of 82

### Form Demographic Change

Field ID	Field	Description
1	Submitting Provider	Displays the following information for the Support Coordinator Agency: <ul style="list-style-type: none"> <li>Submitting Provider</li> <li>Facility Representative</li> </ul>
2	Participant Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>First Name</li> <li>Middle Name</li> <li>Last Name</li> <li>Suffix</li> <li>Sex</li> <li>Date of Birth</li> <li>Social Security Number</li> <li>Medicaid Number</li> </ul>
3	Participant Contact Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>Residential Address</li> <li>City</li> <li>State</li> <li>Zip Code</li> <li>Phone Number</li> <li>Select Yes to the <b><i>Is the mailing address the same as the residential address above?</i></b> to pre-populate the information in this section.</li> </ul>
4	Personal Representative/ Curator	Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.
5	Electronic Signature	Enter the following information to electronically sign and submit the form: <ul style="list-style-type: none"> <li>First Name</li> <li>Last Name</li> <li>PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>

142BH

1

SUBMITTING PROVIDER

Submitting Provider: Amsi

Facility Representative: Amsi Agarwal

2

PARTICIPANT INFORMATION

Do you need to make an update to the personal information below?

\* First Name: Johnny

Middle Name:

\* Last Name: Applesseed

Suffix:

\* Sex: ☒ Male ☐ Female

\* Date of Birth: 03/11/1995

Social Security Number: - - - - -

Medicaid No.: 7769999487112

3

PARTICIPANT CONTACT INFORMATION

Do you need to make an update to the address(es) and/or phone number below?

\* 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:

4

ADDITIONAL DETAILS

Marital Status: Single-Never Married

5

FORM INFORMATION

Select whether the participant is enrolling or disenrolling:

☒ Coordinated System of Care (CSoC) Enrollment
☐ Coordinated System of Care (CSoC) Disenrollment

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

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 142 BH

Page 46 of 82

Field ID	Field	Description
1	Submitting Provider	Displays the following information for the Support Coordinator Agency: <ul style="list-style-type: none"> <li>• Submitting Provider</li> <li>• Facility Representative</li> </ul>
2	Participant Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>• Do you need to make an update to the personal information below?</li> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul>
3	Participant Contact Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>• Do you need to update the address(es) and/or phone number below?</li> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Phone Number</li> <li>• Select Yes to the <b><i>Is the mailing address the same as the residential address above?</i></b> to pre-populate the information in this section.</li> </ul>
4	Additional Details	Enter the following information for the individual: <ul style="list-style-type: none"> <li>• Marital Status</li> </ul>

5	Form Information	<p>Select whether the participant is enrolling or disenrolling by clicking one of the following radio buttons:</p> <ul style="list-style-type: none"> <li>Coordinated System of Care (CSoC) Enrollment</li> <li>Coordinated System of Care (CSoC) Disenrollment</li> </ul> <p><b>Note:</b> 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.</p> <p><b>Coordinated System of Care (CSoC) Enrollment</b></p> <ul style="list-style-type: none"> <li>Select the radio button for one of the following <b>Waiver Types</b>: <ul style="list-style-type: none"> <li>1915(c)</li> <li>1915(b)(3)</li> </ul> </li> <li>Select the <b>Freedom of Choice Date Signed</b></li> <li>Select the appropriate value from the <b>CANS Level</b> drop-down: <ul style="list-style-type: none"> <li>Psychiatric Inpatient/5</li> <li>Nursing Facility/3</li> <li>PRTF/4</li> <li>Therapeutic Group Home/2d</li> <li>CSOC Criteria/2</li> </ul> </li> <li>Select the correct Living Setting from the <b>Living Setting</b> drop-down</li> <li>Effective Date Range</li> <li>Enter the Waiver Proposal Begin Date</li> <li>Enter the Waiver Proposal End Date</li> </ul> <p><b>Coordinated System of Care (CSoC) Disenrollment</b></p> <ul style="list-style-type: none"> <li>If the Coordinated System of Care (CSoC) Disenrollment radio button was chosen, the following fields displays and must be completed.</li> </ul> <p>Enter the Waiver Proposal End Date</p>
6	Personal Representative/ Curator	<p>Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.</p>



7	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"><li>• First Name</li><li>• Last Name</li><li>• PIN</li></ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>
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148 Transfer

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

ADDITIONAL DETAILS

Medicare No.: Insurance Co.: Parish:

MBI: Policy #: Marital Status:

At admission, was the applicant receiving Waiver services? ▼

5

TRANSFER INFORMATION

\* Transfer Date: mm/dd/yyyy

Facility Name:

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 Transfer

Field ID	Field	Description
1	Submitting Provider	Displays the following information for the Support Coordinator Agency: <ul style="list-style-type: none"> <li>• Submitting Provider</li> <li>• Facility Representative</li> </ul>
2	Participant Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul>
3	Participant Contact Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Phone Number</li> <li>• Select Yes to the <i><b>Is the mailing address the same as the residential address above?</b></i> to pre-populate the information in this section.</li> </ul>
4	Additional Details	Enter the following information for the individual: <ul style="list-style-type: none"> <li>• Medicare No.</li> <li>• Insurance Co.</li> <li>• Parish</li> <li>• MBI</li> <li>• Policy #</li> <li>• Marital Status</li> <li>• At admission, was the applicant receiving Waiver services?</li> </ul>
5	Transfer Information	<ul style="list-style-type: none"> <li>• Enter the <b>Transfer Date</b></li> <li>• Enter the <b>Facility Name</b></li> </ul>
6	Personal Representative/ Curator	Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.

7	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"><li>• First Name</li><li>• Last Name</li><li>• PIN</li></ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>
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148 Status Change

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.: 776995616259

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

Medicare No.:  Insurance Co.:  Parish:

MBI:  Policy #:  Marital Status:

At admission, was the applicant receiving Waiver services?

5

STATUS CHANGE INFORMATION

\* Select the status change(s) you would like to submit:

☐ Leaving Facility  
☐ Returning to Facility  
☐ Resume Billing  
☐ Change Payment Source

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 Status Change

Field ID	Field	Description
1	Submitting Provider	Displays the following information for the Support Coordinator Agency: <ul style="list-style-type: none"> <li>• Submitting Provider</li> <li>• Facility Representative</li> </ul>
2	Participant Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>• Do you need to make an update to the personal information below?</li> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul>
3	Participant Contact Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Phone Number</li> <li>• Select Yes to the <b><i>Is the mailing address the same as the residential address above?</i></b> to pre-populate the information in this section.</li> </ul>
4	Additional Details	Enter the following information for the individual: <ul style="list-style-type: none"> <li>• At admission, was the applicant receiving Waiver services?</li> <li>• Medicare No.</li> <li>• Insurance Co.</li> <li>• Parish</li> <li>• MBI</li> <li>• Policy #</li> <li>• Marital Status</li> </ul>

5	Status Change Information	<ul style="list-style-type: none"> <li>Choose the status change(s) to submit by selecting one of the following checkboxes: <ul style="list-style-type: none"> <li>Leaving Family</li> <li>Returning to Facility</li> <li>Resume Billing</li> <li>Change Payment Source</li> </ul> </li> </ul>
6	Personal Representative/ Curator	Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.
7	Electronic Signature	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"> <li>First Name</li> <li>Last Name</li> <li>PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>

148 PLI

1

SUBMITTING PROVIDER

Submitting Provider: RAMGOOLAM ANDRES MD

Facility Representative: Amit Aganwal

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: <ul style="list-style-type: none"> <li>Submitting Provider</li> <li>Facility Representative</li> </ul>
2	Participant Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>First Name</li> <li>Middle Name</li> <li>Last Name</li> <li>Suffix</li> <li>Sex</li> <li>Date of Birth</li> <li>Social Security Number</li> <li>Medicaid Number</li> </ul>
3	Participant Contact Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>Residential Address</li> <li>City</li> <li>State</li> <li>Zip Code</li> <li>Phone Number</li> <li>Select Yes to the <i><b>Is the mailing address the same as the residential address above?</b></i> to pre-populate the information in this section.</li> </ul>
4	Additional Details	Enter the following information for the individual: <ul style="list-style-type: none"> <li>Marital Status</li> <li>Level of Care</li> </ul>
5	Add Details	<ul style="list-style-type: none"> <li>Click the <b>Add Details</b> button to enter an <b>Internal Claim Number</b> and <b>Status</b></li> <li>Select the <b>Update</b> button in the <b>Action</b> column to save the changes.</li> </ul>
6	Personal Representative/ Curator	Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.

7	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"><li>• First Name</li><li>• Last Name</li><li>• PIN</li></ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>
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148 Discharge

1

SUBMITTING PROVIDER

Submitting Provider: SULTAN

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

ADDITIONAL DETAILS

Medicare No.: Insurance Co.: Parish:

MBI: Policy #: Marital Status:

At admission, was the applicant receiving Waiver services?

5

DISCHARGE INFORMATION

\* Discharge Date: mm/dd/yyyy \* Admit Date: mm/dd/yyyy

\* Discharge to:

\* Do you expect this individual to return to your facility?:

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 Discharge

Field ID	Field	Description
1	Submitting Provider	Displays the following information for the Support Coordinator Agency: <ul style="list-style-type: none"> <li>• Submitting Provider</li> <li>• Facility Representative</li> </ul>
2	Participant Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul>
3	Participant Contact Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Phone Number</li> <li>• Select Yes to the <i><b>Is the mailing address the same as the residential address above?</b></i> to pre-populate the information in this section.</li> </ul>
4	Additional Details	Enter the following information for the individual: <ul style="list-style-type: none"> <li>• Medicare No.</li> <li>• Insurance Co.</li> <li>• Parish</li> <li>• MBI</li> <li>• Policy #</li> <li>• Marital Status</li> <li>• At admission, was the applicant receiving Waiver services?</li> </ul>
5	Discharge Information	<ul style="list-style-type: none"> <li>• Enter the <b>Discharge Date</b></li> <li>• Enter the <b>Admit Date</b></li> <li>• Select the appropriate value from the <b>Discharge to:</b> drop-down.</li> <li>• Select Yes or No from the <b>Do you expect this individual to return to your facility</b> drop-down.</li> </ul>

6	<b>Personal Representative/ Curator</b>	Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.
7	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>

148 Notice of Death

1

SUBMITTING PROVIDER

Submitting Provider: Sultan

Facility Representative: Amit Agarwal

2

PARTICIPANT INFORMATION

\* First Name:

Middle Name:

\* Last Name:

Suffix:

\* Sex: ☐ Male ☐ Female

\* Date of Birth:

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

ADDITIONAL DETAILS

Medicare No.:

Insurance Co.:

Parish:

MBI:

Policy #:

Marital Status:

At admission, was the applicant receiving Waiver services?

5

DEATH INFORMATION

\* Date of Death:

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 Notice of Death

Field ID	Field	Description
1	Submitting Provider	Displays the following information for the Support Coordinator Agency: <ul style="list-style-type: none"> <li>Submitting Provider</li> <li>Facility Representative</li> </ul>
2	Participant Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>First Name</li> <li>Middle Name</li> <li>Last Name</li> <li>Suffix</li> <li>Sex</li> <li>Date of Birth</li> <li>Social Security Number</li> <li>Medicaid Number</li> </ul>
3	Participant Contact Information	Displays the following pre-populated information for the applicant: <ul style="list-style-type: none"> <li>Residential Address</li> <li>City</li> <li>State</li> <li>Zip Code</li> <li>Phone Number</li> <li>Select Yes to the <i>Is the mailing address the same as the residential address above?</i> to pre-populate the information in this section.</li> </ul>
4	Additional Details	Enter the following information for the individual: <ul style="list-style-type: none"> <li>Medicare No.</li> <li>Insurance Co.</li> <li>Parish</li> <li>MBI</li> <li>Policy #</li> <li>Marital Status</li> </ul>
5	Death Information	<ul style="list-style-type: none"> <li>Enter the <b>Date of Death</b> for the individual.</li> </ul>
6	Personal Representative/ Curator	Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.

7	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"><li>• First Name</li><li>• Last Name</li><li>• PIN</li></ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>
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148W Linkage

1

SUPPORT COORDINATOR AGENCY

Name: SURtan Provider #: 11007 Facility Representative: Amit Agarwal

Address: ALONE

Phone Number: 1234567890

2

WAIVER TYPE

\* Waiver Type:

3

PARTICIPANT INFORMATION

\* Do you need to make an update to the personal information below?

\* First Name: Sam Middle Name: Last Name: Smith Suffix:

\* Sex: ☒ Male ☐ Female \* Date of Birth: 11/05/2001 Social Security Number:  -  -

Medicaid No.: 7769999519597

4

PARTICIPANT CONTACT INFORMATION

\* Do you need to make an update to the address(es) and/or phone number below?

\* Residential Address: 12th Main Street

Apt., Suite, etc.:

\* City: Baton Rouge \* State: Louisiana \* Zip Code: 70801

\* Parish: East Baton Rouge

Phone:  -  -

\* Is the mailing address the same as the residential address above?

\* Mailing Address:

Apt., Suite, etc.:

\* City: \* State: \* Zip Code:

5

ADDITIONAL DETAILS

Medicare No.:  Insurance Co.:  Parish:

MBI:  Policy #:  Marital Status:

6

LINKAGE INFORMATION

\* Select whether the participant is new to the program or received as a transition:

☐ Program Linkage Date

☐ Received as a transition

7

PERSONAL REPRESENTATIVE/CURATOR

\* Do you need to add a Personal Representative/Curator? (NOTE: to be answered by non-HCBS providers only.)

8

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 148W Linkage

Field ID	Field	Description
1	<b>Support Coordinator Agency</b>	<p>Displays the following information for the Support Coordinator Agency:</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• Provider ID</li> <li>• Facility Representative</li> <li>• Address</li> <li>• Phone Number</li> </ul>
2	<b>Waiver Type</b>	<p>Select the appropriate value from the Waiver Type drop-down:</p> <ul style="list-style-type: none"> <li>• ADHC</li> <li>• Community Choice</li> </ul>
3	<b>Participant Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to personal information below?</b> drop-down.</p>
4	<b>Participant Contact Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Parish</li> <li>• Phone Number</li> <li>• <i>Is the mailing address the same as the residential address above?</i></li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Contact Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to the address(es) and/or phone number below?</b> drop-down.</p>

5	<b>Additional Details</b>	<p>Enter the following information:</p> <ul style="list-style-type: none"> <li>• Medicare No.</li> <li>• Parish</li> <li>• MBI</li> <li>• Insurance Co.</li> <li>• Policy #</li> <li>• Marital Status</li> </ul>
6	<b>Linkage Information</b>	<p>Denote whether the participant is new to the program or received as a transition by selecting one of the following <b>Linkage Information</b> radio buttons:</p> <ul style="list-style-type: none"> <li>• Program Linkage Date</li> <li>• Received as transition</li> </ul>
7	<b>Personal Representative/ Curator</b>	<p>Select <i>Yes</i> or <i>No</i> from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.</p> <p><b>Note:</b> This field is answered by non-HCBS providers only.</p>
8	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>

148W Discharge

1

SUPPORT COORDINATOR AGENCY

Name: Sultan Provider #: 11007 Facility Representative: Amit Agarwal

Address: ALONE

Phone Number: 1234567890

2

WAIVER TYPE

\* Waiver Type:

3

PARTICIPANT INFORMATION

\* Do you need to make an update to the personal information below?

\* First Name: Sam Middle Name: Last Name: Smith Suffix:

\* Sex: ☒ Male ☐ Female \* Date of Birth: 11/05/2001 Social Security Number: \*\*\* - \*\* - \*\*\*\*

Medicaid No.: 7769999519597

4

PARTICIPANT CONTACT INFORMATION

\* Do you need to make an update to the address(es) and/or phone number below?

\* Residential Address: 12th Main Street

Apt., Suite, etc.:

\* City: Baton Rouge \* State: Louisiana \* Zip Code: 70801

\* Parish: East Baton Rouge

Phone:  -  -

\* Is the mailing address the same as the residential address above?

\* Mailing Address:

Apt., Suite, etc.:

\* City: \* State: \* Zip Code:

5

ADDITIONAL DETAILS

Medicare No.:  Insurance Co.:

Parish:  Policy #:

MBI:  Marital Status:

6

DISCHARGE INFORMATION

\* Date of Discharge: mm/dd/yyyy Admit Date: mm/dd/yyyy

\* Reason:

\* Discharge to:

7

PERSONAL REPRESENTATIVE/CURATOR

\* Do you need to add a Personal Representative/Curator? (NOTE: to be answered by non-HCBS providers only.)

8

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 148W Discharge

Field ID	Field	Description
1	<b>Support Coordinator Agency</b>	<p>Displays the following information for the Support Coordinator Agency:</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• Provider ID</li> <li>• Facility Representative</li> <li>• Address</li> <li>• Phone Number</li> </ul>
2	<b>Waiver Type</b>	<p>Select the appropriate value from the Waiver Type drop-down:</p> <ul style="list-style-type: none"> <li>• ADHC</li> <li>• Community Choice</li> </ul>
3	<b>Participant Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to personal information below?</b> drop-down.</p>
4	<b>Participant Contact Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Parish</li> <li>• Phone Number</li> <li>• <i>Is the mailing address the same as the residential address above?</i></li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Contact Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to the address(es) and/or phone number below?</b> drop-down.</p>

5	<b>Additional Details</b>	<p>Enter the following information:</p> <ul style="list-style-type: none"> <li>• Medicare No.</li> <li>• Parish</li> <li>• MBI</li> <li>• Insurance Co.</li> <li>• Policy #</li> <li>• Marital Status</li> </ul>
6	<b>Discharge Information</b>	<ul style="list-style-type: none"> <li>• Enter the <b>Discharge Date</b></li> <li>• Enter the <b>Admit Date</b></li> <li>• Select the appropriate reason for discharge from the <b>Reason</b> drop-down.</li> <li>• Select the appropriate value from the <b>Discharge to:</b> drop-down.</li> </ul>
7	<b>Personal Representative/ Curator</b>	<p>Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.</p> <p><b>Note:</b> This field is answered by non-HCBS providers only.</p>
8	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>

148W Status Change

1

SUPPORT COORDINATOR AGENCY

Name: SULTAN Provider #: 11007 Facility Representative: Amit Agarwal

Address: ALONE

Phone Number: 1234567890

2

WAIVER TYPE

\* Waiver Type:

3

PARTICIPANT INFORMATION

\* First Name:  Middle Name:  \* Last Name:  Suffix:

\* Sex: ☐ Male ☐ Female \* Date of Birth:  Social Security Number:  -  -

4

PARTICIPANT CONTACT INFORMATION

\* Residential Address:

Apt., Suite, etc.:

\*  \* State:  \* Zip Code:

City:

Phone:  -

\* Is the mailing address the same as the residential address above?

\* Mailing Address:

Apt., Suite, etc.:

\*  \* State:  \* Zip Code:

City:

5

ADDITIONAL DETAILS

Medicare No.:  Insurance Co.:  Parish:

MBI:  Policy #:  Marital Status:

6

STATUS CHANGE INFORMATION (INCLUDES TRANSFERS)

\* Select the status change(s) you would like to submit:

☐ Temporary Facility/Rehabilitation Placement (NOT Discharged from Waiver)

☐ 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

\* Do you need to add a Personal Representative/Curator? (NOTE: to be answered by non-HCBS providers only.)

8

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 148W Status Change

Field ID	Field	Description
1	<b>Support Coordinator Agency</b>	<p>Displays the following information for the Support Coordinator Agency:</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• Provider ID</li> <li>• Facility Representative</li> <li>• Address</li> <li>• Phone Number</li> </ul>
2	<b>Waiver Type</b>	<p>Select the appropriate value from the Waiver Type drop-down:</p> <ul style="list-style-type: none"> <li>• ADHC</li> <li>• Community Choice</li> </ul>
3	<b>Participant Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to personal information below?</b> drop-down.</p>
4	<b>Participant Contact Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Phone Number</li> <li>• <i>Is the mailing address the same as the residential address above?</i></li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Contact Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to the address(es) and/or phone number below?</b> drop-down.</p>



5	<b>Additional Details</b>	<p>Enter the following information:</p> <ul style="list-style-type: none"> <li>• Medicare No.</li> <li>• Parish</li> <li>• MBI</li> <li>• Insurance Co.</li> <li>• Policy #</li> <li>• Marital Status</li> </ul>
6	<b>Status Change Information</b>	<ul style="list-style-type: none"> <li>• Choose the status change(s) to submit by selecting one of the following checkboxes: <ul style="list-style-type: none"> <li>○ Temporary Facility/Rehabilitation Placement</li> <li>○ Returned to Waiver from Temporary Facility/Rehabilitation Placement</li> <li>○ Transferred from Region</li> <li>○ Transitioned</li> <li>○ Support Coordinator Agency Transfer</li> <li>○ Resident Discharged from Facility and Transitioned to Community</li> </ul> </li> </ul>
7	<b>Personal Representative/ Curator</b>	<p>Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.</p> <p><b>Note:</b> This field is answered by non-HCBS providers only.</p>
8	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>

148W Withdrawal

1

SUPPORT COORDINATOR AGENCY

Name: RAMGOOLAM ANDRES MD Provider #: 100011 Facility Representative: Anst Agarwal

Address: 800 OHIO ST CLARKSDALEMS

Phone Number:

2

WAIVER TYPE

\* Waiver Type:

3

PARTICIPANT INFORMATION

\* Do you need to make an update to the personal information below?

\* First Name: Sam Middle Name: Last Name: Smith Suffix:

\* Sex: ☒ Male ☐ Female \* Date of Birth: 11/05/2001 Social Security Number: \*\*\* - \*\* - \*\*\*\*

Medicaid No.: 7769999515597

4

PARTICIPANT CONTACT INFORMATION

\* Do you need to make an update to the address(es) and/or phone number below?

\* Residential Address: 12th Main Street

Apt., Suite, etc.:

\* City: Baton Rouge State: Louisiana Zip Code: 70801

\* Parish: East Baton Rouge

Phone:  -  -

\* Is the mailing address the same as the residential address above?

\* Mailing Address:

Apt., Suite, etc.:

\* City: State: Zip Code:

5

ADDITIONAL DETAILS

Medicare No.: Insurance Co.:

Parish: Policy #:

MBI: Marital Status:

6

WITHDRAWAL INFORMATION

\* Date of Withdrawal: mm/dd/yyyy

7

PERSONAL REPRESENTATIVE/CURATOR

\* Do you need to add a Personal Representative/Curator? (NOTE: to be answered by non-HCBS providers only.)

8

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 148W Withdrawal

Field ID	Field	Description
1	<b>Support Coordinator Agency</b>	<p>Displays the following information for the Support Coordinator Agency:</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• Provider ID</li> <li>• Facility Representative</li> <li>• Address</li> <li>• Phone Number</li> </ul>
2	<b>Waiver Type</b>	<p>Select the appropriate value from the Waiver Type drop-down:</p> <ul style="list-style-type: none"> <li>• ADHC</li> <li>• Community Choice</li> </ul>
3	<b>Participant Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to personal information below?</b> drop-down.</p>
4	<b>Participant Contact Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Parish</li> <li>• Phone Number</li> <li>• <i>Is the mailing address the same as the residential address above?</i></li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Contact Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to the address(es) and/or phone number below?</b> drop-down.</p>

5	<b>Additional Details</b>	<p>Enter the following information:</p> <ul style="list-style-type: none"> <li>• Medicare No.</li> <li>• Parish</li> <li>• MBI</li> <li>• Insurance Co.</li> <li>• Policy #</li> <li>• Marital Status</li> </ul>
6	<b>Withdrawal Information</b>	<ul style="list-style-type: none"> <li>• Enter the <b>Date of Withdrawal</b></li> </ul>
7	<b>Personal Representative/ Curator</b>	<p>Select <i>Yes</i> or <i>No</i> from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.</p> <p><b>Note:</b> This field is answered by non-HCBS providers only.</p>
8	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>

148W Declined

1

SUPPORT COORDINATOR AGENCY

Name: RAMGOOLAM ANDRES MD Provider #: 1000011 Facility Representative: Armit Agarwal

Address: 800 OHIO STCLARKSDALEMS

Phone Number:

2

WAIVER TYPE

\* Waiver Type:

3

PARTICIPANT INFORMATION

\* First Name:  Middle Name:  \* Last Name:  Suffix:

\* Sex: ☐ Male ☐ Female \* Date of Birth:  Social Security Number:  -  -

4

PARTICIPANT CONTACT INFORMATION

\* Residential Address:

Apt., Suite, etc.:

\*  \* State:  \* Zip Code:

City:

Phone:  -

\* Is the mailing address the same as the residential address above?

\* Mailing Address:

Apt., Suite, etc.:

\*  \* State:  \* Zip Code:

City:

5

ADDITIONAL DETAILS

Medicare No.:  Insurance Co.:

Parish:  Policy #:

MBI:  Marital Status:

6

DECLINED INFORMATION

\* Declined date:

7

PERSONAL REPRESENTATIVE/CURATOR

\* Do you need to add a Personal Representative/Curator? (NOTE: to be answered by non-HCBS providers only.)

8

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 148W Declined

Field ID	Field	Description
1	<b>Support Coordinator Agency</b>	<p>Displays the following information for the Support Coordinator Agency:</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• Provider ID</li> <li>• Facility Representative</li> <li>• Address</li> <li>• Phone Number</li> </ul>
2	<b>Waiver Type</b>	<p>Select the appropriate value from the Waiver Type drop-down:</p> <ul style="list-style-type: none"> <li>• ADHC</li> <li>• Community Choice</li> </ul>
3	<b>Participant Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to personal information below?</b> drop-down.</p>
4	<b>Participant Contact Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Phone Number</li> <li>• <i>Is the mailing address the same as the residential address above?</i></li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Contact Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to the address(es) and/or phone number below?</b> drop-down.</p>

5	<b>Additional Details</b>	<p>Enter the following information:</p> <ul style="list-style-type: none"> <li>• Medicare No.</li> <li>• Parish</li> <li>• MBI</li> <li>• Insurance Co.</li> <li>• Policy #</li> <li>• Marital Status</li> </ul>
6	<b>Declined Information</b>	<ul style="list-style-type: none"> <li>• Enter the Declined Information</li> </ul>
7	<b>Personal Representative/ Curator</b>	<p>Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.</p> <p><b>Note:</b> This field is answered by non-HCBS providers only.</p>
8	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>

148W Notice of Death

1

SUPPORT COORDINATOR AGENCY

Name: RAMGOOLAM ANDRES MD Provider #: 1000011 Facility Representative: Amit Agarwal

Address: 800 OHIO STCLARKSDALEMS

Phone Number:

2

WAIVER TYPE

\* Waiver Type:

3

PARTICIPANT INFORMATION

\* First Name:  Middle Name:  \* Last Name:  Suffix:

\* Sex: ☐ Male ☐ Female \* Date of Birth:  Social Security Number:  -  -

4

PARTICIPANT CONTACT INFORMATION

\* Residential Address:

Apt., Suite, etc.:

\*  \* State:  \* Zip:

City:  Code:

Phone:  -

\* Is the mailing address the same as the residential address above?

\* Mailing Address:

Apt., Suite, etc.:

\*  \* State:  \* Zip:

City:  Code:

5

ADDITIONAL DETAILS

Medicare No.:  Insurance Co.:

Parish:  Policy #:

MBI:  Marital Status:

6

DEATH INFORMATION

\* Date of Death:

7

PERSONAL REPRESENTATIVE/CURATOR

\* Do you need to add a Personal Representative/Curator? (NOTE: to be answered by non-HCBS providers only.)

8

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 148W Notice of Death



Field ID	Field	Description
1	<b>Support Coordinator Agency</b>	<p>Displays the following information for the Support Coordinator Agency:</p> <ul style="list-style-type: none"> <li>• Name</li> <li>• Provider ID</li> <li>• Facility Representative</li> <li>• Address</li> <li>• Phone Number</li> </ul>
2	<b>Waiver Type</b>	<p>Select the appropriate value from the Waiver Type drop-down:</p> <ul style="list-style-type: none"> <li>• ADHC</li> <li>• Community Choice</li> </ul>
3	<b>Participant Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Middle Name</li> <li>• Last Name</li> <li>• Suffix</li> <li>• Sex</li> <li>• Date of Birth</li> <li>• Social Security Number</li> <li>• Medicaid Number</li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to personal information below?</b> drop-down.</p>
4	<b>Participant Contact Information</b>	<p>Displays the following pre-populated information for the applicant:</p> <ul style="list-style-type: none"> <li>• Residential Address</li> <li>• City</li> <li>• State</li> <li>• Zip Code</li> <li>• Phone Number</li> <li>• <i>Is the mailing address the same as the residential address above?</i></li> </ul> <p><b>Note:</b> If any of the information in the <b>Participant Contact Information</b> section needs to be updated, select Yes from the <b>Do you need to make an update to the address(es) and/or phone number below?</b> drop-down.</p>

5	<b>Additional Details</b>	<p>Enter the following information:</p> <ul style="list-style-type: none"> <li>• Medicare No.</li> <li>• Parish</li> <li>• MBI</li> <li>• Insurance Co.</li> <li>• Policy #</li> <li>• Marital Status</li> </ul>
6	<b>Death Information</b>	<ul style="list-style-type: none"> <li>• Enter the <b>Date of Death</b> for the individual.</li> </ul>
7	<b>Personal Representative/ Curator</b>	<p>Select Yes or No from the <b>Do you need to add a Personal Representative/Curator?</b> drop-down.</p> <p><b>Note:</b> This field is answered by non-HCBS providers only.</p>
8	<b>Electronic Signature</b>	<p>Enter the following information to electronically sign and submit the form:</p> <ul style="list-style-type: none"> <li>• First Name</li> <li>• Last Name</li> <li>• PIN</li> </ul> <p><b>Note:</b> If the PIN information is forgotten, save the information on the screen and navigate to the <b>Manage My Account</b> screen to identify the PIN.</p>