



# **THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid Program)**

## **MANAGED CARE ENTITY (MCE) REGISTRATION PACKET**

# MANAGED CARE ENTITY (MCE) REGISTRATION

## CHECKLIST OF REQUIRED FORMS AND DOCUMENTS

Completed	Form or Document Name
<input type="checkbox"/> *	1. MCE Registration Form.
<input type="checkbox"/> *	2. MCE Medicaid Direct Deposit (EFT) Authorization Agreement.
<input type="checkbox"/>	3. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited <b>(deposit slips are not accepted)</b> .
<input type="checkbox"/> *	4. MCE Election to Employ Electronic Data Interchange of Encounters for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form <b>and</b> Power of Attorney Form (if applicable).
<input type="checkbox"/>	5. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records <b>(W-9 forms are not accepted)</b> .
<input type="checkbox"/> *	6. Completed Disclosure of Ownership form.
<input type="checkbox"/>	7. To report "Specialty" for this provider type on Section A of the PE-50, please use Code 5Q (Coordinated Care Networks - Prepaid).

\* Forms are contained in this registration packet.

**USE THE ABOVE CHECKLIST TO ENSURE THAT ALL REQUIRED FORMS AND DOCUMENTS ARE SUBMITTED.**

Submit all required documentation to:  
**Gainwell Provider Enrollment Unit**  
**PO Box 80159**  
**Baton Rouge, LA 70898-0159**

# State of Louisiana

## Instructions for completing the MANAGED CARE ENTITY (MCE) Registration Form

### GENERAL INFORMATION

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

A Medicaid MCE number can have only one (1) mailing address. Therefore, this address **MUST** be the address that the entity or business wishes to receive all notices from Louisiana Medicaid.

**Louisiana Medicaid MCE Number** – enter your 7-digit Louisiana Medicaid MCE number (if known) in the boxes.  
**Registering for** – check the appropriate box to indicate if this registration is new, an update of existing information, reactivation of a Medicaid MCE Number, some other reason, or a Change of Ownership (CHOW).

### SECTION A – ENTITY/BUSINESS INFORMATION & LOCATION

**“Doing Business As” Name** – enter the “Doing Business As” (DBA) Name.

**Area Code and Telephone Number** - enter the telephone number at the street location of the business named in “*Doing Business As*” Name.

**Street Address** – enter the street address of the main location of the business. Occasionally, there will be an instance when mail, a document, or a correspondence may be sent to the street address. If mail cannot be received at the Street Address because there is no receptacle and the postal carrier will not bring the mail inside the building, include a brief note that explains the problem and provide an alternative delivery address.

**City** – enter the city in which your *Street Address* is located.

**State** – enter the state in which your *Street Address* is located.

**Zip Code** – enter the zip code in which your *Street Address* is located.

**Parish/County** – enter the parish / county of the *Street Address* (for out-of-state businesses, see county codes below).

**Parish Code** – for businesses located in Louisiana, enter the parish code of the *Street Address* (see list below and enter appropriate code for the parish entered in the *Parish* field).

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

**For businesses located outside of Louisiana, use the chart below to determine the county/state codes.**

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

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

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

**State Status Location** – check “In-State (0)” if your *Street Address* is located within Louisiana or “Out-of-State (1)” if it is located outside Louisiana.

**Location Type** – check “Urban (1)” if your *Business/Practice City* is an urban (city) location or “Rural (2)” if it is a rural (away from city centers) location.

#### SECTION B – IRS NAME AND MAILING ADDRESS

**Business Name Registered with the IRS** – enter the name registered with the IRS. This is the name the year-end 1099s are issued under – enter the name EXACTLY as found on the top line of the pre-printed IRS documentation enclosed with the application. Do not abbreviate or add punctuation not found on the IRS documentation. If the Business Name on this form **DOES NOT** match the IRS documentation exactly, the form may be returned to you for correction.

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

**Mailing Address** – enter the address to which all correspondence are to be mailed.

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

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

**Mailing Zip** – enter the Zip + four code in which your *Mailing Address* is located.

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

**Year-End Date** – enter the Fiscal Year-end month of this business, if applicable.

#### SECTION C – GENERAL

**Effective Date** – The effective date (will be determined by the Department)

**MCE Type Description/Code** –MCE (PT-05)

**MCE Specialty** –MCE (5Q)

#### SECTION D – CONTACT INFORMATION

**Contact Name** – enter the name of the person who may be contacted for additional information.

**Contact Phone Number** – enter the phone number of the person who may be contacted for additional information.

**Contact Fax Number** - enter the fax number of the person who may be contacted for additional information.

**Contact Email** – enter the email address of the person who may be contacted for additional information.

#### SECTION E – CERTIFICATION OF INFORMATION

**Print the Name of the Authorized Representative** – print the name of the authorized representative,

**Authorized Representative’s Signature** – the authorized representative must sign the form. Signatures must be original, preferably in blue ink. Stamped signatures and initials are not accepted.

**Date of Signature** – enter the date this form was signed.



# MANAGED CARE ENTITY (MCE) GENERAL INFORMATION FOR THE DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

Only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.

Original signatures only; no stamps or copied signatures will be accepted. (Blue or colored ink preferred – not black ink).

The provider name on this form must match the provider name associated with the Louisiana Medicaid number, the NPI, or both.

Call Gainwell Provider Enrollment at (225) 216-6370 if you have questions regarding the completion of this form or the status of your request. You may also go to [lamedicaid.com](http://lamedicaid.com) under the Provider Enrollment link for Provider Enrollment contact information.

Once you are enrolled for EFT and if there is a time when the electronic payments are missing or late, first contact the Automated Clearinghouse (ACH) representative at your bank, not a bank teller. If the bank is unable to locate the deposit, check to ensure that the account has not been closed or changed. Finally, if still unable to locate a deposit, call Gainwell Provider Enrollment at (225) 216-6370 and report the late and/or missing EFT transaction.

***If you sign up for EFT and also receive your remittance advice data in the v501x12 835 transaction (ERA), you must contact your financial institution if you wish to arrange for delivery of the CORE-required Minimum CCD+ data elements needed for re-association of the payment and the ERA.***

# LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

## INSTRUCTIONS

1. Provider Name Complete legal name of institution, corporate entity, practice or individual provider.
2. DBA Name The name by which the provider is conducting business.
3. Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) A Federal Tax Identification Number, also known as an Employer Identification Number (EIN) is used to identify a business entity (9 digits).
4. National Provider Identifier (NPI) A Health Insurance Portability and Accountability Act (HIPAA) identification number Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
5. Medicaid Trading Partner ID (7 digits) The provider's 7-digit Louisiana Medicaid identification number.
6. Provider Contact Name Name of a contact in the provider's office for handling EFT issues.
7. Telephone Number Associated with contact person.
8. Email Address An electronic mail address at which the health plan might contact the provider.
9. Financial Institution Name Official name of the provider's financial institution.
10. Financial Institution Routing Number A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
11. Type of Account at Financial Institution The type of account the provider will use to receive EFT payments, e.g., Checking, Saving (check the appropriate box).
12. Provider Account Number with Financial Institution Provider's account number at the financial institution to which EFT payments are to be deposited (up to 10 digits).
13. Account Number Linkage to Provider Identifier Check one: Provider Tax Identification Number (TIN), or National Provider Identifier (NPI).
14. Reason for submission New Enrollment is pre-checked for your convenience.
15. Voided Check A voided check is attached to provide confirmation of Identification/Account Numbers.
16. Written Signature of Person Submitting Enrollment A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity.
17. Printed Name of Person Submitting The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment.
18. Printed Title of Person Submitting Enrollment The printed title of the person signing the form.
19. Submission Date CCYYMMDD



**Addendum to the  
LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT**

A. If the Reason for Submission is "Change Enrollment,"  Change of Ownership  Change of Bank or Financial Institution  Other  
specify the reason:

If Other, please specify: \_\_\_\_\_

**NOTE: If a change of ownership (CHOW) occurs, an entire enrollment packet is required and direct deposit information cannot be changed for the current provider account.**

B. Is the bank account you specified located in the  Yes  No  
United States?

Of No, please identify the country of location: \_\_\_\_\_

**NOTE: If the specified bank account is not in the United States, Gainwell Provider Enrollment will reject this request due to Medicaid funds not being allowed to be deposited into out of country accounts.**

## **MANAGED CARE ENTITY (MCE) Louisiana Medicaid Program**

### **INSTRUCTIONS FOR MCE ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS AND ENCOUNTERS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM**

Prior to submitting electronic encounters to Louisiana Medicaid, a seven-digit Submitter number (450XXXX) must be obtained from the Gainwell Provider Enrollment Unit. The Submitter number must be linked to all Medicaid MCE numbers for whom encounters will be submitted.

The following form(s) is (are) to be completed if the MCE plans to submit encounters electronically to Louisiana Medicaid.

#### **EDI Contract**

**Louisiana Medicaid MCE Number** – enter the Louisiana Medicaid MCE number, if known, for which encounters will be electronically submitted to Gainwell .

**DBA Name of MCE** – enter the name of the business.

**Name of Contact Person** – enter the name of the person designated as the point of contact for questions regarding this request.

**Contact Phone Number** – enter the phone number of Contact Person.

**Submitter Number** – if linking to a submitter who already has a Louisiana Submitter number, then you are required to enter the Louisiana Medicaid Submitter number you want to link to. (Leave blank if applying for a new Submitter number.)

**Billing Agent / Submitter Business Name** – enter the business name of the billing / submitting agent.

**Signature of Authorized Representative** – original signature of the authorized representative, preferably in blue ink.

**Date of Signature** – enter the date the authorized representative signed the form.

**MANAGED CARE ORGANIZATION'S ELECTION TO EMPLOY ELECTRONIC DATA  
INTERCHANGE OF ENCOUNTERS  
FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM  
(EDI CONTRACT FOR MCE)**

<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> <p><b>Louisiana Medicaid MCE Number (7 digits)</b></p>									<table border="1" style="width: 100%; height: 20px;"> <tr> <td style="width: 12.5%; text-align: center;"><b>4</b></td> <td style="width: 12.5%; text-align: center;"><b>5</b></td> <td style="width: 12.5%; text-align: center;"><b>0</b></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table> <p>Submitter Number (7 digits) (leave blank if applying for new number)</p>	<b>4</b>	<b>5</b>	<b>0</b>				
<b>4</b>	<b>5</b>	<b>0</b>														
DBA Name of MCE:	<p><b>Billing Agent/ Submitter Name / Name of Business</b> that will be submitting encounters (business name or third party biller's name):</p>															
Contact Name:																
Contact Phone Number:																

The Medicaid File can only hold a maximum of three Submitter numbers per Medicaid MCE Number at any one time. Old Submitter numbers will be closed as new ones are opened, unless otherwise instructed. It is vital that you identify which Submitter number will be designated to download the Electronic Remittance Advices ( 835 ERA).

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

4	5	0				
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By checking this box you are giving authorization to have 835s produced and made available for download by either this new Submitter number or the previously assigned Submitter number.

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

4	5	0				
4	5	0				

1. On the date of the signature below, the undersigned elects and agrees to submit its encounters for provider claims for Louisiana Medicaid recipients who are enrolled members of a MANAGED CARE ENTITY (MCE) that is contracted with the Louisiana Medicaid program, by means of the electronic media in accordance with Paragraphs 2 through 17 below. This is done in consideration for the MCE's contracted requirement to submit encounters electronically.
2. All published specifications set forth shall be met with every encounter sought to be processed. The effective date for this Electronic Data Interchange (EDI) submission will be set by LDH-BHSF, once this EDI contract has been processed.
3. The MANAGED CARE ENTITY(hereinafter referred to as "MCE") shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers.
4. The MCE shall provide, upon request of the Director of the Louisiana Department of Health- Bureau of Health Services Financing (LDH-BHSF), any supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow chart, file description, accounting procedures and the like.

5. The MCE shall continue to be ultimately responsible for the accuracy and truthfulness of all encounters submitted and agrees to submit the required Annual Certification Form.
6. It is expressly understood that LDH-BHSF, or LDH's Fiscal Intermediary (Gainwell) may reject an entire submission at any time for failure to comply with the official specifications for submitting encounters electronically or for any other reason.
7. The MCE agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as to encounter submission procedures which will be transmitted in electronic format.
8. The MCE and LDH-BHSF mutually agree this Agreement may be amended by mutual consent of the representatives of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement cannot be verbally amended.
9. The MCE agrees to submit to LDH-BHSF, LDH-BHSF's Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for the member encounters submitted and for which reimbursement is claimed.
10. The MCE acknowledges and accepts responsibility for the provisions of public Law 95-142, 42 CFR Part 455 – Program Integrity: Medicaid, and 42 CFR Part 438, Subpart H – Certifications and Program Integrity pertaining to fraud.
11. The MCE and LDH-BHSF agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.
12. Further, for a period of six(6) years, the MCE must maintain, copy and submit any and all encounter data along with its supporting documentation, as requested by LDH/BHSF to support a Federal and/or State audit or investigation.
13. The MCE agrees this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify the MCE's limited obligations as set in a certain Agreement between the LDH-BHSF and the MCE.
14. I attest all MCE member encounters submitted under the conditions of this Agreement are certified to be true, accurate and complete.
15. I understand all encounters submitted under the conditions of this Agreement will be paid from a part of the PMPM payments made to the MCE that are comprised of Federal and State Medicaid funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.
16. I attest all the information supplied with this Agreement is true, accurate and complete.
17. Applicable to those receiving 835's: I authorize the LDH-BHSF's Fiscal Intermediary to send all HIPPPAA required data in the 835 transaction.

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**Print the Name of the Authorized Representative**

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**Title / Position of Authorized Representative**

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**Signature of Authorized Representative**

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**Date of Signature**