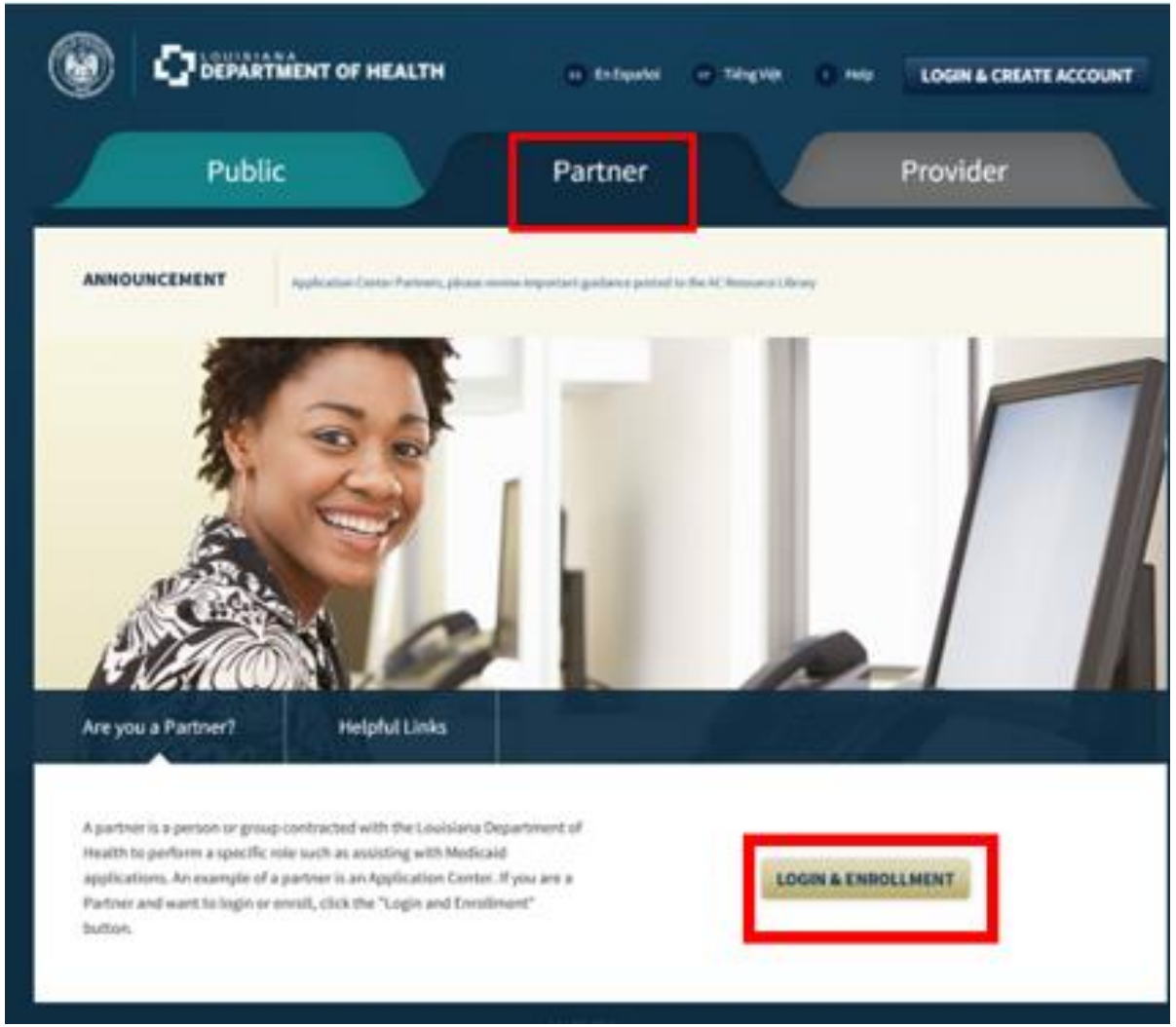
LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Louisiana Medicaid: Online Application

LOUISIANA DEPARTMENT OF HEALTH
Medicaid



Log in to the Self-Service Portal (SSP)

- First click on Partner
- Next, click on Login & Enrollment

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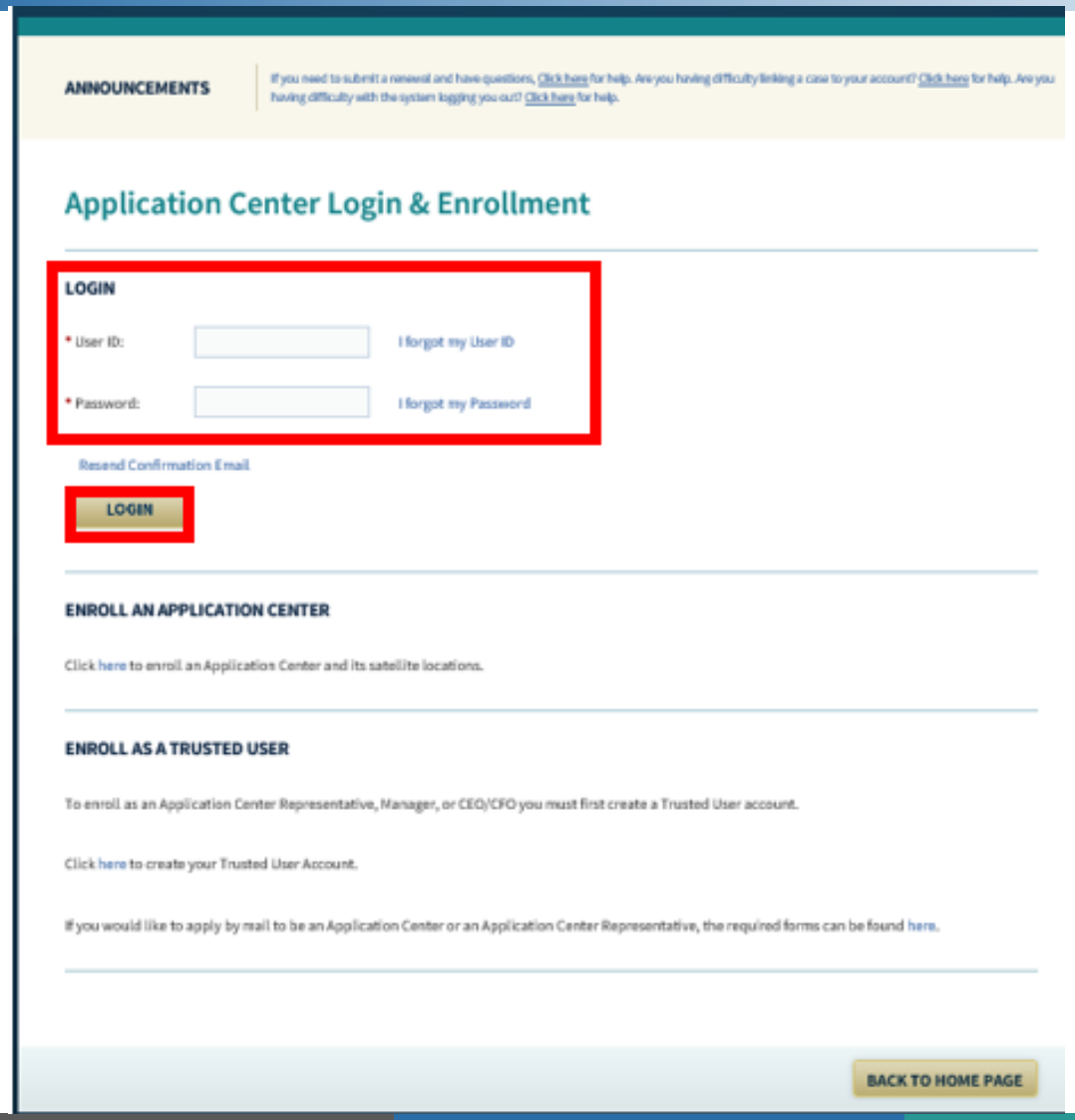

Application Center Login & Enrollment

- Enter your User ID
- Enter you Password
- Click Login

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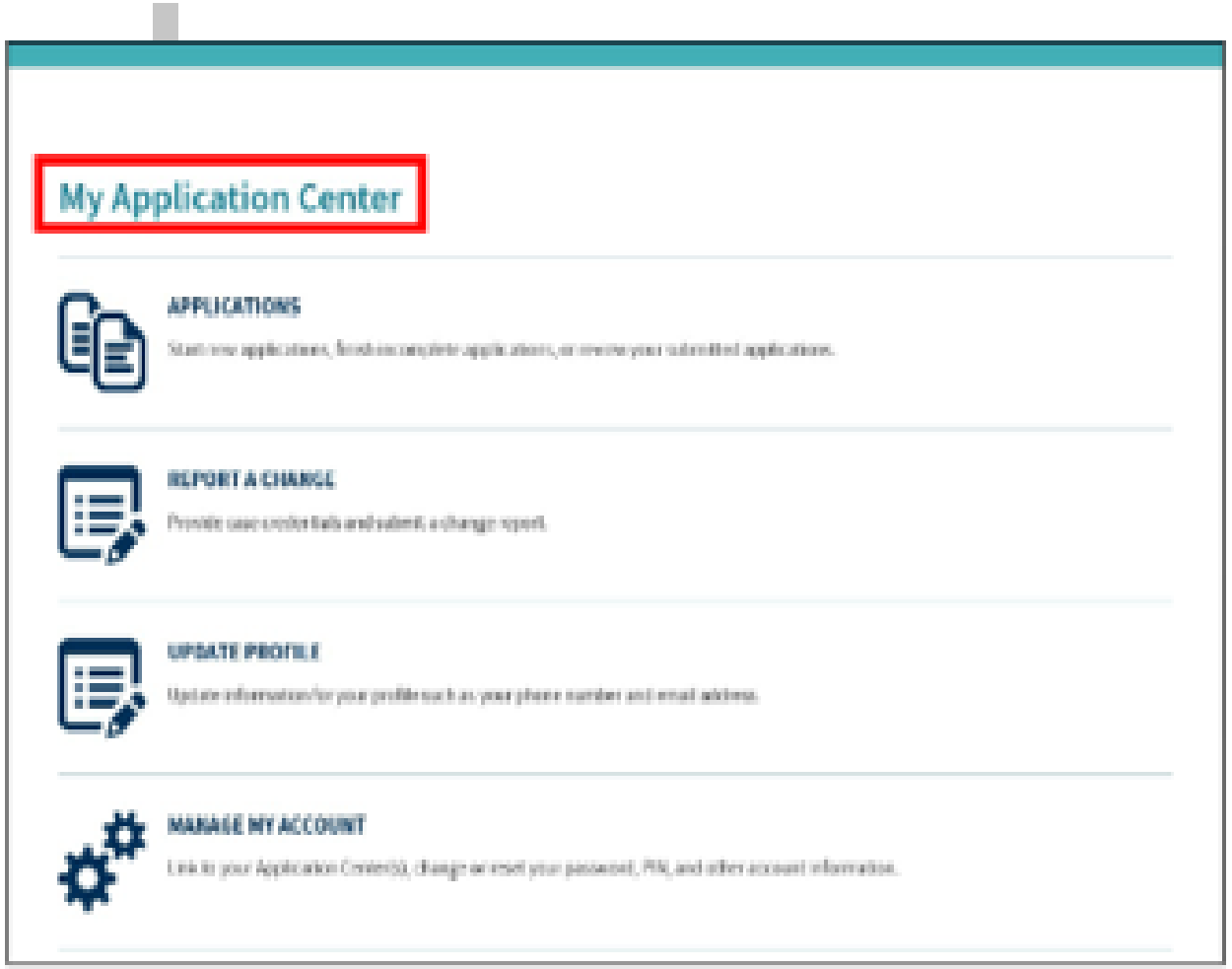

My Application Center: Trusted User

- Submit Applications
- Report Changes
- Update Profile
- Manage My Account.

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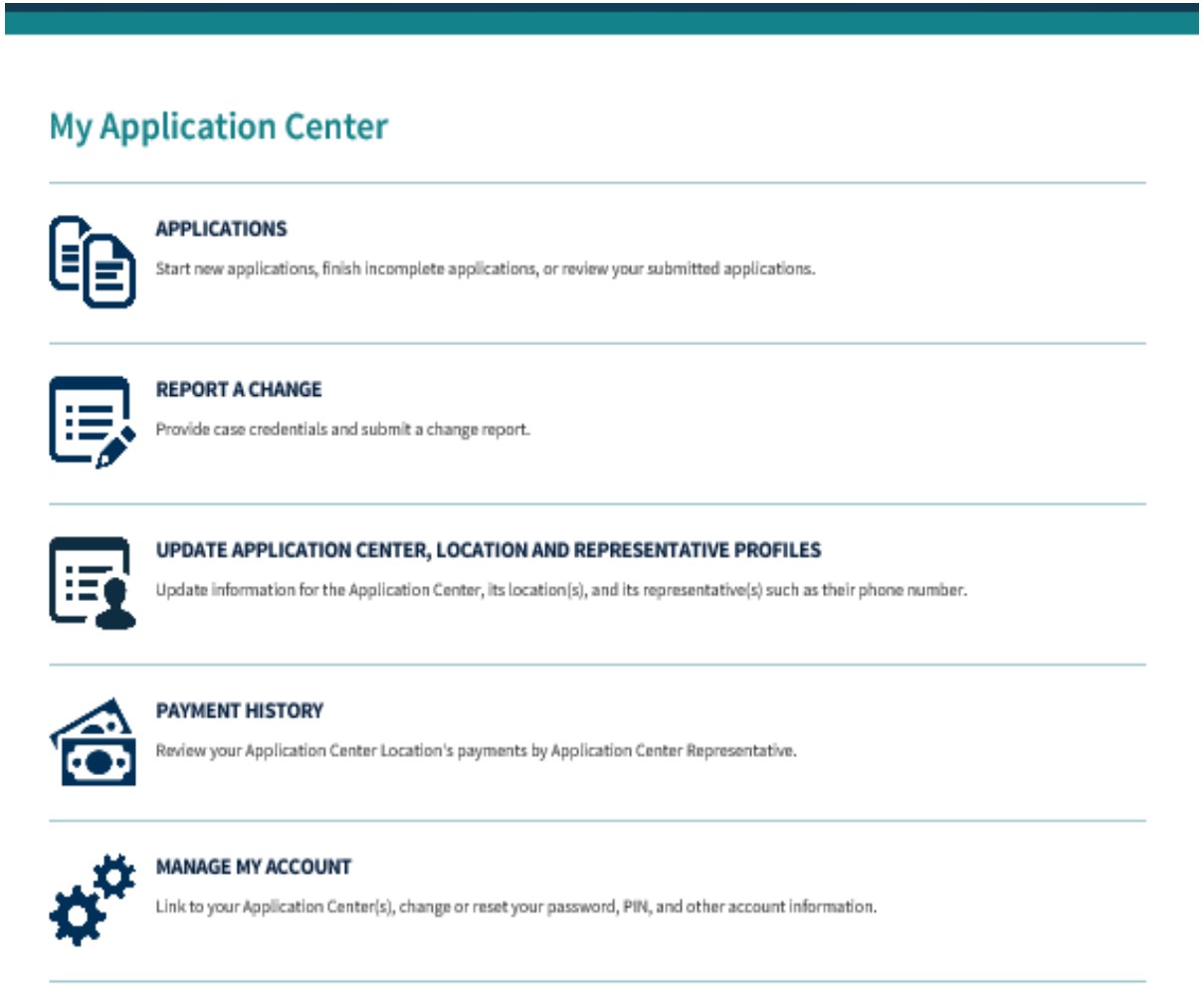

My Application Center: Managers & CEO/CFO

- Submit Applications
- Report Changes
- Update Profile
- Manage My Account
- Payment History
- Update Application Center Location and Representative Profiles

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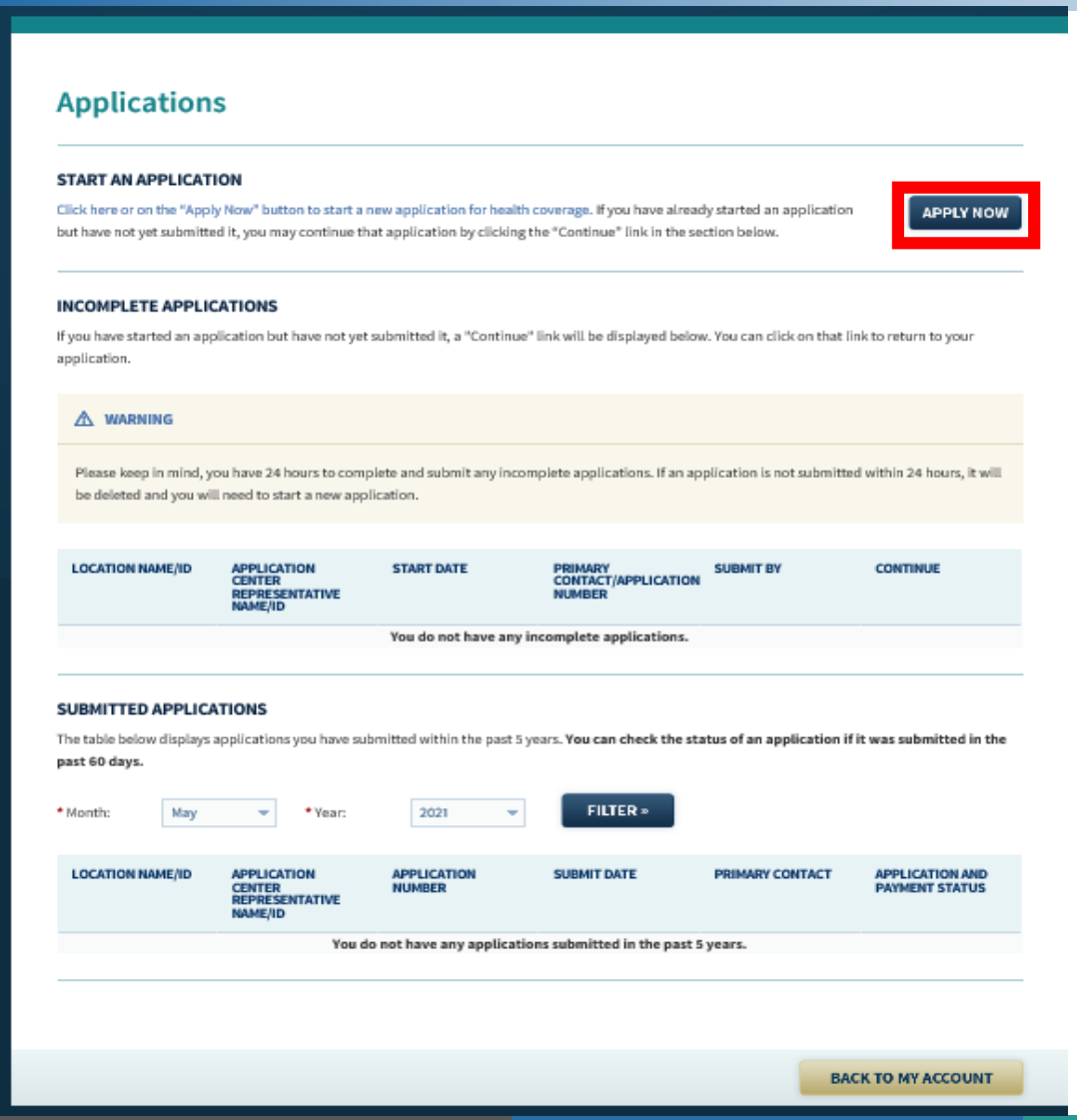
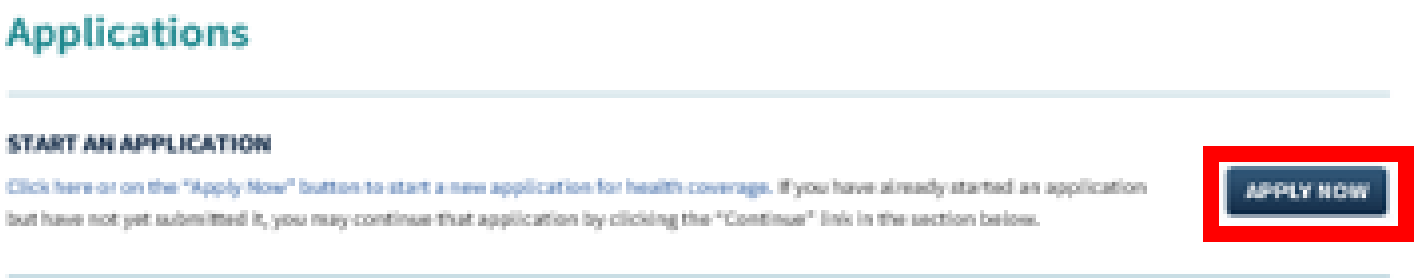


Applications

- Start an Application
- Incomplete Applications
- Submitted Applications

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

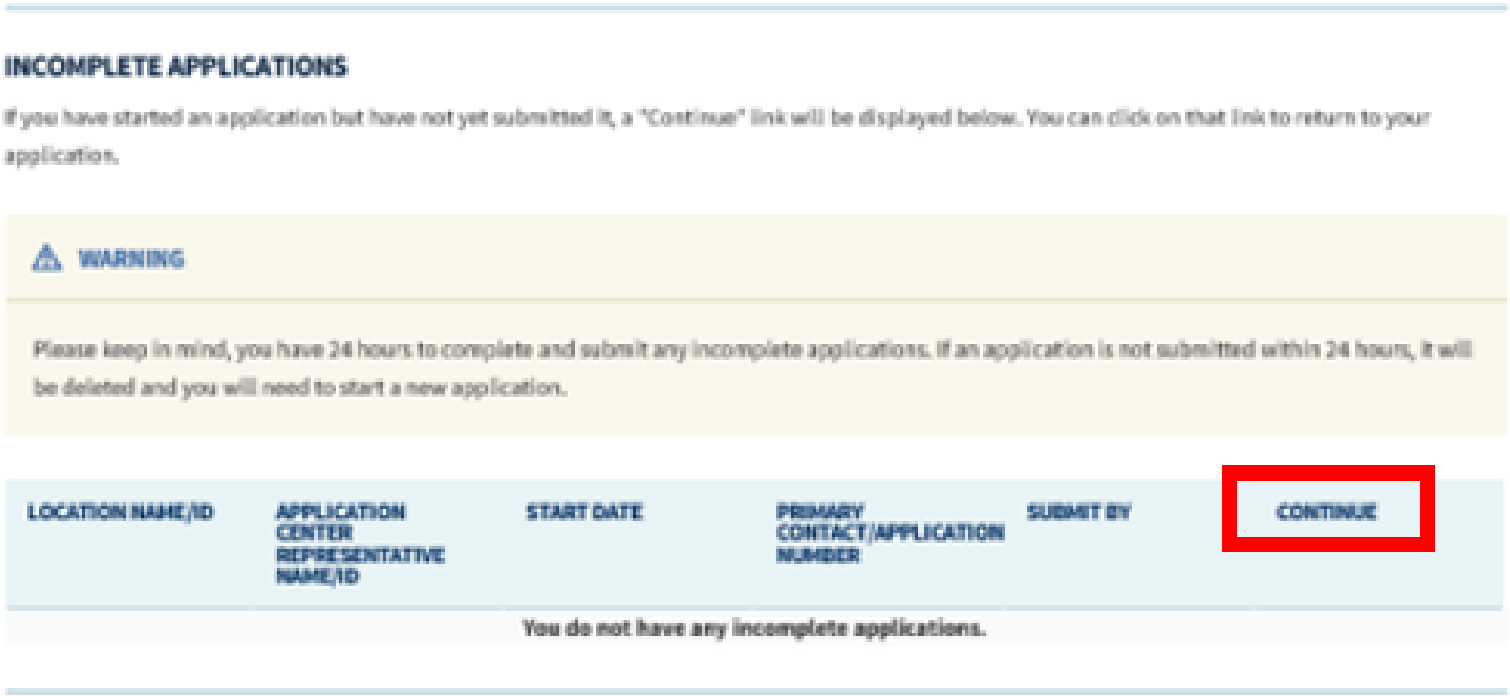
Start an Application



- Individual is not currently receiving Medicaid.
- Click the Apply Now button to start a new application

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Incomplete Applications


INCOMPLETE APPLICATIONS

If you have started an application but have not yet submitted it, a "Continue" link will be displayed below. You can click on that link to return to your application.

WARNING

Please keep in mind, you have 24 hours to complete and submit any incomplete applications. If an application is not submitted within 24 hours, it will be deleted and you will need to start a new application.

LOCATION NAME/ID	APPLICATION CENTER REPRESENTATIVE NAME/ID	START DATE	PRIMARY CONTACT/APPLICATION NUMBER	SUBMIT BY	CONTINUE
You do not have any incomplete applications.					

Click on the Continue hyperlink to navigate to the last screen saved on the selected application

LOUISIANA DEPARTMENT OF HEALTH
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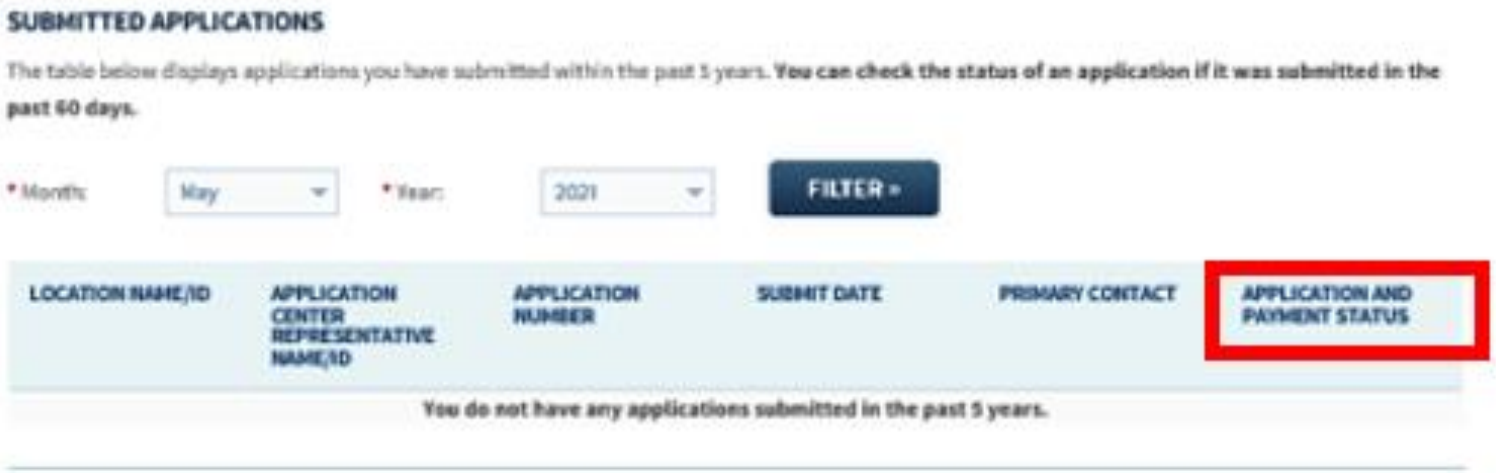
Submitted Applications



Click on the Application and Payment Status hyperlink for information about the selected application.

LOUISIANA DEPARTMENT OF HEALTH
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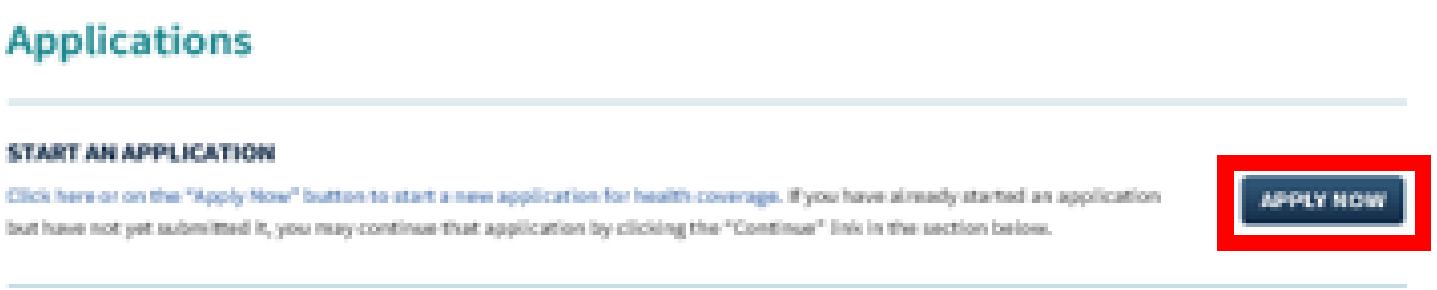
Start an Application



- Individual is not currently receiving Medicaid.
- Click the Apply Now button to start a new application

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Apply For Assistance

You are ready to start your application. Here are some helpful hints.

WHO CAN USE THIS APPLICATION

- Use this application for anyone needing health care assistance.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.

WHAT YOU WILL NEED

When you apply for coverage you'll need to provide some information about you and your household, including income, any insurance you currently have, and some additional items. Information you give us will be used to help determine benefit levels.

Please have the following items while completing your application:

- Social Security Numbers
- Citizenship or immigration information
- Income information for every member of your household
- Policy numbers for any current health insurance plans covering members of your household
- Medical bills from the past 3 months

If anyone in your household is claiming a disability or over age 65, you may also be asked for the following information:

- Power of attorney, Curator or Interdiction Documents
- Succession documents
- Account information for all Bank Accounts, Annuities, Certificates of deposit (CDs), IRAs, 401-Ks, Keoghs and Retirement accounts
- List of Safe-deposit box items
- Stock and Bonds information
- Vehicle Registration or Titles
- Property Owned or inherited property
- Life and Burial Insurance Policies
- Burial or Funeral Accounts including Pre-arranged Burial Contracts with Funeral Homes
- Burial Space Items
- Trust Documents
- Act of Donation and Bill of Sale Items

HOW TO COMPLETE THE APPLICATION

- It may take between 30-60 minutes to complete the application.
- You may use the "Previous" and "Next" buttons at the bottom of each page to go through the application.
- Your information is automatically saved every time you click "Next".
- You can start and then save your application. You can log back in to continue and complete your application(s).
- Once you have answered all the questions, click the "Submit" button at the end of the application.
- We will contact you if more information is needed regarding your application.
- Fields noted with an asterisk (*) are required.

Click the "Next" button to save your information and continue.

WHO TO INCLUDE ON THE APPLICATION

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

Do Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

DO NOT Include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return
- Non-relatives that will not be included as a dependent when you file taxes

« PREVIOUS NEXT »

Apply for assistance

- Informational screen
- Click Next to continue

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Who Can Use this Application

- Anyone
- Parents
- Families of Immigrants

WHO CAN USE THIS APPLICATION

- Use this application for anyone needing health care assistance.
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LOUISIANA DEPARTMENT OF HEALTH
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What You Will Need

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LOUISIANA DEPARTMENT OF HEALTH
Medicaid

How to Complete the Application

HOW TO COMPLETE THE APPLICATION

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LOUISIANA DEPARTMENT OF HEALTH
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DO Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

You DON'T have to include:

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

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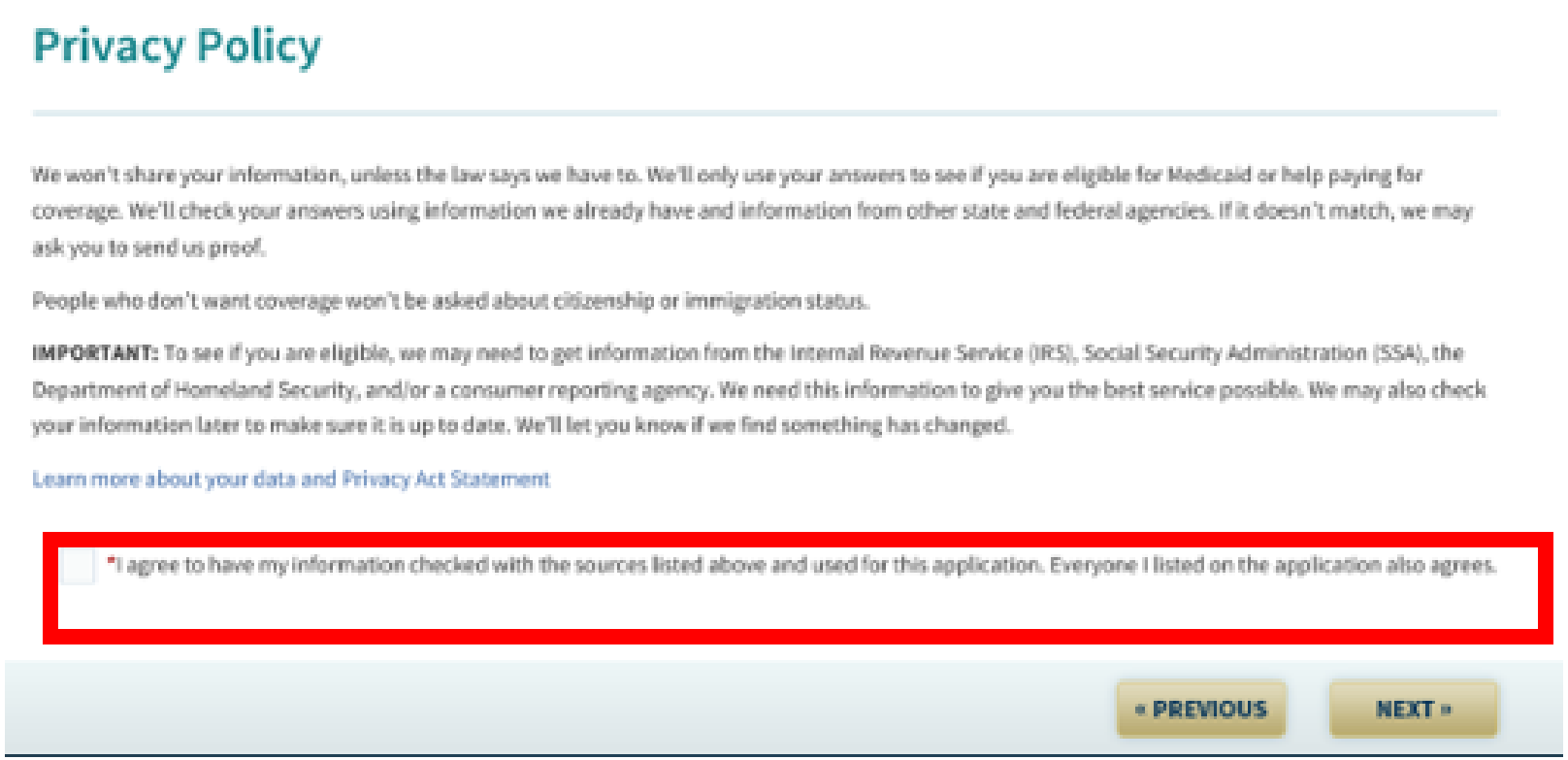
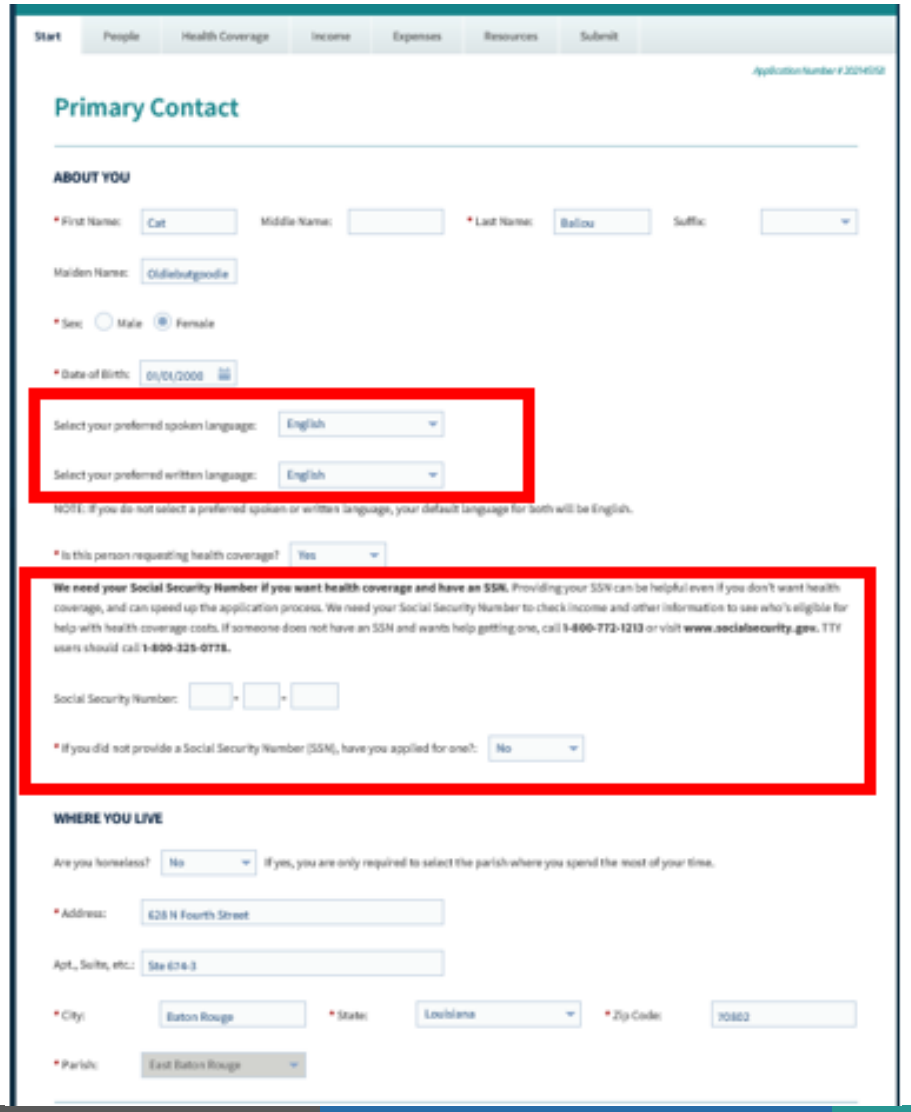
Privacy Policy



LOUISIANA DEPARTMENT OF HEALTH
Medicaid



Primary Contact

- Adult household member completing interview.
- Language preference is important.
- SSN
  - May be requested but not required
  - Don’t make them up!

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

MAILING ADDRESS

Is your mailing address the same as your home address above? Yes

* Address: 628 N Fourth Street

Apt., Suite, etc.: Ste 674-3

* City: Baton Rouge * State: Louisiana * Zip Code: 70802

CONTACT INFORMATION

NOTE: We encourage you to enter at least one phone number so that you can be contacted about this application if necessary.

Home Phone:

Work Phone:

Mobile Phone:

Other Phone: 225 - 219 - 0942

Personal Email Address: licationcenter.service@la.gov

Work Email Address: licationcenter.service@la.gov

AUTHORIZED REPRESENTATIVE

You can give someone you trust permission to help us with this application. They would be able to: talk with us, see your information and act for you (do things like provide information we ask for or sign the application for you). This person is called an "authorized representative". If you ever need to change your authorized representative, you may either report a change through your account or contact Medicaid.

* Do you want to name someone as an authorized representative? No

Mailing Address

- Adult household member
- Address and contact info
- AR designation, if requested

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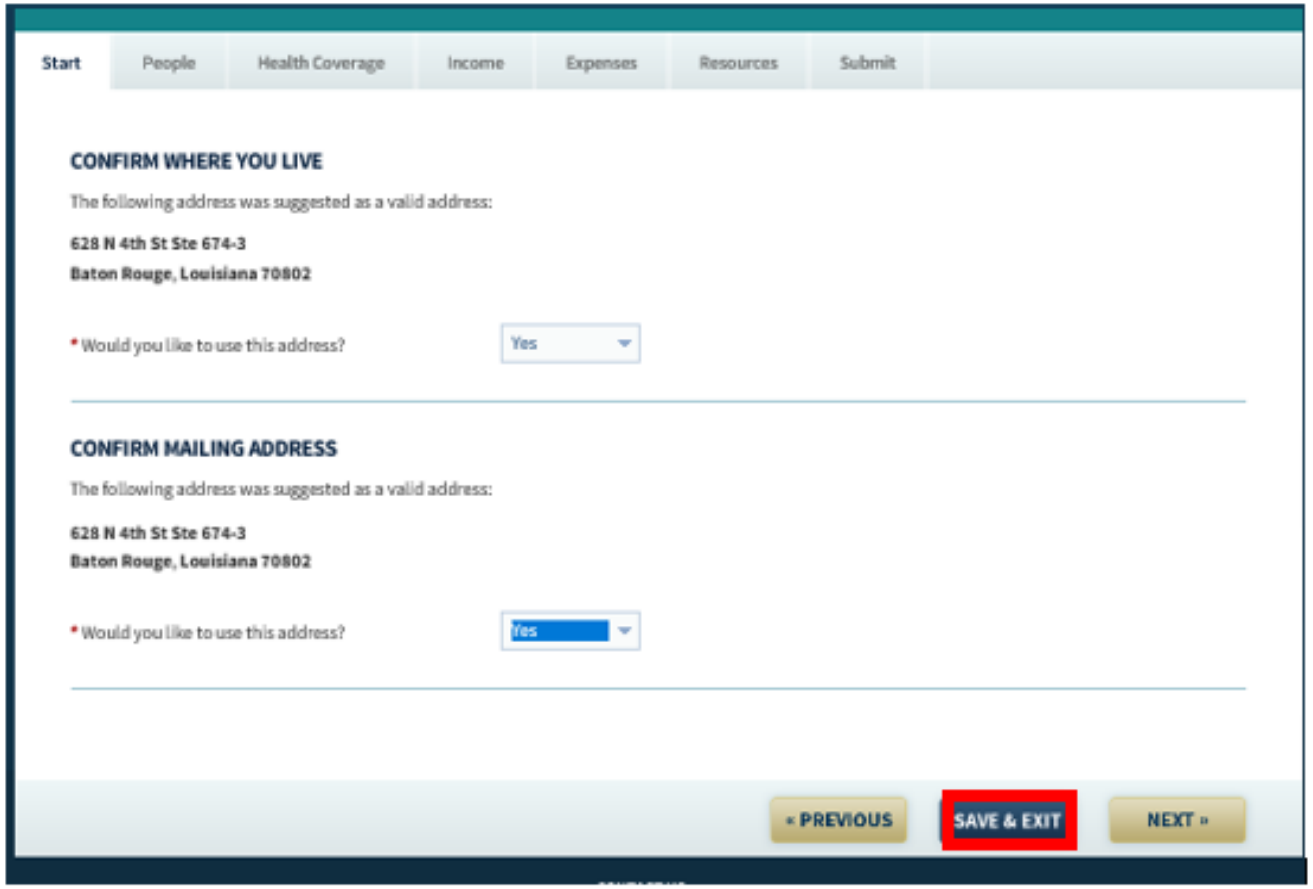
Medicaid



Confirm

- Physical Address – Correct?
- Mailing Address – Correct?

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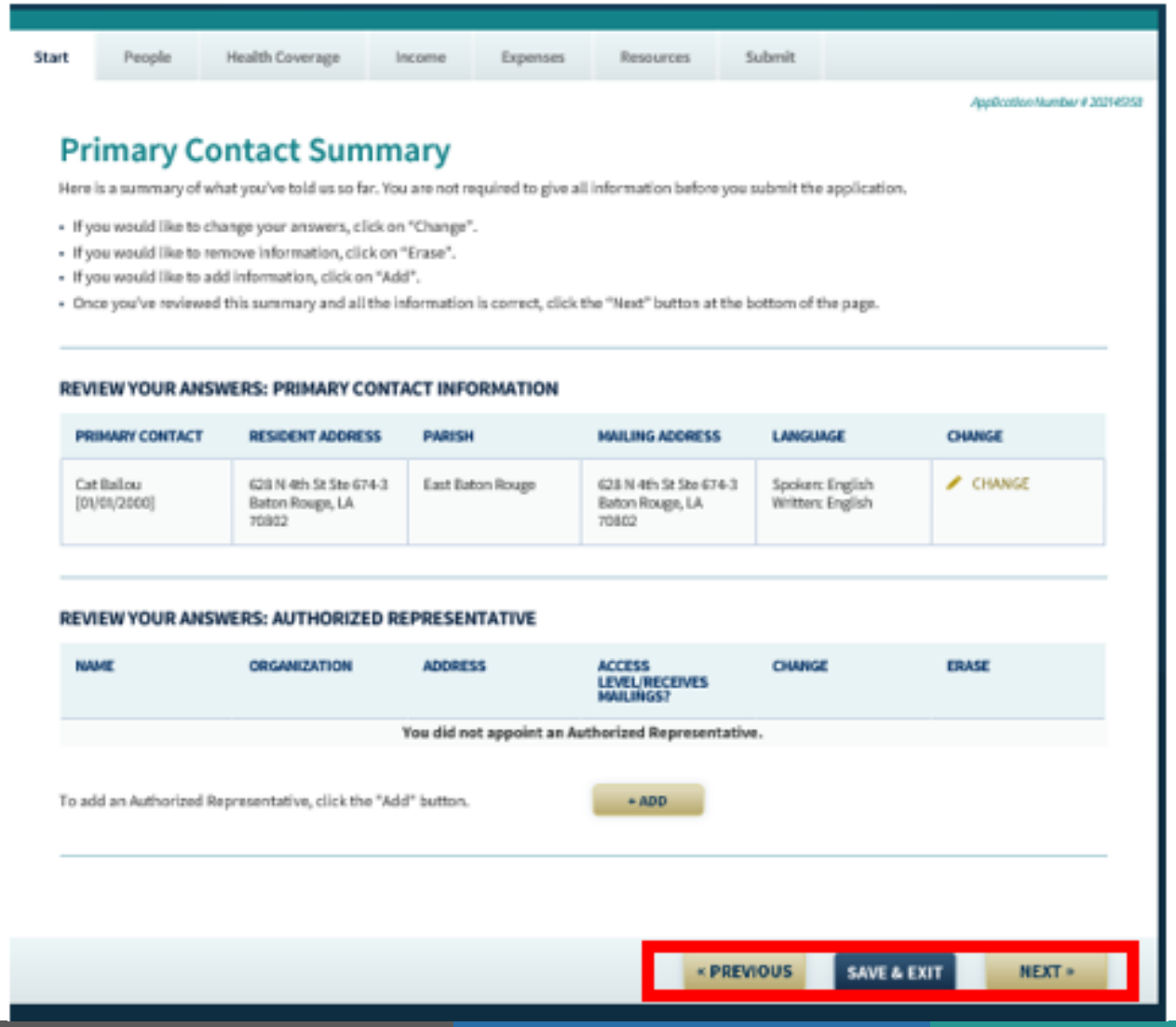

Primary Contact Summary

- Allow applicant to review
- Options
  1. Previous
  2. Save and Exit
  3. Next

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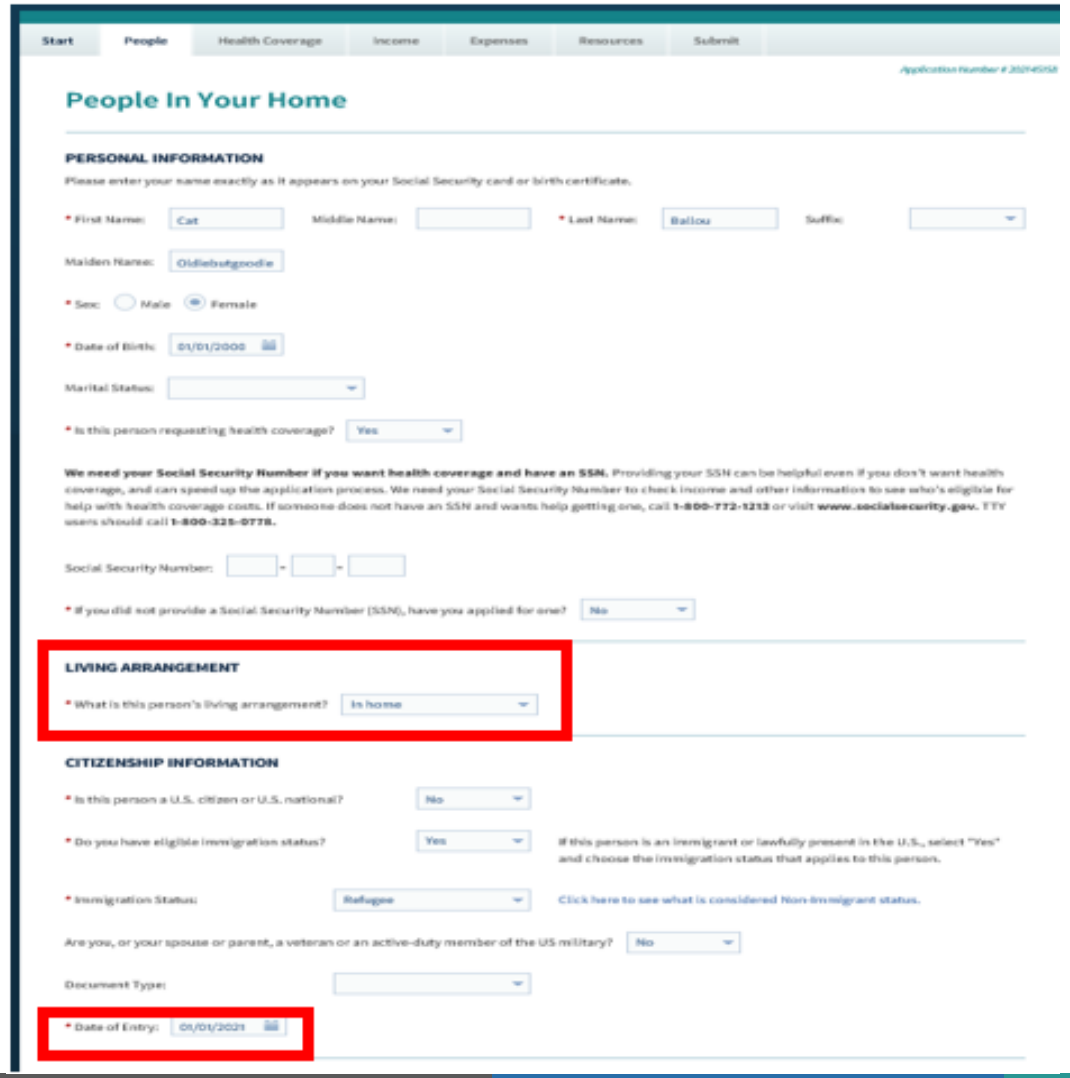
Medicaid



People in Your Home: Primary Contact

- Taxable Household
- Important
  - Living arrangement
  - Date of Entry

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Ethnicity and Race

ETHNICITY

If this person is of Hispanic, Latino, or Spanish origin, check all that apply. (optional)

- [ ] Puerto Rican
- [ ] Mexican
- [ ] Mexican American
- [ ] Chicano/a
- [ ] Cuban
- [x] Other
- [ ] Unknown

RACE

Select this person's race. Check all that apply. (optional)

- [ ] American Indian/Alaska Native
- [ ] Asian Indian
- [ ] Black or African American
- [ ] Chinese
- [ ] Filipino
- [ ] Guamanian or Chamorro
- [ ] Japanese
- [ ] Korean
- [ ] Native Hawaiian
- [ ] Other Asian
- [ ] Other Pacific Islander
- [ ] Samoan
- [ ] Vietnamese
- [ ] White
- [x] Other

* American Indians and Alaska Natives may not have to pay cost sharing and may get special enrollment periods. Are you an American Indian, Alaska Native, or someone who is eligible to receive or has ever received services at Indian Health Services, tribal health providers, or urban Indian health providers?

No

MEDICAL BILLS IN THE LAST 3 MONTHS

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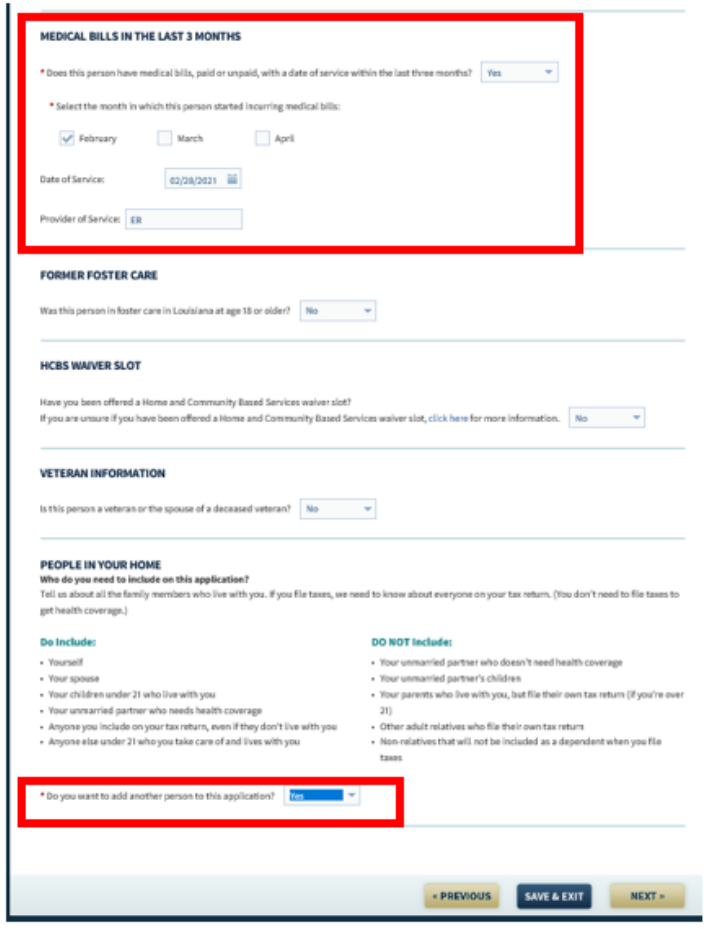
Medical Bills and Family Members



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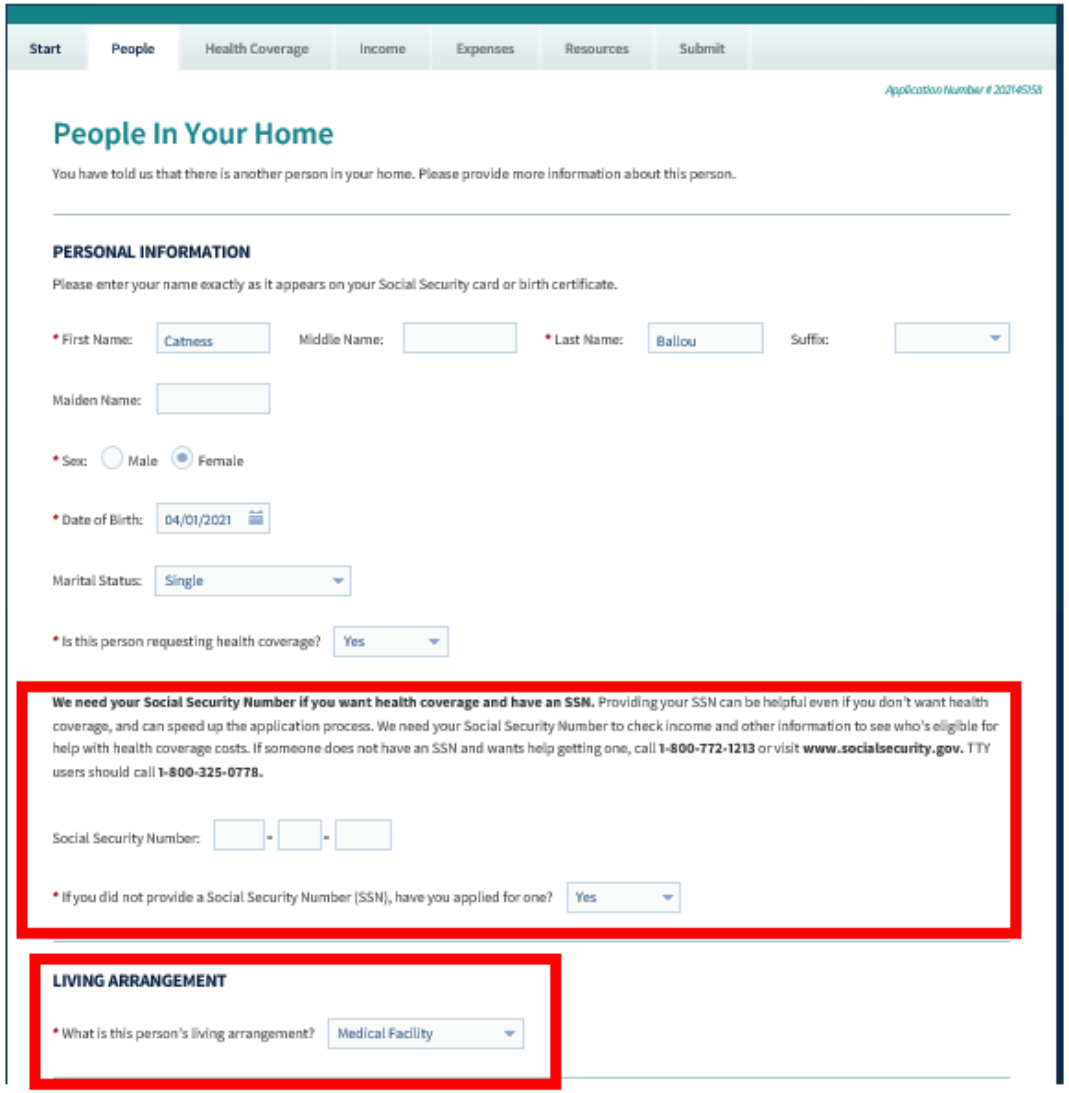

People in Your Home

- Personal information
- SSN request
- Living Arrangement

DO NOT refuse assistance

because

SSN or verifications are unavailable

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

People in Your Home

CITIZENSHIP INFORMATION

* Is this person a U.S. citizen or U.S. national? Yes

* Is this person a naturalized or derived citizen? No

ETHNICITY

If this person is of Hispanic, Latino, or Spanish origin, check all that apply. (optional)

- [ ] Puerto Rican
- [ ] Mexican
- [ ] Mexican American
- [ ] Chicano/a
- [ ] Cuban
- [ ] Other
- [ ] Unknown

RACE

Select this person's race. Check all that apply. (optional)

- [ ] American Indian/Alaska Native
- [ ] Asian Indian
- [ ] Black or African American
- [ ] Chinese
- [ ] Filipino
- [ ] Guamanian or Chamorro
- [ ] Japanese
- [ ] Korean
- [ ] Native Hawaiian
- [ ] Other Asian
- [ ] Other Pacific Islander
- [ ] Samoan
- [ ] Vietnamese
- [ ] White
- [x] Other

* American Indians and Alaska Natives may not have to pay cost sharing and may get special enrollment periods. Are you an American Indian, Alaska Native, or someone who is eligible to receive or has ever received services at Indian Health Services, tribal health providers, or urban Indian health providers?

No

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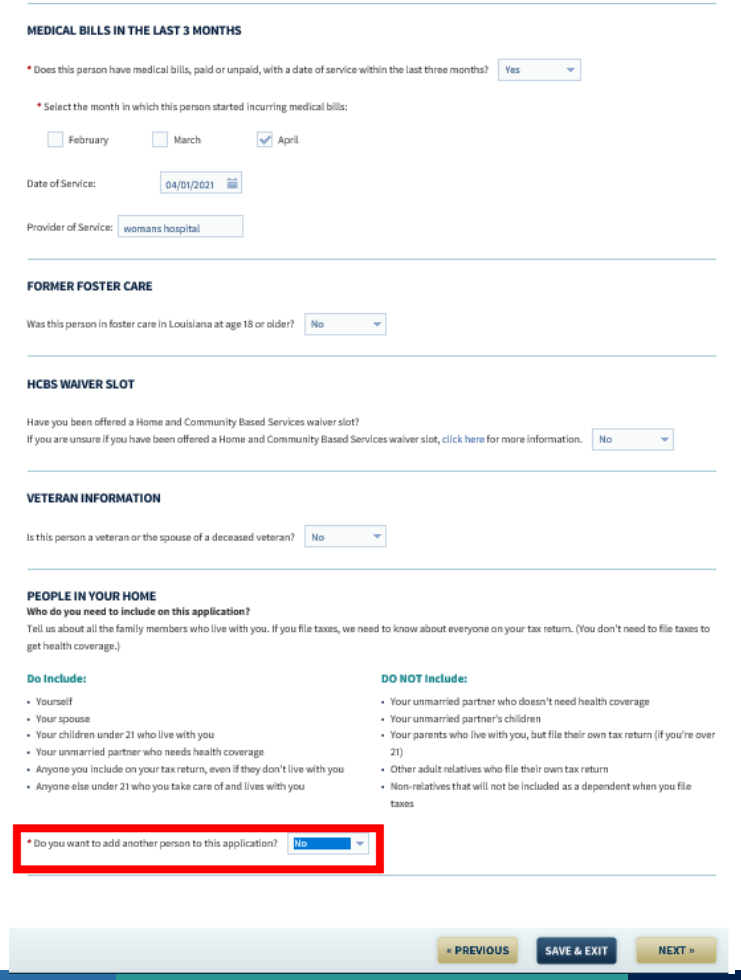
People in Your Home



MEDICAL BILLS IN THE LAST 3 MONTHS

* Does this person have medical bills, paid or unpaid, with a date of service within the last three months? Yes

* Select the month in which this person started incurring medical bills:

☐ February ☐ March ☑ April

Date of Service: 04/01/2021

Provider of Service: womans hospital

FORMER FOSTER CARE

Was this person in foster care in Louisiana at age 18 or older? No

HCBS WAIVER SLOT

Have you been offered a Home and Community Based Services waiver slot?
If you are unsure if you have been offered a Home and Community Based Services waiver slot, click here for more information. No

VETERAN INFORMATION

Is this person a veteran or the spouse of a deceased veteran? No

PEOPLE IN YOUR HOME

Who do you need to include on this application?

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage.)

Do Include:

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

DO NOT Include:

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- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return
- Non-relatives that will not be included as a dependent when you file taxes

* Do you want to add another person to this application? No

« PREVIOUS SAVE & EXIT NEXT »

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Former Foster Care

Application Number # 202145358

BEFORE YOU GO TO THE NEXT PAGE:

- **Error:** This individual is under the age of 18, so they do not need to provide answers to the Foster Care questions below. Please update the age or change your answer.

People In Your Home

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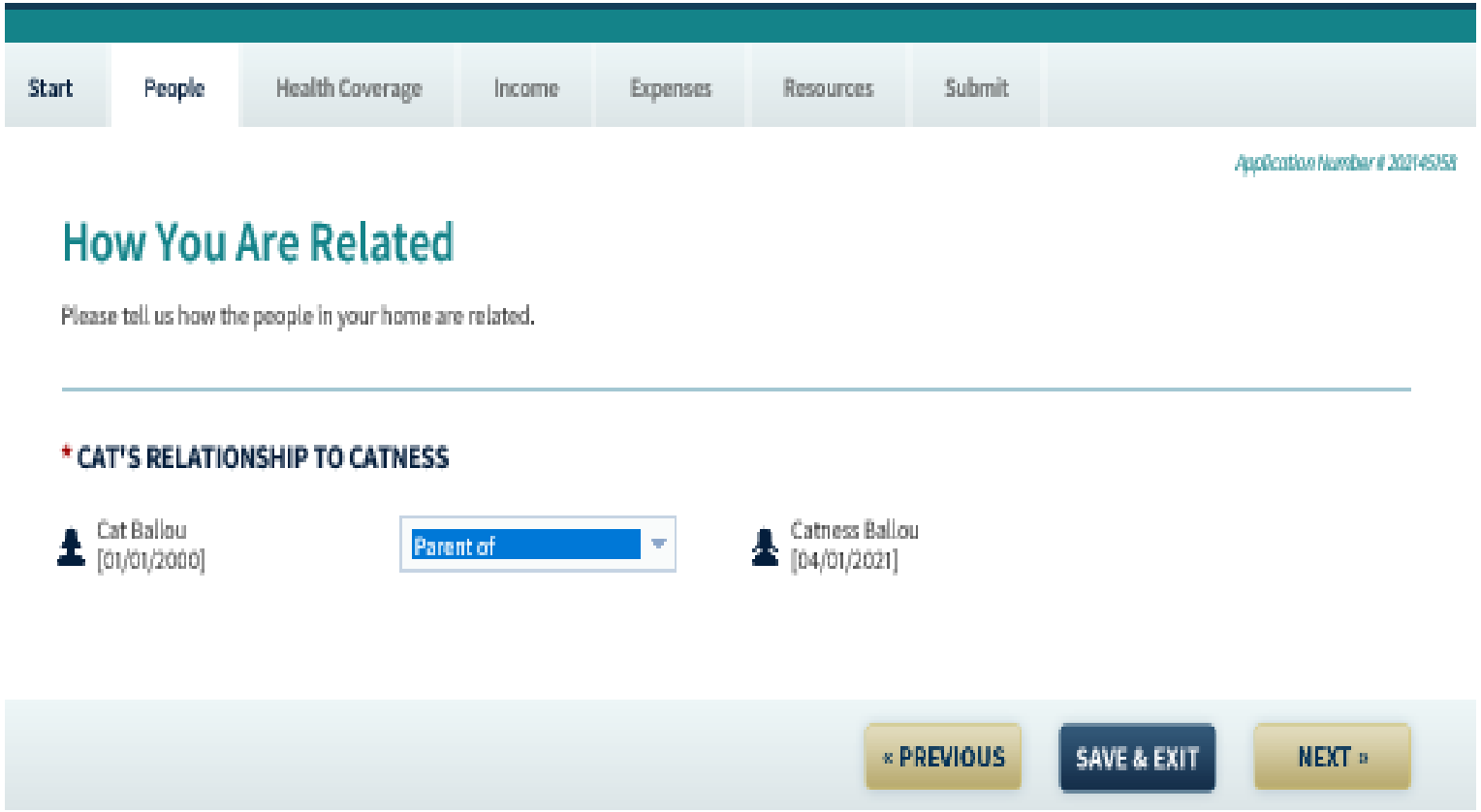
How Are You Related



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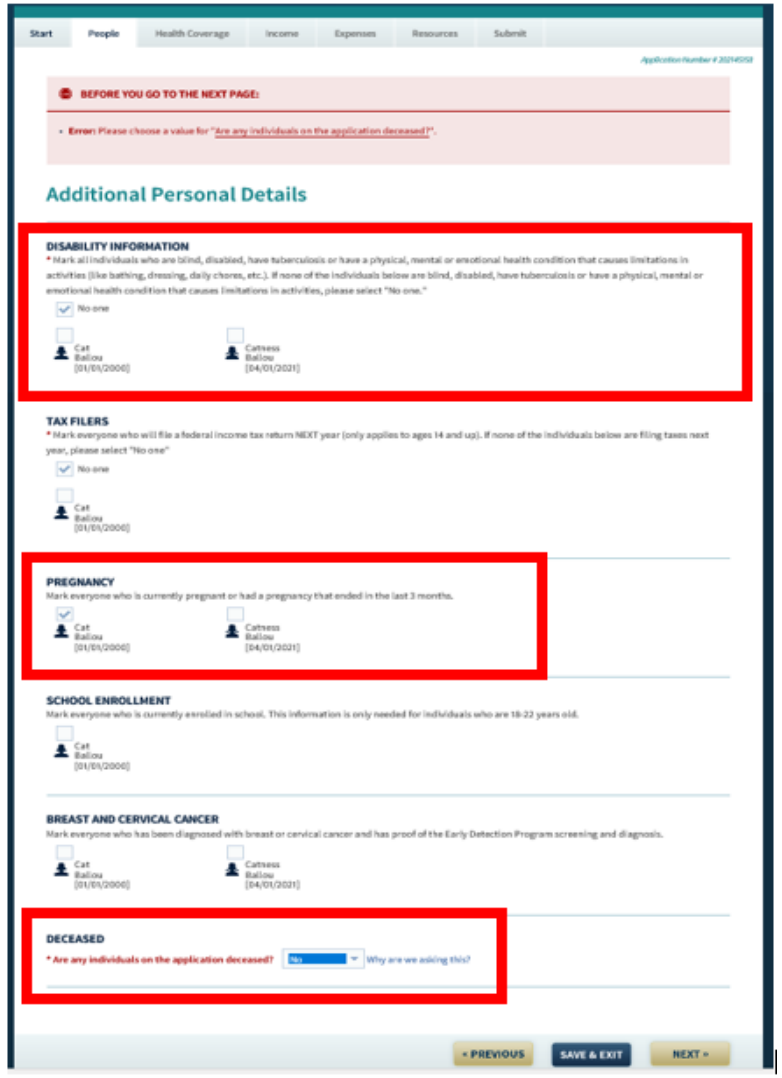

Additional Personal Details

- Disability
- Tax Filers
- Pregnancy
- School enrollment
- Breast and Cervical Cancer
- Deceased

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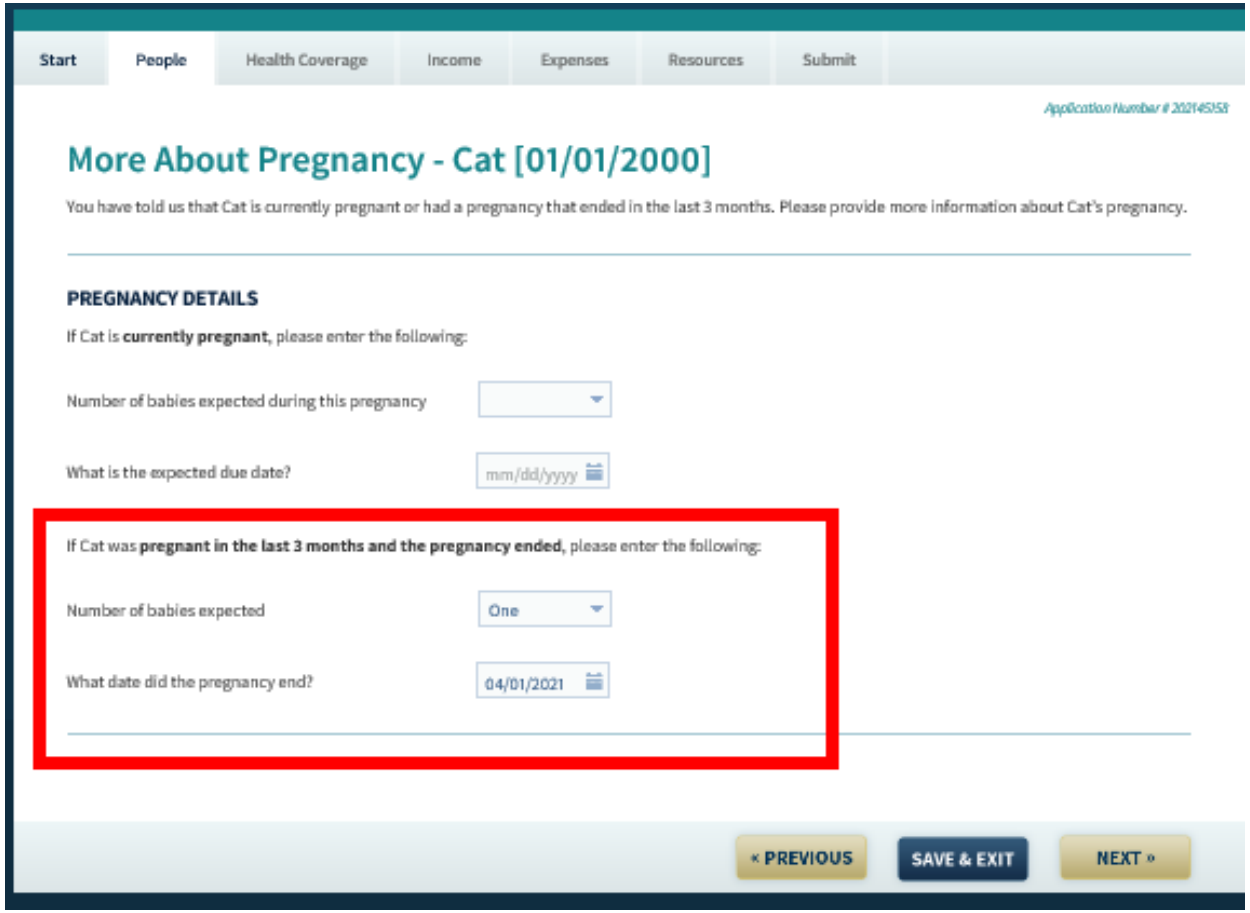
More About Pregnancy



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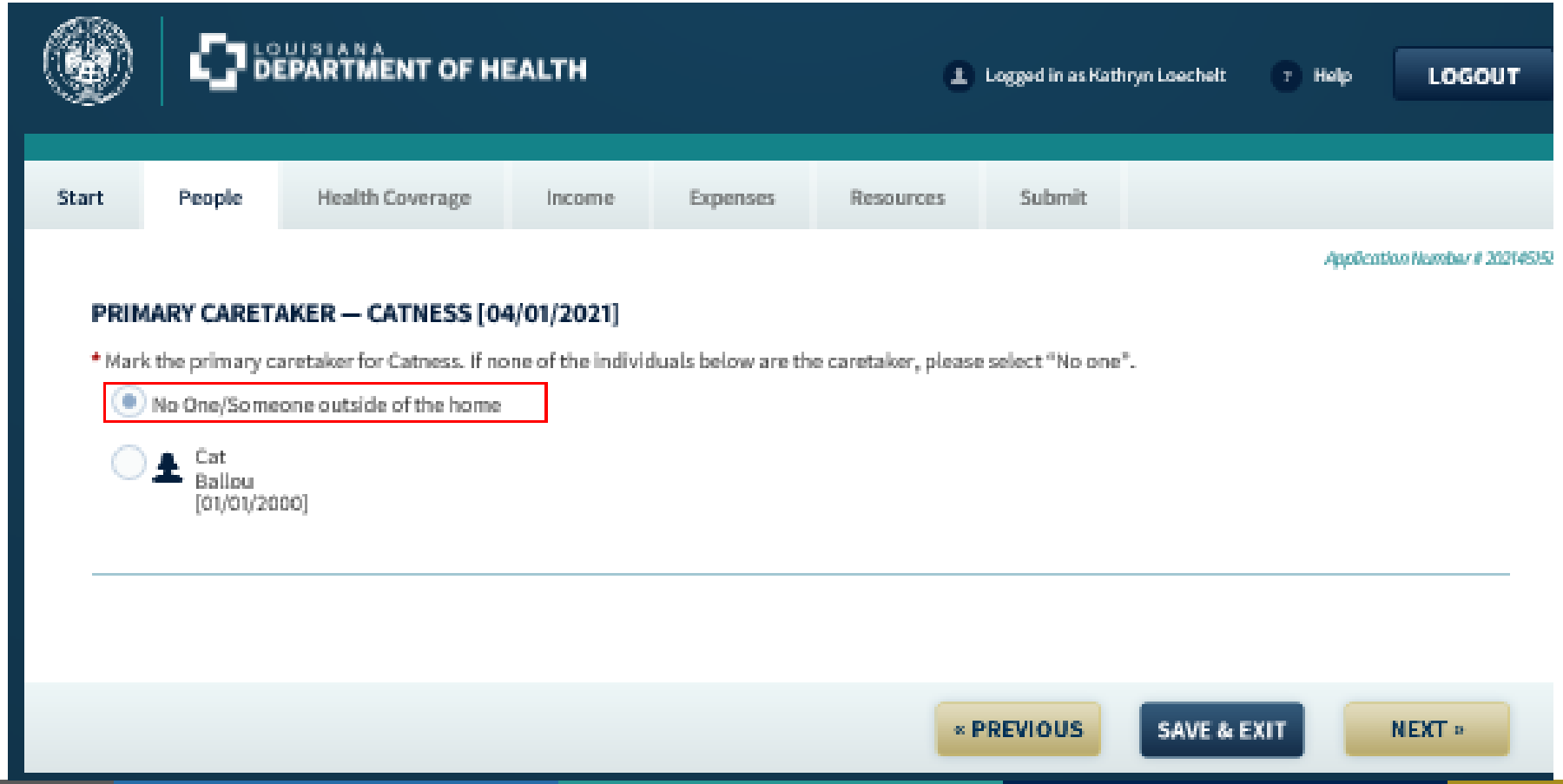
Primary Caretaker



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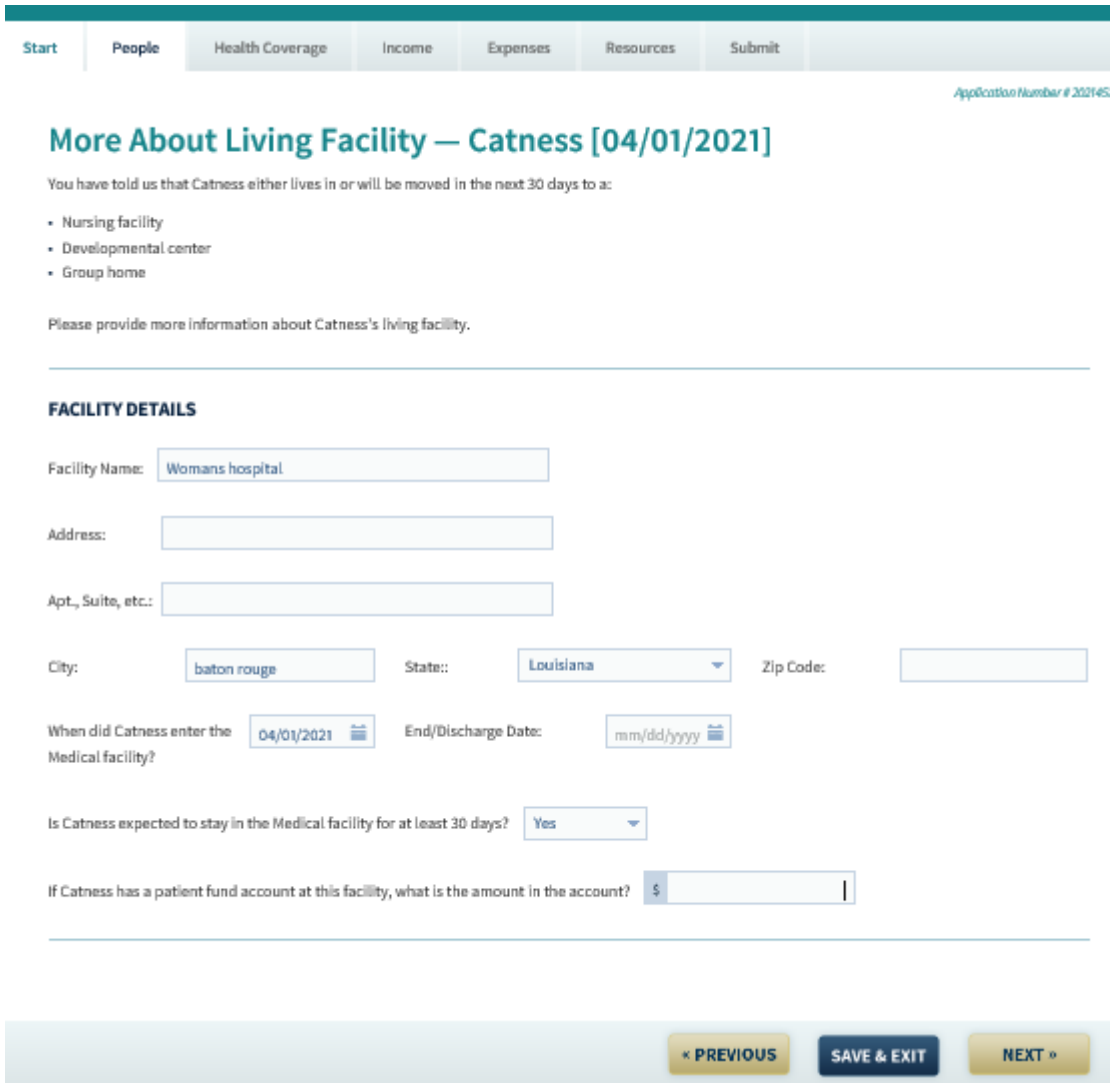

More About Living Facility

Provide Facility Information:

- Type
- Name
- Address
- Dates of residence
  - Date entered
  - Date Discharged
- 30 Days?
- Patient Fund Account?

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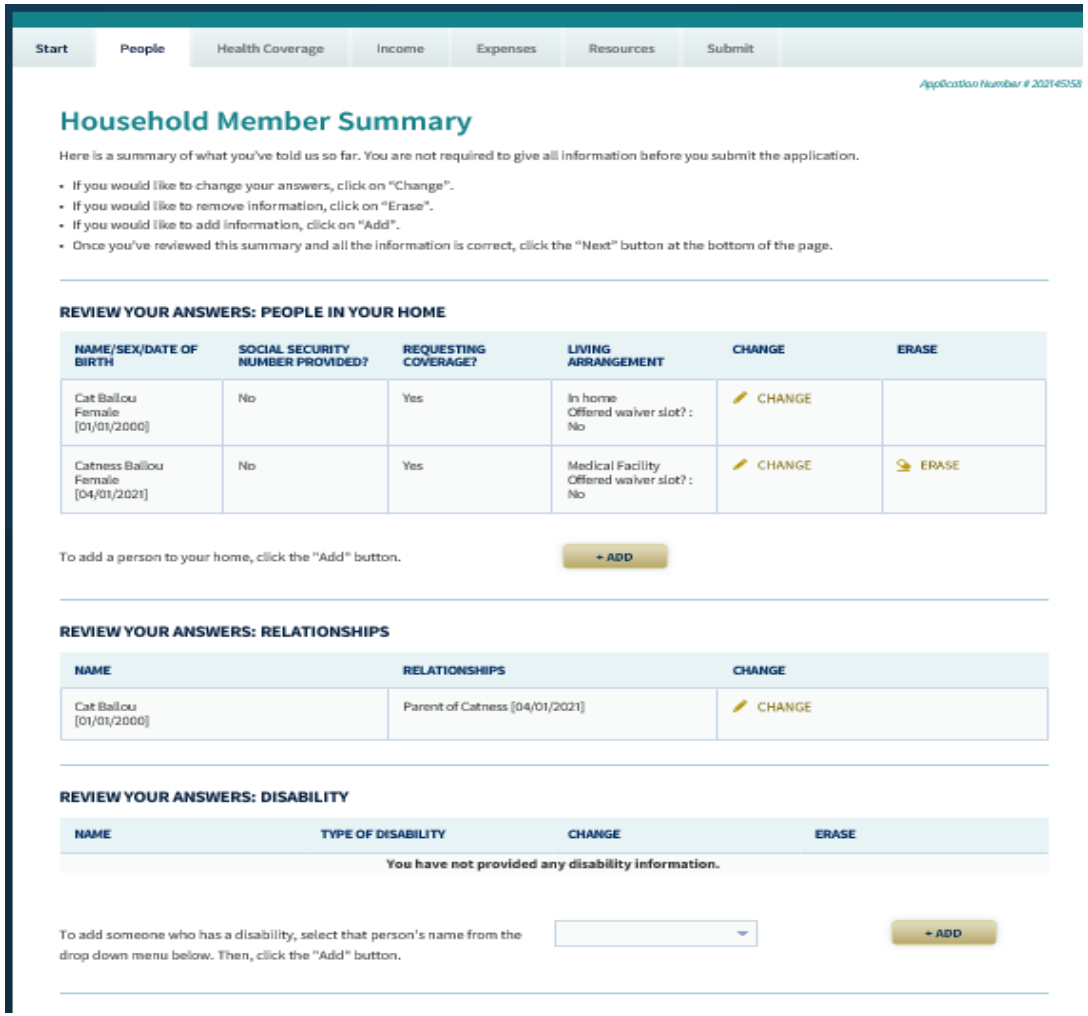

Household Member Summary

Review to ensure accuracy of information entered up to this point!

- People in your home
- Relationships
- Disability

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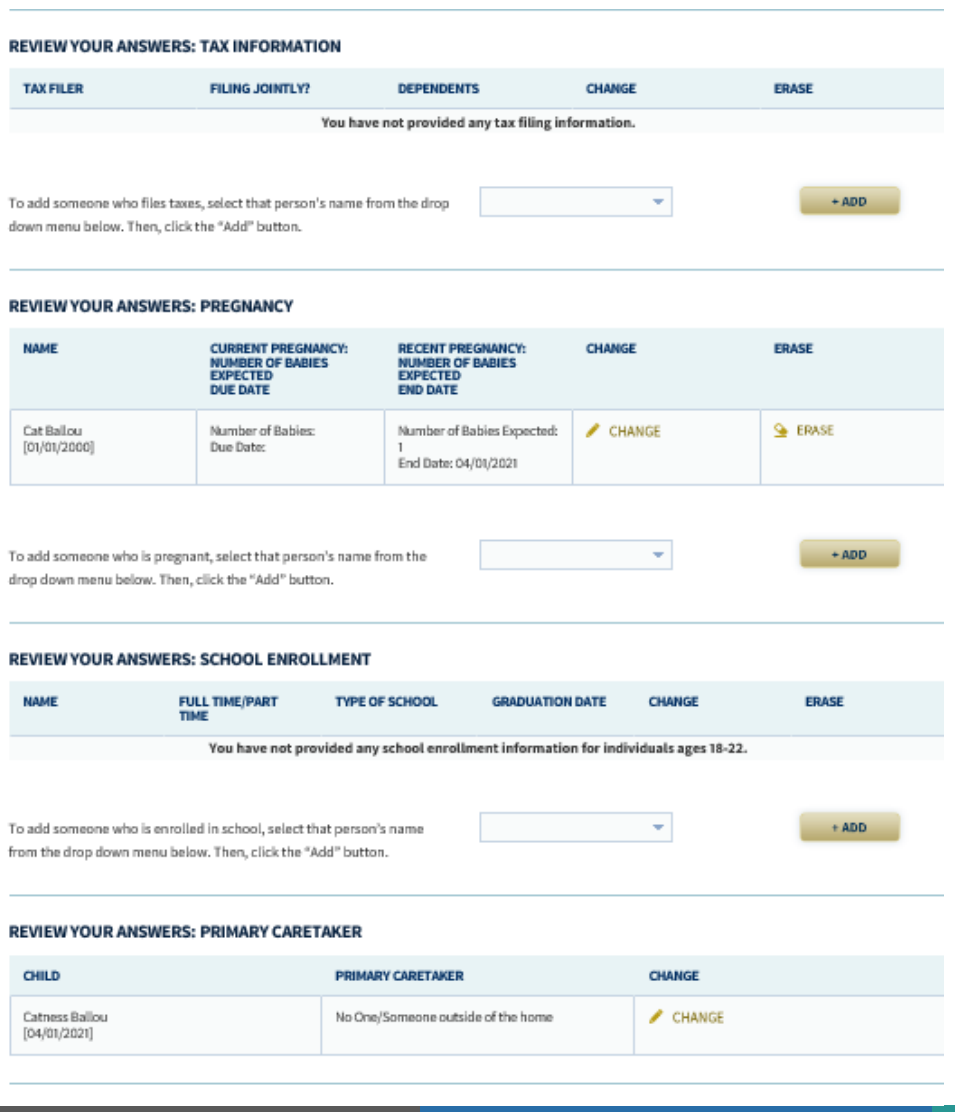
Medicaid



REVIEW YOUR ANSWERS: TAX INFORMATION

TAX FILER	FILING JOINTLY?	DEPENDENTS	CHANGE	ERASE
You have not provided any tax filing information.				

To add someone who files taxes, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

REVIEW YOUR ANSWERS: PREGNANCY

NAME	CURRENT PREGNANCY: NUMBER OF BABIES EXPECTED DUE DATE	RECENT PREGNANCY: NUMBER OF BABIES EXPECTED END DATE	CHANGE	ERASE
Cat Ballou (01/01/2000)	Number of Babies: Due Date:	Number of Babies Expected: 1 End Date: 04/01/2021	CHANGE	ERASE

To add someone who is pregnant, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

REVIEW YOUR ANSWERS: SCHOOL ENROLLMENT

NAME	FULL TIME/PART TIME	TYPE OF SCHOOL	GRADUATION DATE	CHANGE	ERASE
You have not provided any school enrollment information for individuals ages 18-22.					

To add someone who is enrolled in school, select that person's name from the drop down menu below. Then, click the "Add" button.

+ ADD

REVIEW YOUR ANSWERS: PRIMARY CARETAKER

CHILD	PRIMARY CARETAKER	CHANGE
Catness Ballou (04/01/2021)	No One/Someone outside of the home	CHANGE

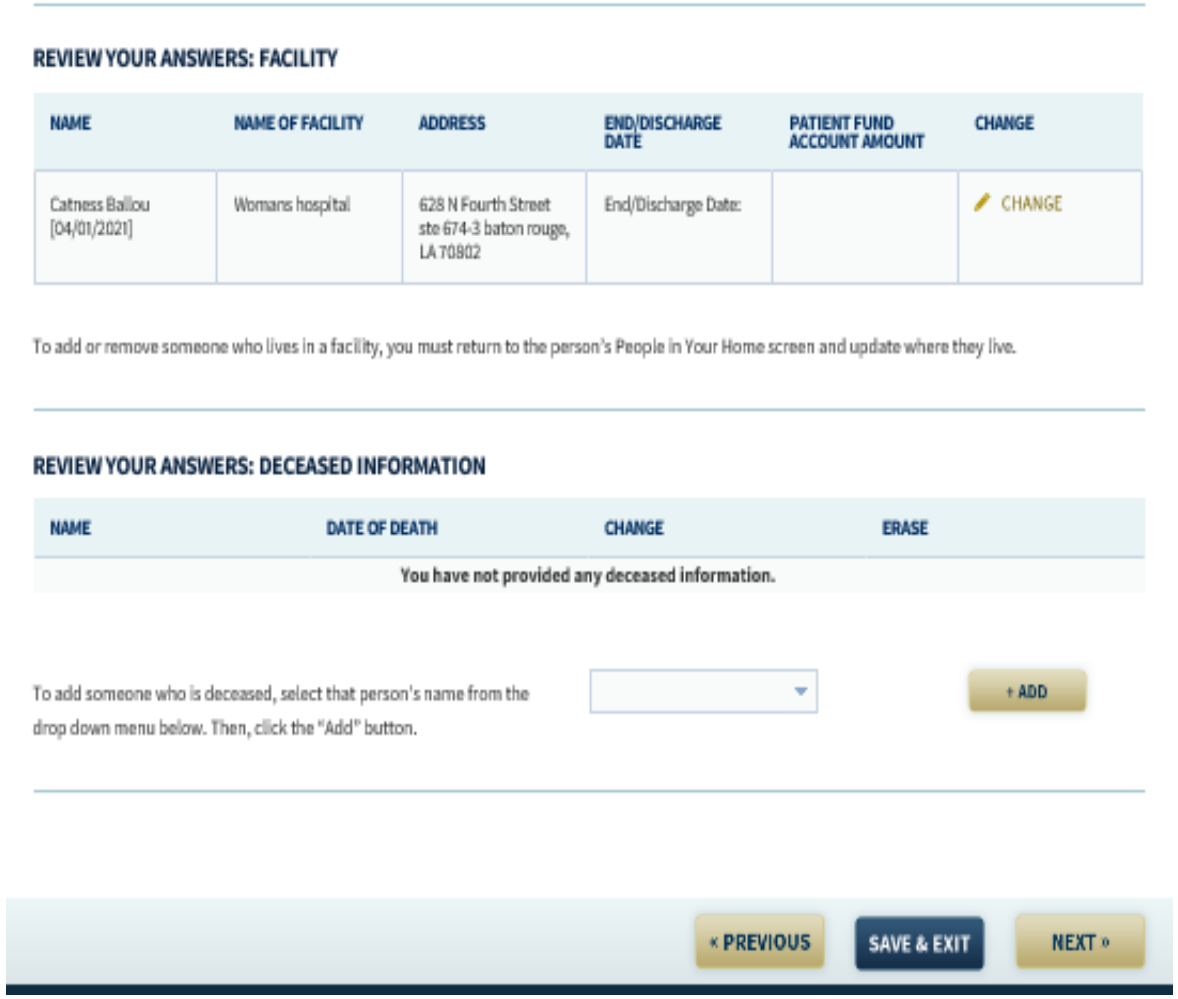
Household Member Summary

- Tax Information
- Pregnancy
- School Enrollment
- Primary Caretaker

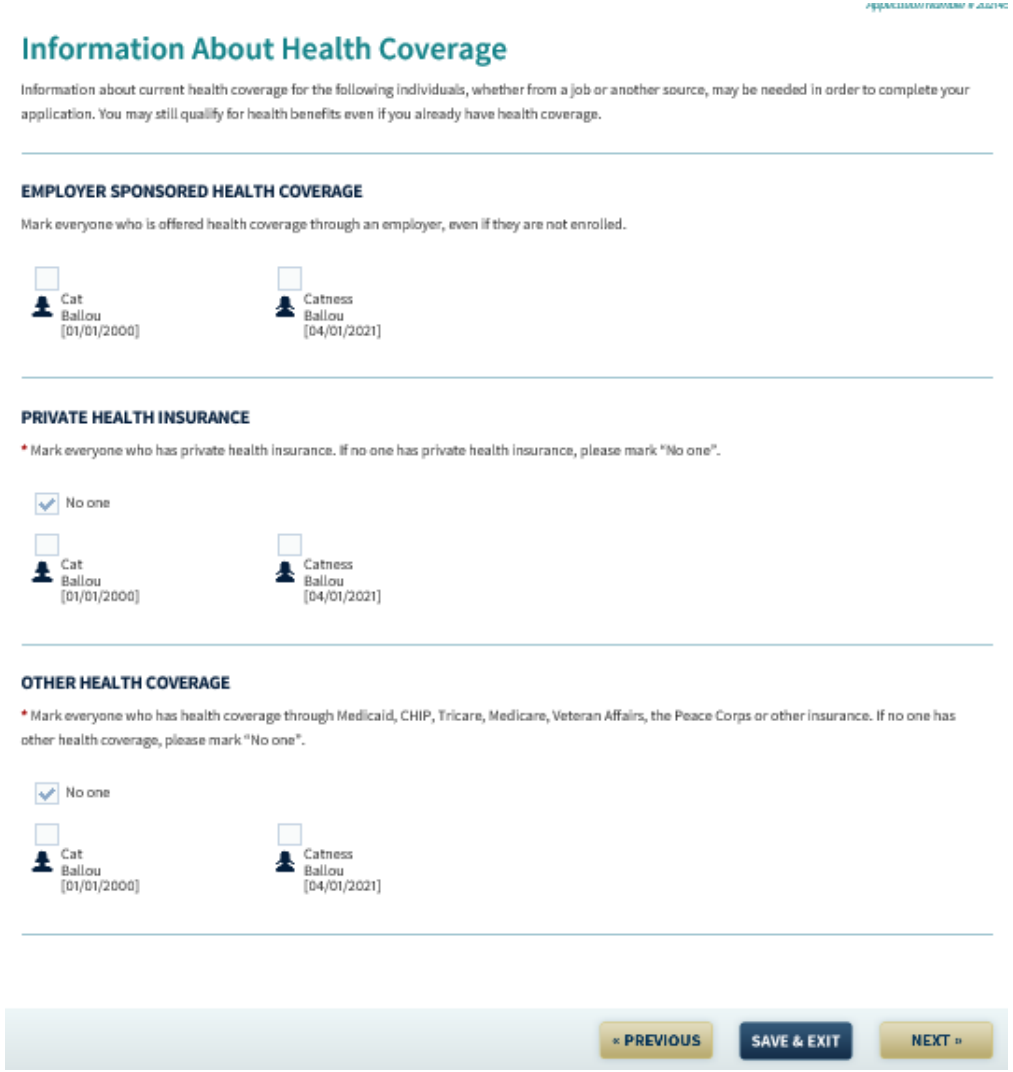
LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Household Member Summary

- Facility
- Deceased



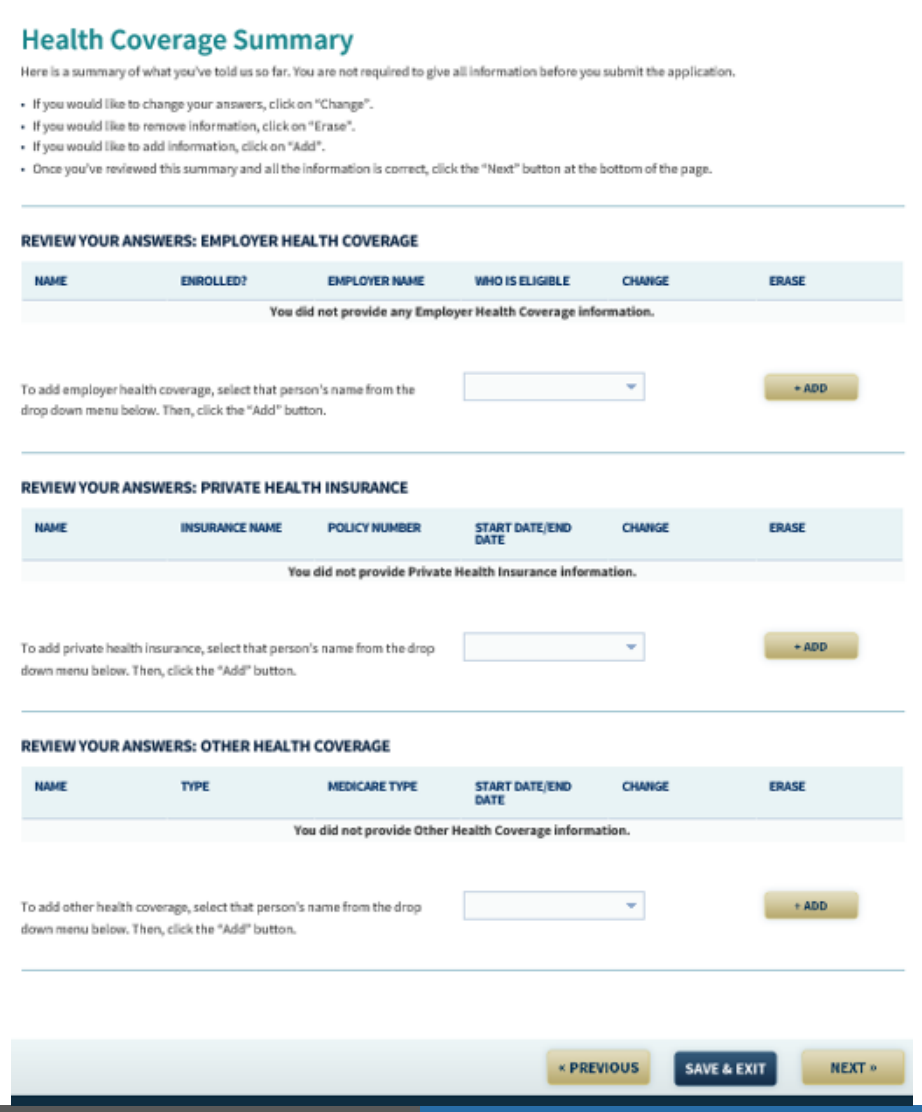
LOUISIANA DEPARTMENT OF HEALTH
Medicaid



Information about Health Coverage

- Employer Sponsored
- Private Health Insurance
- Other Health Coverage

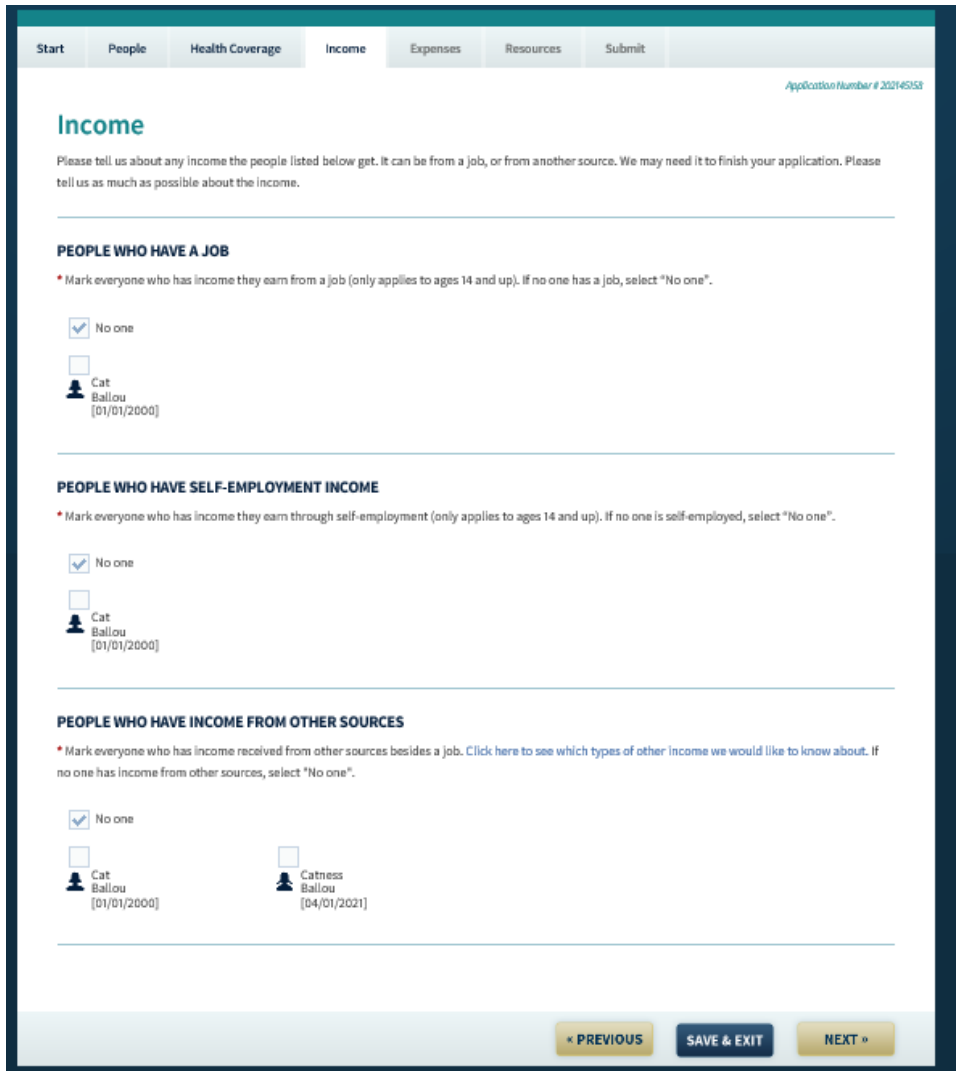
LOUISIANA DEPARTMENT OF HEALTH
Medicaid



Health Coverage Summary

Review to ensure accuracy of information entered up to this point!

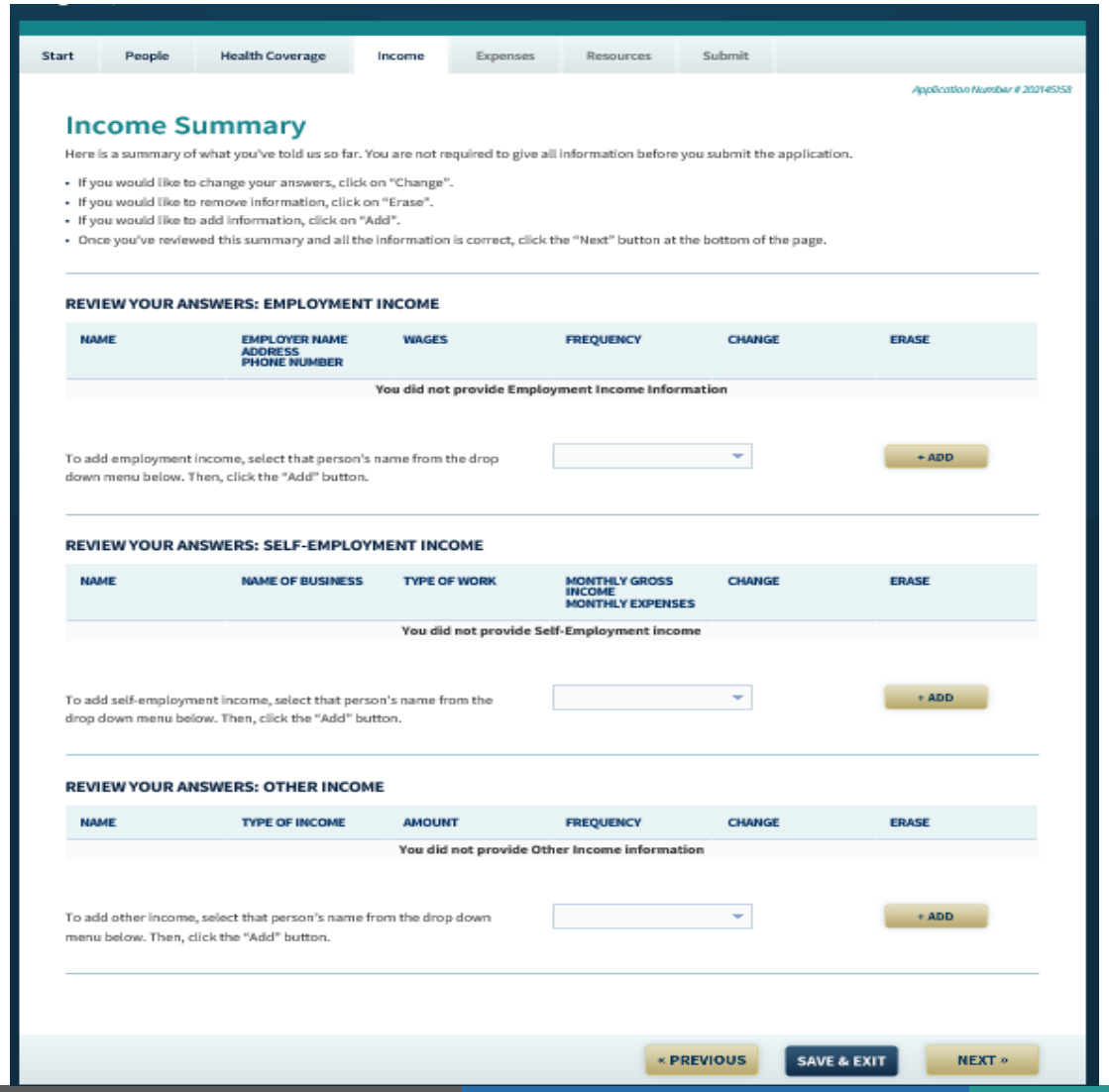
LOUISIANA DEPARTMENT OF HEALTH
Medicaid



Income

- People who have a job
- People who have self-employment income
- People who have income from other sources

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

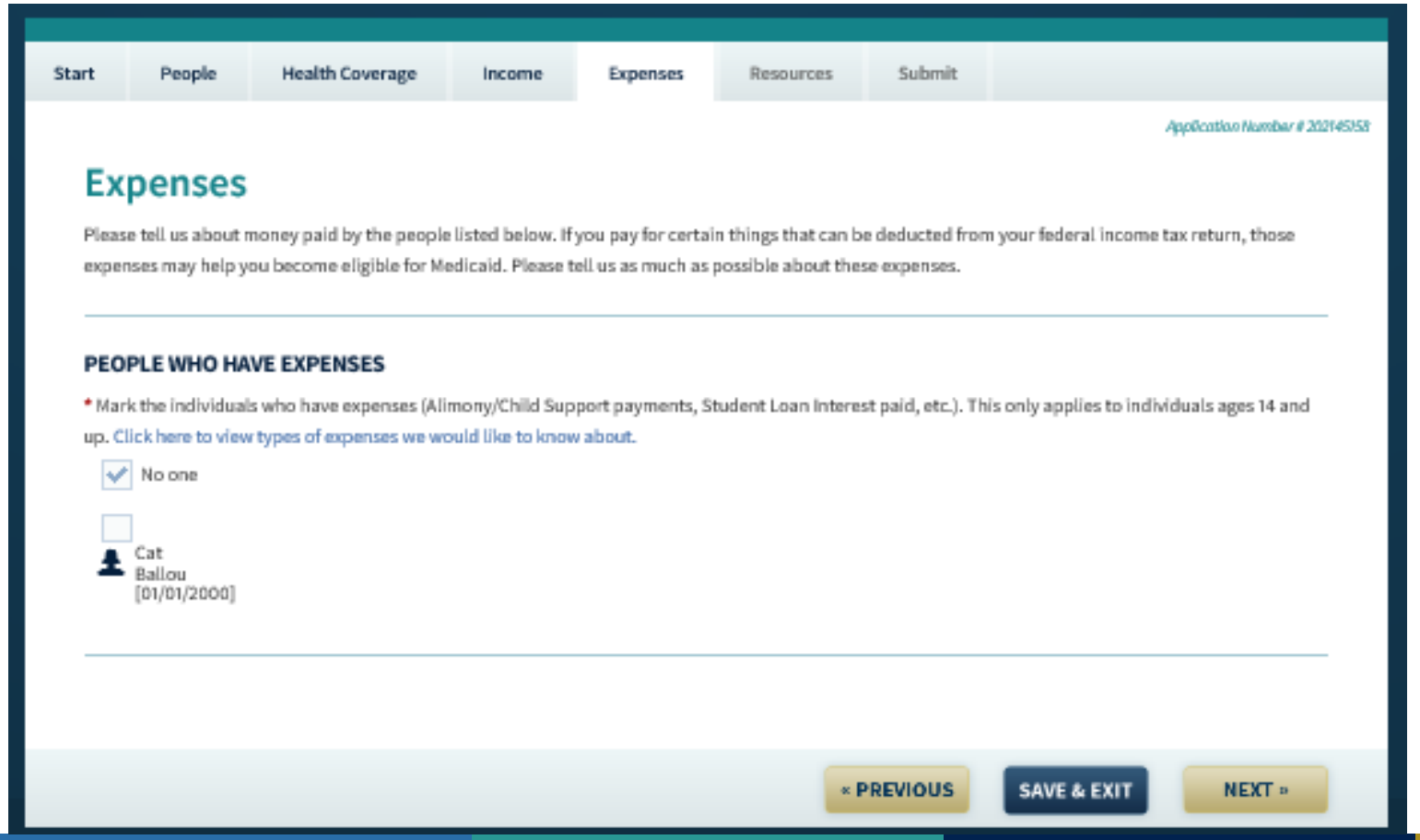


Income Summary

Review to ensure accuracy of information entered up to this point!

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Expenses



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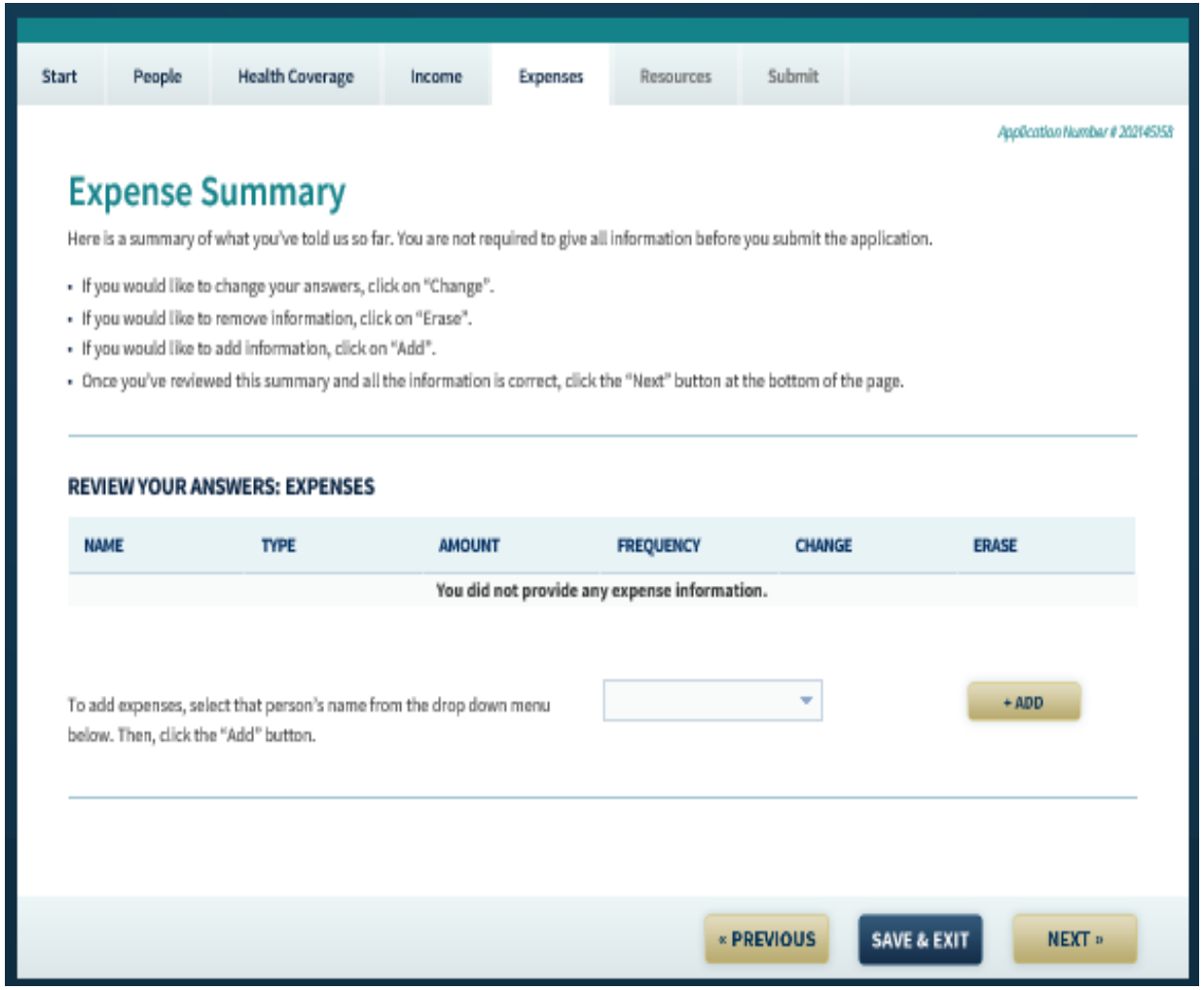
Medicaid



Expense Summary

Review to ensure accuracy of information entered up to this point!

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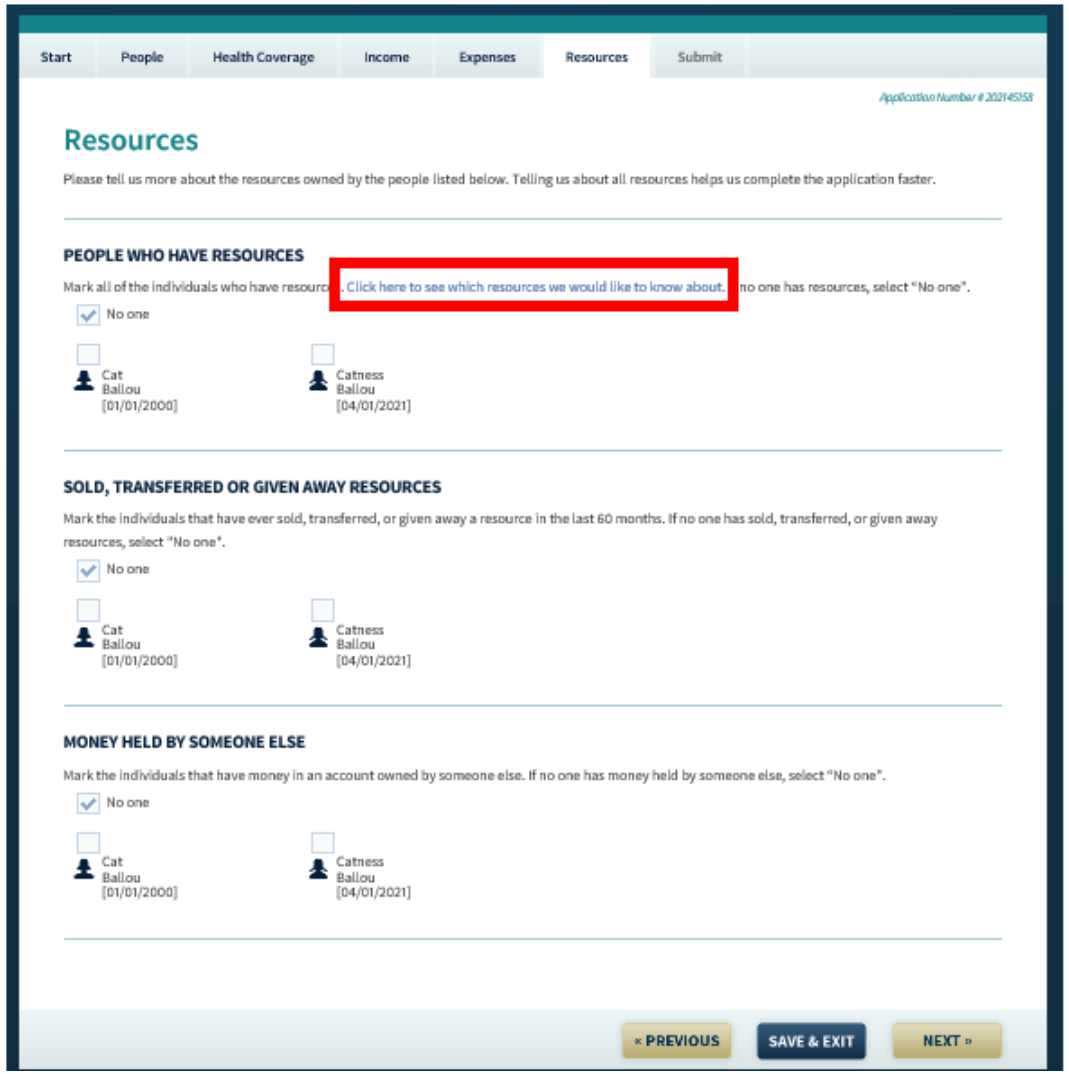
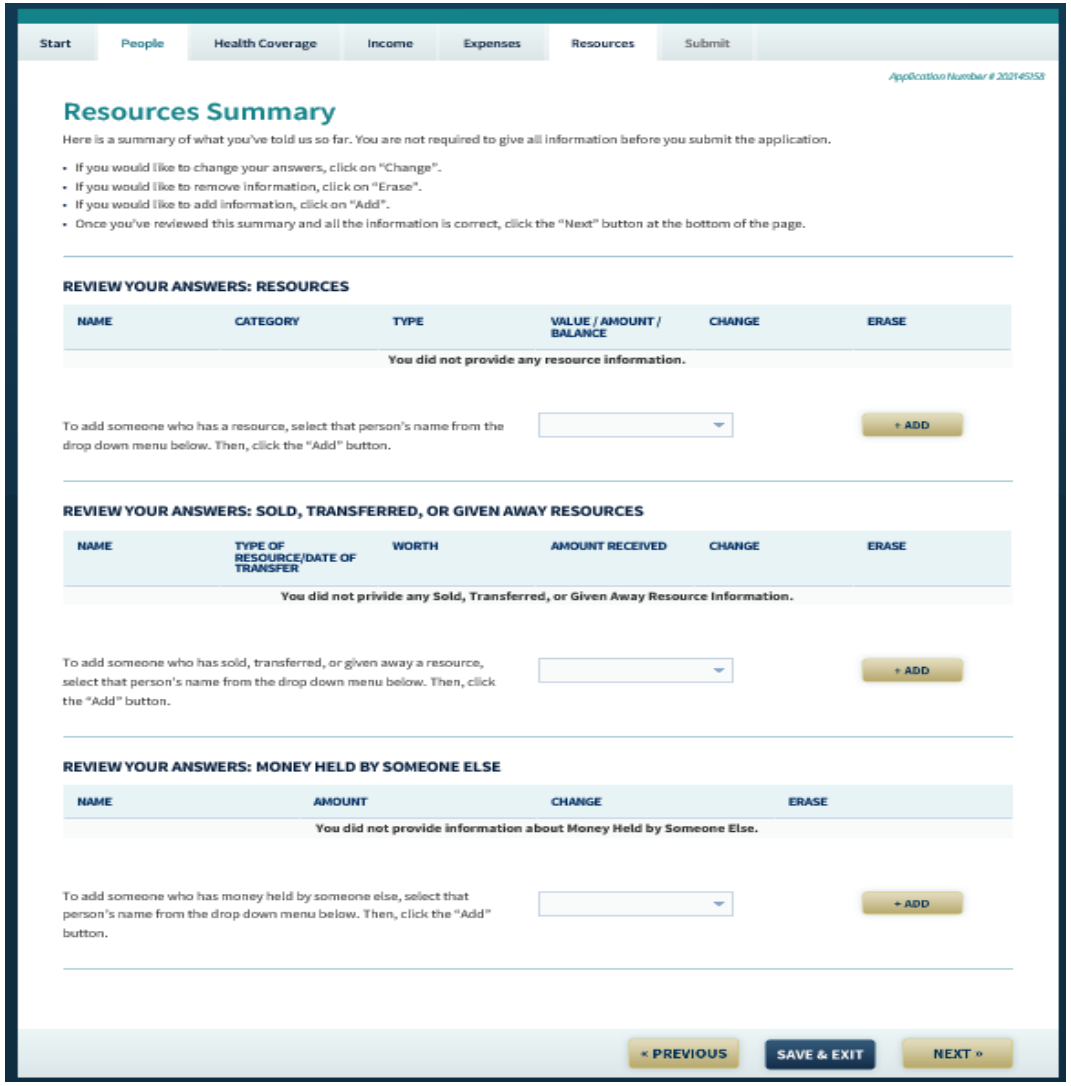
Medicaid



Resources

- People who have resources
- Sold, Transferred, or Given away resources
- Money held by someone else

LOUISIANA DEPARTMENT OF HEALTH
Medicaid



Resource Summary

Review to ensure accuracy of information entered up to this point!

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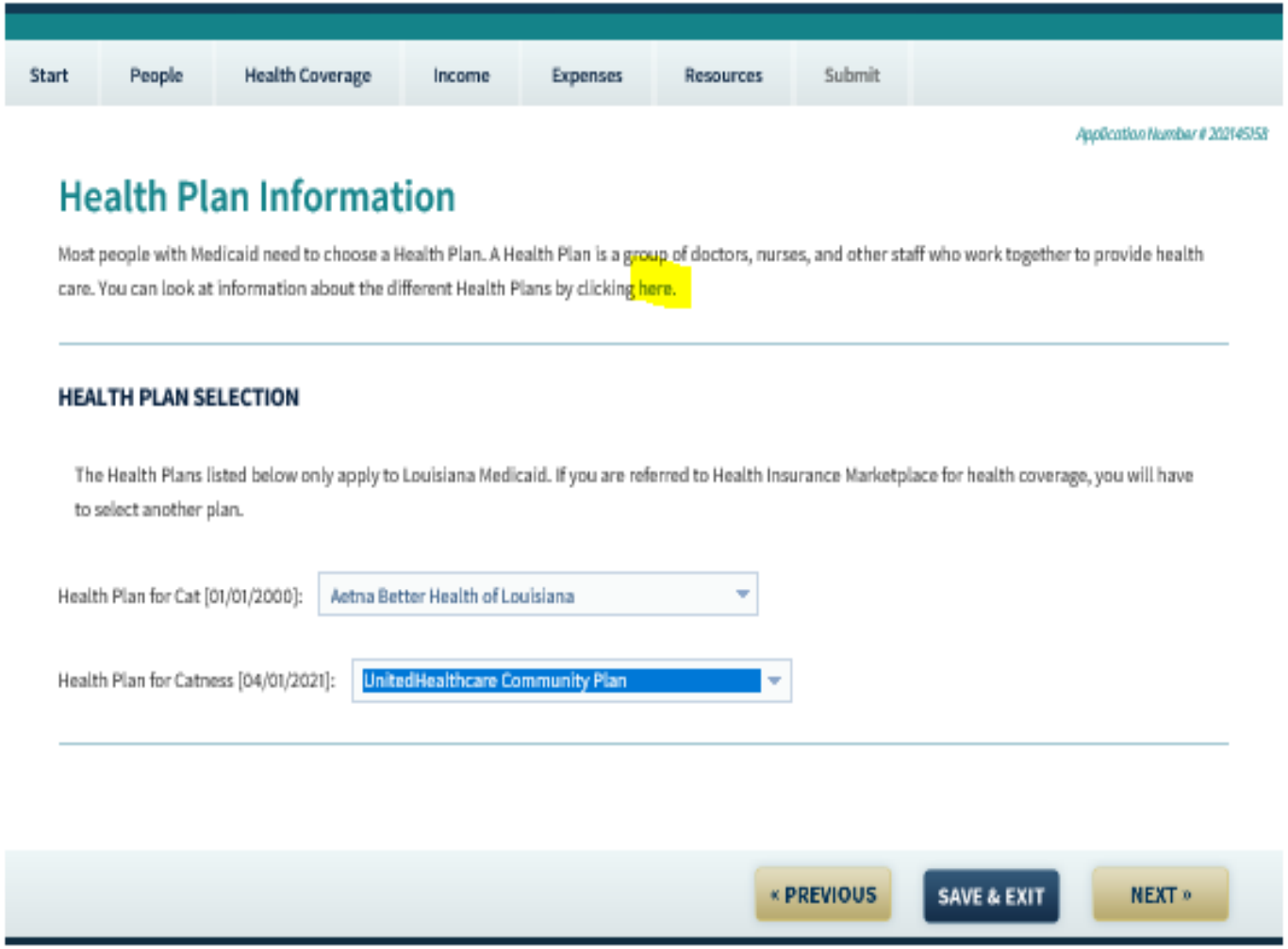
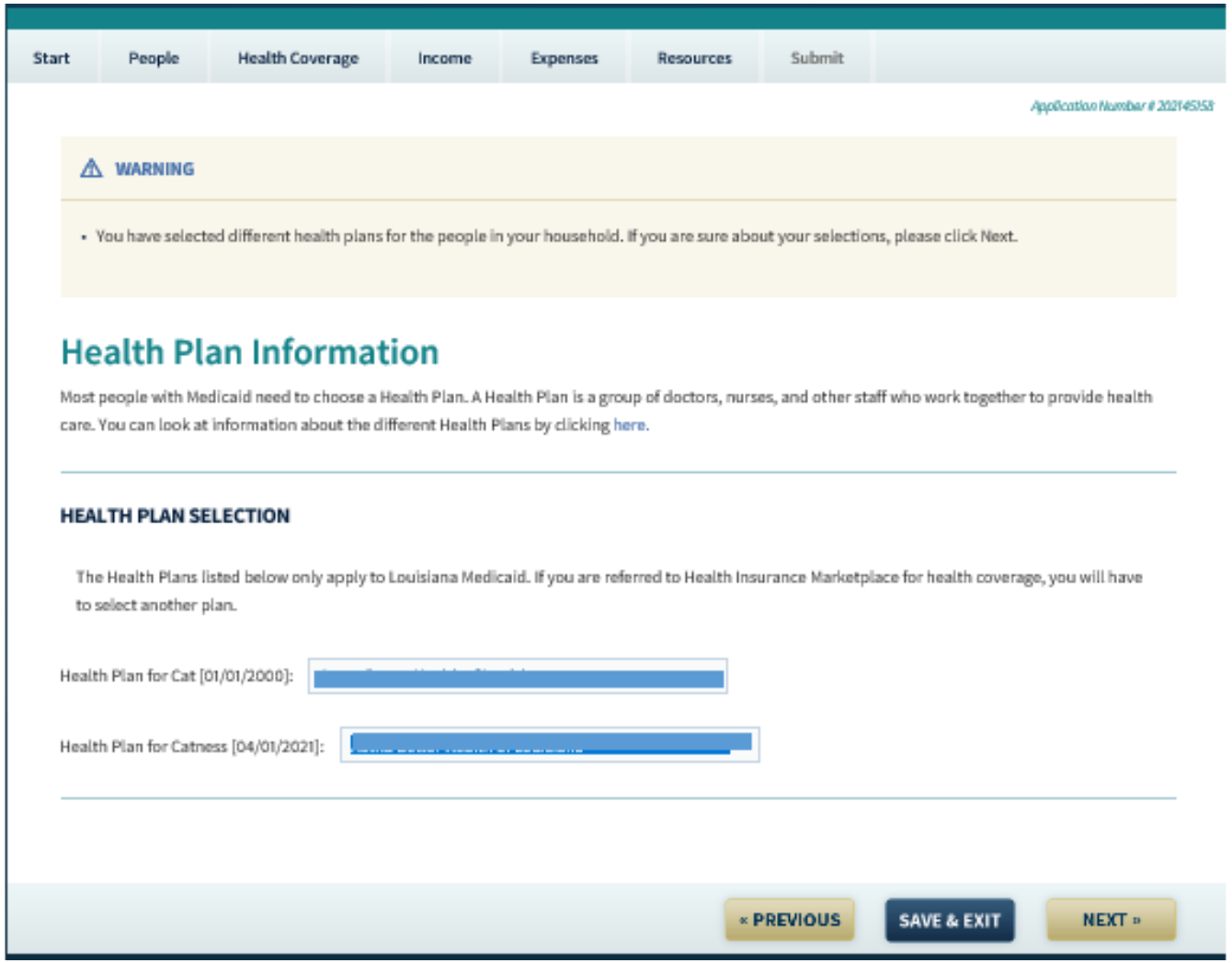
Medicaid



Health Plan Information

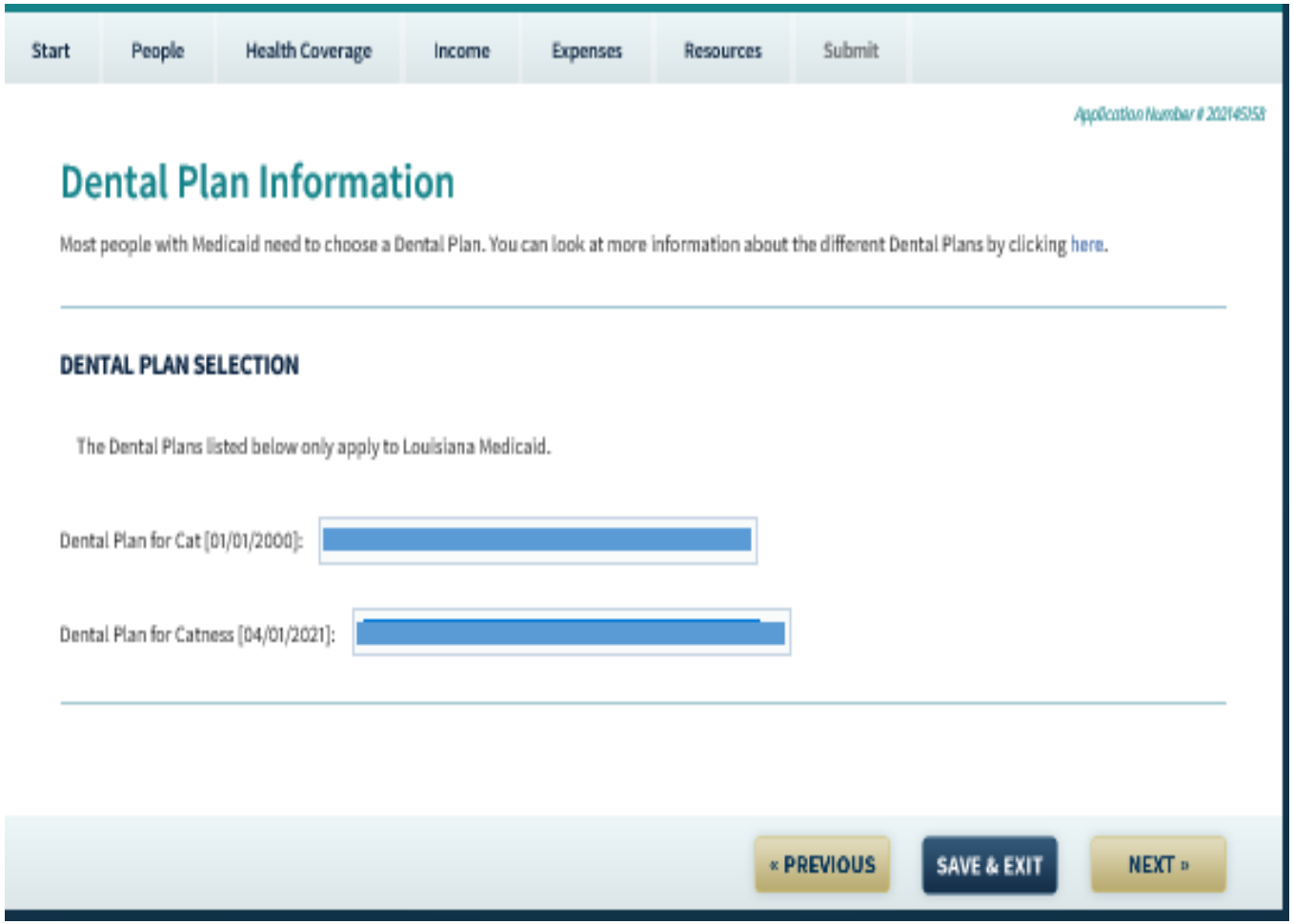
- Compare health plans
- Applicant may select a plan for each individual

LOUISIANA DEPARTMENT OF HEALTH
Medicaid



Health Plan: Warning

Please review your selections.



Dental Plan Information

1. Compare dental plans
2. Applicant may select a plan for each individual

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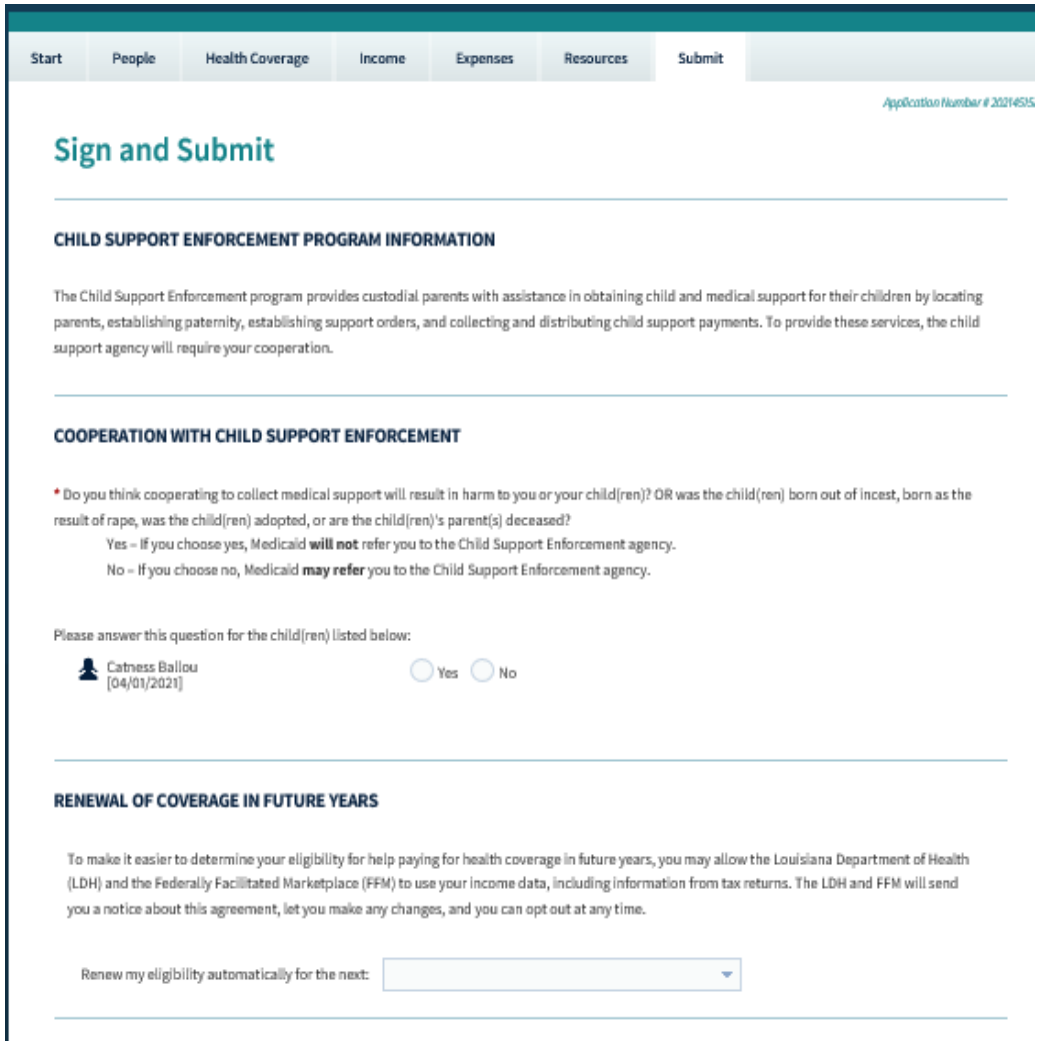
Medicaid



Sign And Submit

1. Child Support Enforcement Program Information
2. Cooperation with Child Support Enforcement
3. Renewal of Coverage in Future Years

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Privacy Option

PRIVACY OPTION

If you or anyone on this application is a victim of domestic violence or abuse, you have the opportunity to make your application and case information private so that it cannot be viewed online. If you are a victim of domestic violence or fear for your safety, you may also call the Louisiana Domestic Hotline at 1-888-411-1333 for free, confidential 24-hour assistance. Even if you are not a victim of domestic violence or abuse, you may still choose to make your case private and not viewable online.

By selecting "Yes", you or others will not be able to view case information, renew your benefits, or report changes online. I would like my case to be marked as private, so that my information cannot be viewed online.

◯ Yes ◯ No

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Rights and Responsibilities

READ THEM

RIGHTS AND RESPONSIBILITIES

By signing and submitting this application, I state that I have permission from all of the people listed on the application to both submit their information to LDH, and receive any information about their eligibility and healthcare coverage. I understand that if anyone on this application enrolls in Medicaid, I am giving LDH our rights to any money owed to us by any other health insurance, legal settlement, a spouse or parent, or other third party.

WHAT THE LOUISIANA DEPARTMENT OF HEALTH (LDH) HAS THE RIGHT TO EXPECT OF YOU (the person applying for health care assistance)

CITIZENSHIP AND IMMIGRATION STATUS: You state that the information about citizenship and immigration status given at the beginning of this application form is true and correct.

REPORTING THE TRUTH: You state that the information you give on this application form is true and correct. You understand if you purposely give information that is not true or if you purposely do not tell information that you are supposed to, you may get health benefits that you should not get. If that happens, you can by law be punished for fraud. Also, you may have to pay money back to LDH for the bills it paid by mistake.

VERIFICATION OF INFORMATION: You understand that LDH is authorized to gather the information requested in this application and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.

You understand that providing the requested information (including social security numbers) is voluntary. However, failing to provide it may delay or prevent you from getting health coverage through Medicaid or any other insurance affordability program.

You understand that LDH will check the information you give us to make sure it is correct. You give LDH permission to contact any outside source(s) necessary to check this information, process your application, determine eligibility, and otherwise operate the Medicaid program. These outside sources may include:

- Federal agencies (such as the Internal Revenue Service, Social Security Administration, and Department of Homeland Security), other state agencies, and/or local government agencies.
- Banks, financial institutions, and consumer reporting agencies.
- Employers identified on applications for eligibility determinations.
- Doctors or other medical providers.
- Applicants/enrollees, and authorized representatives of applicants/enrollees.
- LDH contractors engaged to perform a function for the Medicaid program.
- Anyone else as required or allowed by law.

You give these outside sources permission to give LDH any information about you, or any person necessary for this application, that it may request.

You understand that this permission will end when this application is denied, when your Medicaid eligibility ends, or when you submit a written statement to LDH cancelling this permission, whichever comes first. A cancellation may prevent you from being found to be eligible for Medicaid.

SOCIAL SECURITY NUMBERS: You understand the social security numbers will only be used to get information from these outside sources to verify income, make eligibility determinations, or for other purposes directly connected to the administration of the Medicaid program.

PAYMENT OF MEDICAL CARE BY A THIRD PARTY: You understand by accepting health care assistance, the Department has the right to get money received by you from other sources like insurance payments or lawsuit settlements for services that LDH has paid for you.

REPORTING CHANGES: You agree to tell LDH within 10 days of these changes: 1) if you move out of state; 2) changes in mailing or home address; 3) if anyone moves in or out of your home; 4) changes in health insurance and premiums; and 5) changes in income.

WHAT YOU (the person applying for health care assistance) HAVE THE RIGHT TO EXPECT FROM THE LOUISIANA DEPARTMENT OF HEALTH (LDH)

RIGHT TO A FAIR HEARING: You understand that you can ask for a Fair Hearing if you think any decision made on the case is unfair, incorrect, or made too late.

NO DISCRIMINATION: I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file, calling the US DHHS Regional Office for Civil Rights at 1-800-368-1019, or writing to the LDH at PO Box 4818, Baton Rouge, Louisiana 70821.

ESTATE RECOVERY: You understand that Estate Recovery rules require the Department to recover the cost of certain health care assistance payments from your estate. These costs include the total amount of payments for facility services, waiver services, hospital care, and prescription drugs received at age 55 or older by Long Term Care and/or Home and Community Based Services recipients. The Department will not make a claim against the estate while you or your legal spouse is still living or if you have a dependent child who is under age 21, blind, or disabled. Collection may not be made if it is not cost effective for the Department to do so, or if your heirs apply for a hardship waiver after your death and the hardship waiver is granted by the Department. A hardship may exist if the estate property is the only source of income for the heirs, if that income is limited, or other extenuating circumstances.

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Voter Registration Options

Wish to register?

- Geauxvote.com
- Apply by Mail

VOTER REGISTRATION OPTIONS

If you are not registered to vote where you live now, would you like to register to vote here today?

☐ Yes ☐ No

You may also apply to register to vote online at www.geauxvote.com. A valid Louisiana driver's license or ID card is required.
You may click here to print and mail the Mail Voter Registration Application.
A Mail Voter Registration Application will be mailed to you.

IF YOU DO NOT CHECK EITHER BOX YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. **You may call us toll-free at 1-888-342-6207.** The decision whether to seek or accept help is yours. You may fill out the application form in private.

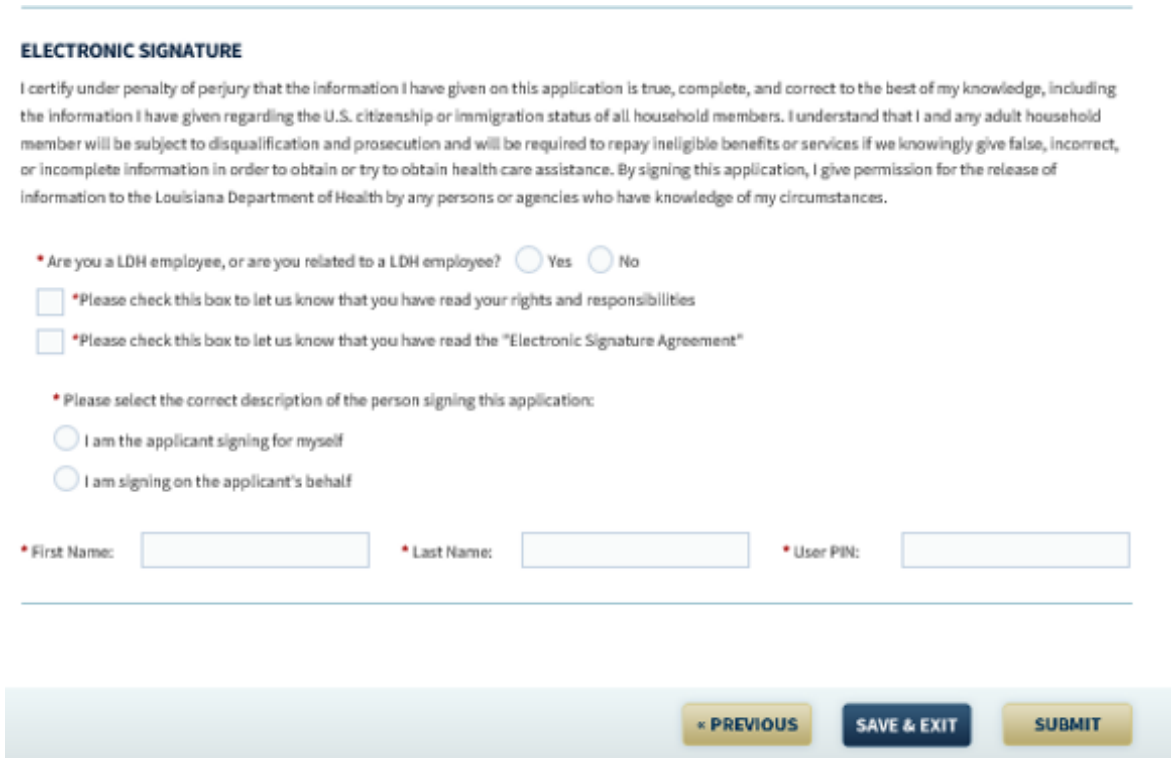
If you choose to register to vote at this time, the information about the location where you completed the application to register will remain confidential and will only be used for voter registration purposes. If you choose not to register to vote, that information will also be kept confidential.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

Louisiana Secretary of State
Commissioner of Elections
P.O. Box 94125
Baton Rouge, LA 70804-9125
Phone: (toll-free) 1-800-883-2805

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

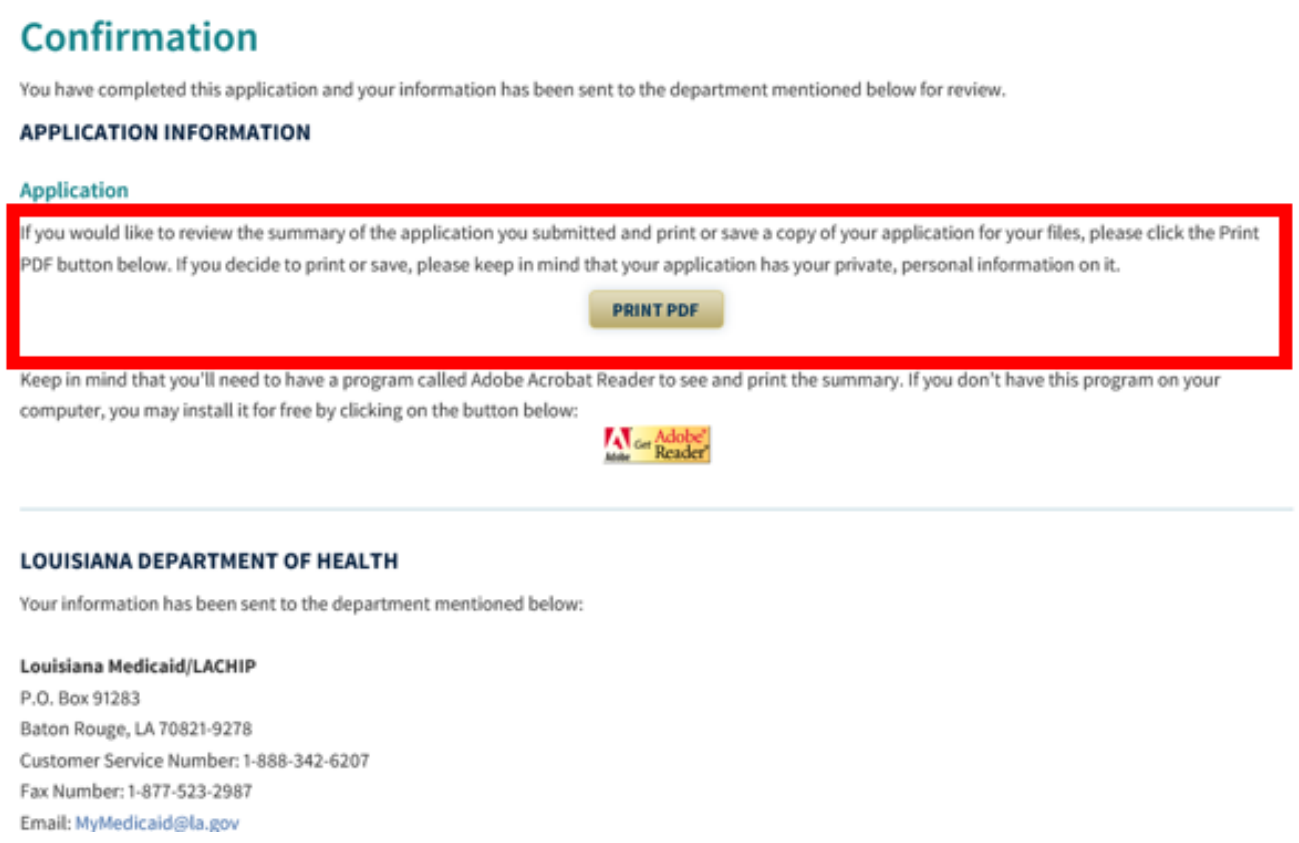
Electronic Signature



- Final step
- Read the statement as written
- Attestations

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Confirmation



Confirmation

You have completed this application and your information has been sent to the department mentioned below for review.

APPLICATION INFORMATION

Application

If you would like to review the summary of the application you submitted and print or save a copy of your application for your files, please click the Print PDF button below. If you decide to print or save, please keep in mind that your application has your private, personal information on it.

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:

Get Adobe Reader

LOUISIANA DEPARTMENT OF HEALTH

Your information has been sent to the department mentioned below:

Louisiana Medicaid/LACHIP
P.O. Box 91283
Baton Rouge, LA 70821-9278
Customer Service Number: 1-888-342-6207
Fax Number: 1-877-523-2987
Email: MyMedicaid@la.gov

Print a copy for the applicant

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Thank you for you Partnership!!!

Helpful Links and Contact Information

AC Resource Library

https://ldh.la.gov/index.cfm/page/1274

Contact Information

Application Centers (AC)

- ApplicationCenter.Service@la.gov
- (225) 342 – 6312
- Valerie McManus

Customer Service Unit (CSU)

- Phone (888) 342 - 6207
- Fax (877) 523 – 2987

EPO Programs Manager

- Kathryn.Loechelt@la.gov
- (225) 219 – 0912

Medicaid Outreach

- MedicaidOutreach@la.gov

Medical Eligibility Determinations Team (MEDT)

- MEDT@la.gov
- (225) 219 – 7873
- Miranda Winters

Newborn Eligibility Unit (NEU)

- NEU@la.gov
- 337-447-4145
- Shauna Meche

Optional State Supplement (OSS)

- OSS@la.gov
- (225) 342 – 1646
- Paige Logan

Outstation

- Outstation@la.gov
- (225) 342 – 1646
- Paige Logan

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

Questions