

# MEDICAID LOUISIANA (MCDLA) PRE-ENROLLMENT INSTRUCTIONS



## WHAT FORM(S) SHOULD I DO?

- Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract for Business/Entity) and Power of Attorney
  - **NOTE:** Original signature is required and the form must be notarized
- 2016 Annual Certification form
  - Must be completed and signed (original signature required) by the provider which Medicaid approved

## WHERE SHOULD I SEND THE FORM(S)?

- Mail the form to:  
Molina EDI Department  
PO Box 91025  
Baton Rouge, LA 70821-9025

## WHAT IS THE TURNAROUND TIME?

- Standard processing time is 3 weeks.

## HOW DO I CHECK STATUS?

- You will receive a letter from Medicaid LA informing you of your approval.
  - You may also call Medicaid LA at (225) 216-6303 and ask if you have been linked to Office Ally's Submitter ID **4507197**.
- If you have been approved, to complete your enrollment follow instructions on the "Note to My Clients Plus users" page and FAX info requested. We will forward to our clearinghouse and notify you by email when your registration is complete.

## WHAT PROVIDER NUMBER DO I USE?

- NPI Number
- Louisiana Medicaid Provider Number

# **Note to My Clients Plus Users:**

Once you have confirmed with the Insurance Payer your billing NPI/ Provider number is linked to Office Ally, please fax the following information to 888-653-7115.

- **Please label with “My Clients Plus” on top**
- **Provider/Practice Name as pre-enrolled with the Insurance Payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my Provider ID has been linked to Office Ally with the Insurance Payer”.**
- **Provider email address where you can be notified of setup completion.**
- **For Noridian Pre-Enrollments Please Also Include: Submitter number**

**Revised 10/1/2012**

## **Entity / Business**

### **Louisiana's Medicaid Program**

# **INSTRUCTIONS FOR PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM**

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

The following form(s) is (are) to be completed if the Entity / Business enrolling at this time plans to submit claims electronically to Louisiana Medicaid.

#### **EDI Contract**

**Louisiana Medicaid Provider Number** – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Molina Medicaid Solutions. (Leave blank if applying for new Provider Number.)

**National Provider Identifier (NPI)** – enter the NPI of the provider for which claims will be electronically submitted.  
Note: Atypical providers leave this blank.

**Doing Business As Name of Enrolling Entity** – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.

**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** – enter the signature of the person authorized to enter into a binding agreement with Louisiana Medicaid.

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

#### **EDI Power of Attorney**

**Louisiana Medicaid Provider Number** – enter the Louisiana Medicaid provider number for which claims will be electronically submitted to Molina Medicaid Solutions. (Leave blank if applying for a new Provider Number.)

**National Provider Identifier (NPI)** – enter the NPI of the provider for which claims will be electronically submitted.  
Note: Atypical providers leave this blank.

**Doing Business As Name of Enrolling Entity** – enter the name of the entity / business enrolling or the business provider name associated with the provider number and NPI listed above.

**Business/Practice Address** – enter the address of the provider name entered.

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

**Billing / Submitter Agent Contact Person** – enter the name of the person designated as the point of contact for the Billing / Submitter Agent business.

**Billing / Submitter Agent Phone Number** – enter the phone number of the Billing / Submitter Agent contact person.

**Enter the Parish (or County) Name where the Notary Public is located**

**Enter City, State and Date of Notarization**

**Signature of Authorized Representative** – enter the signature of the person authorized to enter into a binding agreement with Louisiana Medicaid.

**Notary Public Signature** – the Notary Public should sign the form and affix his/her seal

\*\*If the provider will be using a Third Party Biller or Clearinghouse, a Limited Power of Attorney MUST be completed and notarized. Please complete the enclosed Limited Power of Attorney in its entirety to be mailed with your completed EDI Contract.

**PROVIDER'S ELECTION TO EMPLOY ELECTRONIC DATA INTERCHANGE OF CLAIMS  
FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM  
(EDI CONTRACT FOR BUSINESS / ENTITY)**

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Louisiana Medicaid Provider Number (7 digits)

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National Provider Identifier (NPI) (10 digits)

DBA Name of Enrolling Business / Entity:

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Name of Contact Person: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

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|---|---|---|---|---|---|---|
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|---|---|---|---|---|---|---|

Submitter Number (7 digits)  
(leave blank if applying for new number)

**Billing Agent/ Submitter Name / Name of Business** that will be submitting claims  
(provider name or third party biller's name):

**OFFICE ALLY**

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The Medicaid File can hold a maximum of three Submitter Numbers per Medicaid Provider Number at any one time. Current policy is to close old Submitter Numbers as new ones are opened unless otherwise requested by the provider. It is also vital to identify which Submitter Number will be designated to download the Electronic Remittance Advices (ERA).

In order for Louisiana Medicaid to gather this information, complete the following, if applicable:

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.

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| 4 | 5 | 0 | 7 | 1 | 9 | 7 |
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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.

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

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I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to submit my own claims electronically to Louisiana Medicaid.

I am currently enrolled or am requesting enrollment in Louisiana Medicaid and wish to use a Third Party (Clearinghouse, Billing Agent, Submitter, etc.) to submit my claims electronically to Louisiana Medicaid. **(Power of Attorney form is required.)**

1. On the date of signature below, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 16 below. This is done in consideration for the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing's (hereinafter referred to as "State Agency") processing of provider claims, as well as other valuable considerations.
2. All published specifications set forth shall be met as to every entry sought to be processed. The effective date for my EDI submission will be set by Provider Enrollment once the contract has processed.

Provider Name: \_\_\_\_\_

3. The Provider, or his agent, shall be responsible for total compliance with said specifications including 42CFR 447.10 which governs the payment options for Third Party Billers. The Provider's data processing agent for submission of medical assistance claims is stated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to the State Agency.
4. The Provider shall provide upon request of the Director of the State Agency any supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow charts, file descriptions, accounting procedures and the like.
5. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to submit electronic claims and the Annual Certification form . A copy of the said certification statement is attached and is hereby incorporated by reference into this paragraph.
6. It is expressly understood that the State Agency or its Fiscal Intermediary (Molina Medicaid Solutions) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
7. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
8. The State Agency and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
9. The Provider agrees to submit to the State Agency, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
10. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
11. The Provider and the State Agency 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 five years, during the course of a federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested and produce such for examination and copying.
13. The Provider agrees that 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 State Agency's limited obligations as set in a certain Provider Agreement between the State Agency and the Provider.
14. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate and complete.
15. I understand that all claims submitted under the conditions of this Agreement will be paid and satisfied from federal and state funds, and that any falsification or concealment of a material fact, may be prosecuted under Federal and State laws.
16. I attest that all information supplied with this Agreement is true, accurate and complete.
17. **Applicable to those receiving 835s:** I authorize the Medicaid Fiscal Intermediary to send all HIPAA required data in the 835 transaction which includes claims information; payment information; and bank account information, provided by me and currently on file if enrolled in **Electronic Funds Transfer**, to the submitter identified above. This authorization will remain in effect until discontinued by written request or changed by a future request

\_\_\_\_\_  
**Print the Name of the Authorized Representative**

\_\_\_\_\_  
**Title / Position of Authorized Representative**

\_\_\_\_\_  
**Signature of Authorized Representative**

\_\_\_\_\_  
**Date of Signature**

**ENTITY / BUSINESS  
MEDICAID ELECTRONIC MEDIA LIMITED POWER OF ATTORNEY  
(EDI POWER OF ATTORNEY)**

*This form is required by all providers who will have electronic claims submitted by a third party.*

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|  |   |   |   |   |   |   |  |  |  |   |  |   |   |   |   |   |
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|  |   |   |   |   |   |   |  |  |  |   |  |   |   |   |   |   |
| <p>Doing Business As Name of Enrolling Entity<br/>(Provider Name):</p>   | <p>Billing / Submitter Agent Contact Person:<br/><b>Customer Service</b></p>    |   |   |   |   |   |  |  |  |   |  |   |   |   |   |   |
| <p>Business/Practice Address:</p>  | <p>Billing / Submitter Agent Phone Number:<br/><b>360-975-7000 Option 1</b></p> |   |   |   |   |   |  |  |  |   |  |   |   |   |   |   |

BE IT KNOWN that on this day, BEFORE ME, A Notary Public duly commissioned and qualified in and for the Parish of \_\_\_\_\_, State of Louisiana, therein residing:

PERSONALLY CAME AND APPEARED the above named provider, represented herein by the provider or its duly authorized representative who is of majority and a resident of and domiciled in the State shown under Provider Address above who declared unto me, Notary, that he does by these presents, name, constitute and appoint the above named Billing / Submitter Agent, a person or entity with full legal capacity, to be his true and lawful agent and attorney-in-fact, to execute for him, and in his name, place and stand, the Louisiana Medical Assistance Program the applicable claims for the provider type for magnetic tape, diskette, or telecommunication submission of claims processing, the said appearer further authorizing the said agent to receive all information regarding payments made to the appearer for such claims, and appearer finally declaring that he or it by these presents does agree to indemnify and hold harmless the said agent from any and all liability resulting from claims submitted by the said agent for the said appearer.

THUS DONE AND PASSED BEFORE ME, Notary, in the City of \_\_\_\_\_,  
State  
of \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Notary Public Signature

\_\_\_\_\_  
Print Name of Authorized Representative

|  |
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| <p><i>Notary Seal or Notary Identification Number<br/>(required)</i></p> |
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EDI ANNUAL CERTIFICATION OF ELECTRONIC FILES  
Certification Period: January 1 to December 31, 2016

2016

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Provider Number (7-Digits)

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Submitter Number

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National Provider Identifier (10 Digits)

Submitter Name: Office Ally

Primary Contact Name: Dan Waclawsky Email Address: dan.waclawsky@officeally.com

Secondary Contact Name: Customer Service Email Address: support@officeally.com

**o Submissions by Provider Rendering Services Using their own Submitter ID:**

I certify that all services rendered during the above identified Certification Period were necessary, medically indicated and were rendered by me or under my personal supervision. I have reviewed the claims information submitted and certify that it is true, accurate and complete. I agree to keep such records which will disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency, Medicaid Fraud Control Unit or the Secretary of the United States Department of Health and Human Services (DHHS) may request for five years from date of service or otherwise required by law or regulation. I agree to accept payment from the Bureau of Health Services Financing as payment in full for services and not seek additional payment from the recipient for any unpaid portion of a bill except to Spend-down Medically Needy recipients as indicated on Form 110-MNP. I agree to adhere to the published regulations of the Secretary of DHHS and the regulations, policies, criteria and procedures of BHSF Medical Assistance Program including those rules regarding recoupment.

I understand that payment and satisfaction of these claims will be from federal and state funds, and that any false claims, statements, documents, or concealment of material fact, may be prosecuted under applicable federal and state laws.

**Attach a list of all Providers Names, Medicaid ID#s and NPI Numbers associated with this Submitter Number**

**NOTICE: This is to certify that the foregoing information is true, accurate and complete.**

**o Submissions by Third Party Biller (Billing Agents/Clearinghouses) Using their Submitter ID:**

I certify that the claim information submitted to Louisiana Medicaid is an exact duplicate of detailed claim line information received from the provider and has not been materially altered or revised except for translation to the current 837 transaction format or insertion of minor data. I certify that the information submitted in electronic format is true, accurate and complete as received from the provider. Additionally, I understand that payment of these claims will be Federal and State funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.

I also certify that provider(s) with whom I have a direct relationship have furnished me with an EDI Annual Certification of Medicaid Claims Submitted Electronically Form on which the provider has attested to the truth, accuracy and completeness of the claim information. If I do not have a direct relationship with submitting providers (for instance, if the relationship is with a vendor), Louisiana Medicaid understands that I will not have an EDI Annual Certification Form from the individual(s) or entity(ies) with whom I do not maintain a contractual relationship. I agree to maintain all forms I am required to collect for a period of five (5) years.

Identify all claim types that will be submitted during this Certification Period:

CLAIM TYPE

837P 1500 Claim Form     837I UB4 Claim Form

837D Dental Claim Form     Other

DATE

SUBMITTER SIGNATURE (ORIGINAL)

**NOTE: Updated certification forms MUST be submitted annually. Failure to maintain a completed Certification Form on file will result in the closure of the submitter number without notice to submitter. All files submitted with closed submitter numbers will be dropped from the system without being processed.**

**This Certification Form can only be mailed to either address located below. The form can't be faxed or scanned and emailed.**

**Submit to: Molina – EDI Department, PO Box 91025, Baton Rouge, LA 70821-9025 Phone #: 225/216-6303 Or: 8591 United Plaza Blvd., Bldg. V, Suite 300, Baton Rouge, LA 70809**