



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.
01/17/2012
(<http://www.lamedicaid.com>)

Medicaid LOUISIANA (MCDLA), KIDMED LA (SKLAD) Enrollment Instructions – Professional Claims & ERA

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. Incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date the enrollment was mailed. Keep a copy of the completed request, in case you should need to follow up or resubmit.

MAIL COMPLETED FORMS (ORIGINAL SIGNATURE) TO-
Molina Medicaid Solutions
P. O. Box 80159
Baton Rouge, LA 70898-0159

837-CLAIMS and 835 ERA Enrollment (New) or (Change of Service)

If the provider has NOT submitted claims electronically to this payer or if the provider HAS SUBMITTED electronic claims to this payer VIA ANOTHER CLEARINGHOUSE, and they now want to submit via Practice Insight, the provider must complete these forms:

1. EDI Contract “Provider’s Election to Employ Electronic Data Interchange of Claims for Processing the Louisiana Medical Assistance Program “ (2 pages)

- Pg1, Top Portion- ENTER Medicaid Provider Number, NPI #, Billing Provider Name, Name of Contact Person and Contact Phone Number.
- Pg 1, Lower Portion- SEE box with 4505324 and box with ✓ “By checking this box you are giving Authorization to have 835s produced...”
- Pg 2 – ENTER Billing Provider’s Name top of page. OBTAIN authorized signature, signer’s Printed Name, Title and Date at bottom of page.

IF BILLING PROVIDER IS A GROUP- complete this form.

- 2. Entity / Business Medicaid Electronic Media Limited Power of Attorney “- EDI Power of Attorney (1 page)**
ENTER the billing provider’s Medicaid Provider Number, NPI #, Provider Name and Business Address. Complete the rest of the form as prompted by the verbiage. **THIS FORM MUST ALSO BE NOTARIZED.**

-OR-

IF BILLING PROVIDER IS AN INDIVIDUAL, complete this form.

- 2. Individual Medicaid Electronic Media Limited Power of Attorney - EDI Power Of Attorney (1 page)**
ENTER the billing provider’s Medicaid Provider Number, NPI #, Provider Name and Business Address. Complete the rest of the form as prompted by the verbiage. **THIS FORM MUST ALSO BE NOTARIZED.**

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since this request was submitted and you have not yet received confirmation of enrollment, contact your EDI Support Vendor for assistance.
Or, you can call Unisys, Medicaid Louisiana EDI at 225-216-6303.

**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:

Name of Contact Person: _____

Contact Phone Number: _____

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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):

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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By checking this box you are giving authorization to have 835s produced for the Individual listed above and 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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4	5	0					

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.)**

- 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.
- 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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Doing Business As Name of Enrolling Entity (Provider Name):	Billing / Submitter Agent Contact Person:															
Business/Practice Address:	Billing / Submitter Agent Phone Number:															

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

<i>Notary Seal or Notary Identification Number (required)</i>
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**INDIVIDUAL
 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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Medicaid Provider Number (7 digits)

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National Provider Identifier (10 digits)

Medicaid Provider Name:

Medicaid Provider Address:

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Submitter Number (7 digits)

(leave blank if applying for new number)

Billing / Submitter Agent Business Name:

Billing / Submitter Agent Business Address:

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 and in the presence of the witness hereinafter named and undersigned:

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, and the undersigned competent witnesses, in the City of _____, State of _____ on the _____ day of _____, 20____.

 Signature of Provider

 Notary Public Signature

 Print Provider Name

Notary Seal (required)