LOUISIANA
Department of HEALTH and HOSPITALS

UNISYS

ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM (Louisiana Medicaid Program)

Basic Enrollment Packet

(Emergency Packet for Hurricane Katrina – Services must have been rendered already or a recipient is awaiting services for this emergency process to be used.)

(Enrollment packet is subject to change without notice)

(All Provider Types)
Revised 08/05

Emergency Provider Enrollment Process

As a result of the emergency created in the aftermath of Hurricane Katrina the following procedures are now in effect:

1. Go to www.lamedicaid.com to obtain the Emergency Packet for Hurricane Katrina - Basic Enrollment Packet. If WEB access is unavailable, call 225-216-6370 (Provider Enrollment) or 1-800-473-2783 (Provider Relations) to request this emergency packet.
2. Provider should review the packet in its entirety and complete the Louisiana Medicaid PE-50 Provider Enrollment Form, the PE-50 Addendum – Provider Agreement and Medicaid Direct Deposit (EFT) Authorization Agreement.
3. Provide a copy of license issued by Governing Board or include license number and State of issuance on Form PE-50 in Section A.

- Direct Deposit information is being requested, but, if unavailable, application will be processed and checks issued to the Pay-To address submitted.

- Fax completed, **signed** application to:

  - 225/216-6392 or
  - 225/216-6335 or
  - 225/924-6179.

State of Louisiana

Instructions for Louisiana Medicaid PE-50 Provider Enrollment Form

PREPARATION

Please read the instructions in their entirety before completing forms. Complete Form PE-50 as an **original** document. The completed form may be photocopied for your records. Inaccurate/Incomplete forms will be returned to you for completion.

GENERAL INFORMATION

A Medicaid provider number will be issued to the individual or entity whose name appears in Section A of this form. It is the responsibility of this individual or entity to maintain accurate information on the Louisiana Medicaid provider file through submitting updates (as required) to the Provider Enrollment Unit. No changes will be made to any information on the Louisiana Medicaid provider files without an accompanying original signature of the provider or its designated representative.

Individual Provider Number – a seven-digit Medicaid provider number issued to individuals who meet all eligibility requirements. This number is used for billing purposes.

An individual Medicaid provider number can have only one (1) Pay-To address. Therefore, this address **MUST** be the address that the individual wishes to receive all Remittance Advice notices for claims billed under this individual number. For those providers who provide services at multiple locations, this address should be the address of the individual's main location.

The following fields **MUST** be completed:

Medicaid Provider Number – your seven- (7) digit Medicaid provider number, if known. Indicate if this application is for a new enrollment or an update to an existing enrollment. A new enrollment is for an individual or entity with no prior Louisiana Medicaid provider number. An update to an existing enrollment is for an individual or entity that has had a Louisiana Medicaid provider number in the past and that number is either closed or contains old information.

SECTION A – INDIVIDUAL / ENTITY INFORMATION & PHYSICAL LOCATION

Provider Name – enter the provider name according to the following guidelines:

- If the application is for an individual, enter the individual's name in this field (must match license name, if applicable).
- If the application is for a professional group, enter the group name under which the group does business in this field.
- If the application is for a business, enter the business name in this field (must match license name if applicable).
- If the application is for a pharmacy, enter the name under which the pharmacy permit is issued.
- If the application is for a long-term care facility, enter the name under which the facility does business (must match license name).

Area Code and Telephone # - enter the telephone number at the physical location of the business or individual named in the *Provider Name.*

Social Security Number – enter the social security number assigned to the owner of the business identified in the *Provider Name* field (not required if the name in *Provider Name* is an entity).

Physical Street Address - enter the physical location address of the business named in *Provider Name.*

Mailing Address (if different) – enter the mailing address if mail cannot be received at the Physical Street Address. For example, if the Physical Street Address is 123 Main Street, Anywhere, LA but mail cannot be received there, enter the mailing address such as PO Box 85555, Anywhere, LA.

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

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

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

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

Physical Zip Code – enter the zip code in which your *Physical Street Address* is located.
Mailing Address Zip Code – enter the zip code in which your *Mailing Address* is located.
Parish/County – enter the parish / county in which your *Physical Street Address* is located.
Code – the parish code of your physical location (see list below and enter appropriate code for the parish entered in the *Parish* field).

Parish Codes

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

Out-Of-State Hospital Providers (Arkansas, Mississippi, and Texas), & DME see next page before completing:

Texas	87	Mississippi	88	Arkansas	89	Other	99

Out of State Hospital & DME Trade Areas (2005)

Arkansas Counties (92)	Mississippi Counties (91)	Texas Counties (90)
Ashley	Adams	Cass
Chicot	Amite	Harrison
Columbia	Claiborne	Jefferson
Lafayette	Hancock	Marion
Miller	Issaquena	Newton
Union	Jefferson	Orange
	Marion	Panola
	Pearl River	Sabine
	Pike	Shelby
	Walthall	
	Washington	
	Wilkinson	

State Status – check "In (0)" if your *Provider Street Address* is located within Louisiana or "Out (1)" if it is located outside Louisiana.
Location Type – check "Urban (1)" if your *Provider City* is an urban location or "Rural (2)" if it is a rural location.
License # - the license number (if applicable) for the person or business identified in the *Provider Name* field and the state of issuance.
Medicare Provider # - enter the Medicare number assigned to the person or entity identified in the *Provider Name* field (if applicable).
UPIN – enter your universal provider identification number, if known.
Specialty Type – enter the specialty type for the individual identified in the *Provider Name* field.
Board Certification #- enter the number relating to your Board Certification – this number is issued by the certifying board and is included on your Board Certification certificate.
Date of Birth – If the *Provider Name* is for an individual, the date of birth for the individual is to be entered here. This is a required field and the forms will be returned for correction if it is left blank.

SECTION B – PAY-TO INFORMATION

For Active Provider Numbers – it is important to indicate if the Pay-To information is to be updated with this application. If it is, consider whether the Direct Deposit information also needs to be updated.

Provider Pay-To Name – enter the name to which you wish payments made – this name must match the top line of your enclosed pre-printed IRS documentation EXACTLY! Do not abbreviate or add punctuation not found on the IRS documentation. If the name **DOES NOT** match the IRS documentation exactly, the application will be returned to you for correction.

Attn or Other – enter the name under which your business does business if different than the name entered in *Provider Name* or the name of the person to whom correspondence should be addressed.

Provider Pay-To Address – enter the address to which you wish your payments and/or remittance advices to be mailed.

Provider Pay-To City – enter the city in which your *Provider Pay-To Address* is located.

Provider Pay-To State – enter the state in which your *Provider Pay-To Address* is located.

Provider Pay-To Zip – enter the zip code in which your *Provider Pay-To Address* is located.

IRS Reporting # – the Tax ID number assigned to your Provider number. This number is used in reporting payment amounts for this provider number to the IRS. A copy of a pre-printed IRS document verifying the number is required.

Provider Year-End Date – enter the Fiscal Year-end month of your business. **This is a required field for all providers who will complete an Annual Cost Report.**

National Provider Identifier (NPI) – once obtained, enter your National Provider Identifier number in this field. Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do for more information on obtaining an NPI.

SECTION C – OWNERSHIP INFORMATION

Practice Type – check the appropriate box for the individual/entity entered in *Provider Name* field.

All Providers Except Hospitals and LTC – if the individual / entity entered in *Provider Name* is not a hospital or long-term care (LTC) facility check the appropriate box for ownership information.

SECTION D – HOSPITALS/LTC FACILITIES ONLY

HOSPITALS/LTC – if the individual / entity entered in *Provider Name* is a hospital, or long-term care facility, check the appropriate box for ownership information. All others leave blank.

Hospitals and LTC Facilities only:

 # Certified Beds – enter the total number of beds that have been certified by the Health Standards unit for this provider.

Name of Facility Administrator - if hospital or LTC facility enter name of facility administrator.

SECTION E

Effective Date – enter the date you wish to have your new Medicaid provider number become effective. Effective date entered will be considered in enrollment process, but cannot exceed Timely Filing Guidelines. All eligibility requirements must be met on the date requested for the date to be considered.

Provider Type Description & Code (Required Field) – Review the following table and enter the provider description and code into this field. Entries of provider types other than those listed in this table will result in rejection of this application.

85	ADHC – Home & Community Based Services
51	Ambulance Transportation
54	Ambulatory Surgical Center
34	Audiologist
45	Case Mgmt – Contractor
8	Case Mgmt - Elderly
46	Case Mgmt - HIV
07	Case Mgmt - Infants & Toddlers
43	Case Mgmt - Nurse Home Visits for First-Time Mothers
48	Case Mgmt - Pregnant Women
81	Case Mgmt - Ventilator Assisted Care Program
30	Chiropractor
30	Chiropractor Group
93	Clinical Nurse Specialist
91	CRNA
27	Dental Group

27	Dentist
40	DME Providers (Out-of-State – Crossovers Only)
19	Doctor of Osteopathy (DO)
19	Doctors of Osteopathy (DO) Group
70	EPSDT Health Services
71	Family Planning Clinic
72	Federally Qualified Health Center
76	Hemodialysis Center
44	Home Health Agency
09	Hospice Services
60	Hospital
69	Hospital - Distinct Part Psychiatric
88	ICF(MR) Group Home
23	Independent Lab
66	KIDMED Screening Clinic
74	Mental Health Clinic
64	Mental Health Hospital (Free-Standing)

77	Mental Health Rehab. (Change of Ownership Only)
25	Mobile X-Ray - Radiation Therapy Center
42	Non-Emergency Medical Transportation
78	Nurse Practitioner
90	Nurse-Midwife
80	Nursing Facility
37	Occupational Therapist (Crossovers only)
75	Optical Supplier
28	Optometrist
28	Optometrist Group
24	Personal Care Services (LTC/PCS/PAS)
26	Pharmacy
35	Physical Therapist (Crossovers only)
20	Physician (MD)
20	Physician (MD) Group
94	Physician Assistant
32	Podiatrist
32	Podiatrist Group
67	Prenatal Health Care Clinic
13	Pre-Vocational Habilitation
31	Psychologist
65	Rehabilitation Center
87	Rural Health Center (Independent)
79	Rural Health Clinic (Provider Based)
38	School Based Health Center
73	Social Worker (Crossovers only)
68	Substance Abuse and Alcohol Abuse Center - (Crossovers only)
29	Title V, Part C Agency Services (EarlySteps)
62	Tuberculosis Clinic
63	Tuberculosis Inpatient Hospital
61	Venereal Disease Clinic
14	Waiver – Adult Day Habilitation
17	Waiver - Assistive Devices
03	Waiver - Children's Choice
15	Waiver – Environmental Modifications
01	Waiver - Fiscal Agent
98	Waiver - Habilitative Supported Employment
06	Waiver - NOW Professional (RN/LPN/PhD/SW)
82	Waiver - Personal Care Attendant
16	Waiver - Personal Emergency Response System
83	Waiver - Respite Care (Center-Based only)
84	Waiver - Substitute Family Care
89	Waiver - Supervised Indep Living

SECTION F

Indicate how the Louisiana Medicaid Provider Number will be used in billing. This will result in Enrollment Status being set as either "0" or "1". See description below.

Enrollment Status "1"

a. Payment may be generated to this provider number for individual professionals. Payments are issued to the Pay-To Name on file.
b. This number may also be used as an attending provider number on group-submitted claims. All payments for claims submitted by a group with the individual provider number identified on the claim as the attending provider will be sent to the submitting group.

Enrollment Status "0" – (Individuals only)

Payments cannot be generated to this provider number for individual professionals. The number may, however, be used as an attending number for group billing. Payments are generated to the submitting group.

SECTION G – PROVIDER ACCEPTANCE OF MEDICAID REQUIREMENTS AND CONDITIONS

Read the information included in this section.

Print Provider's Name - print the name of the individual provider or the authorized agent that will sign this document.

Provider's Signature – **signatures must be original** (stamped signatures and initials are not accepted)**.**

- If this application is for an individual, then the individual must sign and date the form. Office Manager signatures are not accepted.
- If this application is for a business or facility, then the signature must be that of an authorized agent for the business / facility.

Date – enter the date this agreement was signed.

BHSF Form PE-50
Rev 08/05

(Review Instructions Before Completing)

Louisiana Medicaid PE-50 Provider Enrollment Form

Medicaid Provider # (if known)

This enrollment packet is for a ☐ New Enrollment ☐ Update to Existing Enrollment
☐ Group Linkage Only ☐ Reactivation ☐ Other (Please specify)

Is this a Change of Ownership (CHOW)? ☐ Y ☐ N
See Instructions for definition of CHOW per Louisiana Medicaid policy.
If yes, current LA Medicaid provider number:

A Individual / Entity Information & Physical Location

Provider Name (DBA name if applicable) (Individuals: Last Name, First Name, Middle Initial)	M.D., D.O., etc.	Area Code & Telephone # ( ) -	Social Security # (Required) - -
Physical Street Address - Can Mail Be Received at this address: ☐ Y ☐ N		Mailing Address (if different)	
Physical City	State	Zip Code	Mailing Address City / State / Zip Code
Parish /County	Parish Code	State Status ☐ In (0) ☐ Out (1)	Location Type ☐ Urban (1) ☐ Rural (2) / License # & State of Issuance
Medicare Provider #	UPIN	Specialty Type	Board Certification # / Date of Birth (required)

B Pay-To Information

For providers with active provider number: Do you wish to update your Pay-To Address currently on file? ☐ Yes ☐ No
If yes, have you considered if your Direct Deposit information also needs to be updated? ☐ Yes ☐ No

Provider Pay To Name (MUST match IRS document EXACTLY)	Attn or Other		
Provider Pay To Address	Provider Pay To City	Provider Pay To State	Provider Pay To Zip Code
IRS Reporting #	Provider Year-End Date	National Provider Identifier:	

C Ownership

Practice Type (All Providers)

- ☐ Individual (01)
- ☐ Partnership (02)
- ☐ Corporation (03)
- ☐ Hospital Based Physician (04)
- ☐ Health Maintenance Organization (05)
- ☐ Group Practice (Private) (06)
- ☐ Teaching Provider (Physician / Dentist) (07)
- ☐ Public Clinic or Group (08)

All Providers Except Hospitals & LTC (In-State Only)

- ☐ Privately Owned (1)
- ☐ City/Parish Owned (4)
- ☐ Office of Public Health (6)
- ☐ School Board Owned (8)
- ☐ State Owned (9)

D Hospitals & LTC Only

- ☐ Profit (2)
- ☐ Nonprofit (3)
- ☐ Public (4) (In-State Only)
- ☐ Charity (7) (In-State Only)

Certified Beds

Name of Facility Administrator

E

Effective Date Information	Provider Type Description & Code (required)

F

My Louisiana Medicaid provider number will be used for:

- ☐ (0) Group billing only and not for individual billing;
- ☐ (1) Individual billing only;
- ☐ (1) Individual and Group billing.

The following person may be contacted for additional information regarding this enrollment application:

Contact Person

Contact Phone # ( )

G Provider Attestation of Information

I, the undersigned, certify to the following:

1. I have read the contents of this enrollment packet including the PE-50 Addendum and the information contained herein is true, correct and complete;
2. I understand that it is my responsibility to maintain current information on the Louisiana Medicaid files and failure to do so may result in delayed payments or closure of the Medicaid Provider Number;
3. I am either the individual named in Section A or an authorized party for the entity in Section A and can legally bind this entity to this agreement through my signature below; and
4. I understand that the Louisiana Medicaid files will be updated with information supplied on these forms.

Print Provider's Name | **Provider's Signature** | **Date**

ALL PROVIDERS MUST COMPLETE ENTIRE FORM– INCOMPLETE FORMS WILL BE RETURNED FOR CORRECTION

Emergency Enrollment – Hurricane Katrina

PE-50 ADDENDUM – PROVIDER AGREEMENT

Provider Number (7 digits)
Leave Blank if Applying for New Number

Provider Name

I, the undersigned, certify and agree to the following:

Enrollment in Louisiana Medicaid

1. I have read the contents of this Louisiana Medical Assistance Program Enrollment Packet and the information supplied herein is true, correct and complete;
2. I understand that it is my responsibility to ensure that all information is kept up to date on the Louisiana Medicaid Provider File;
3. I understand that failure to maintain current information may result in payments being delayed or closure of my Medicaid provider number;
4. I understand that if my number is closed due to inaccurate information, I will have to complete a new enrollment packet in its entirety to reactivate my provider number;

Providing Services to Louisiana Medicaid Recipients

5. I agree to abide by Federal and State Medicaid laws, regulations and program instructions that are applicable to the provider type for which I am enrolled. I understand that the payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions;
6. I agree to conduct my activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL) Louisiana R.S. Title 46, Chapter 3, Part VI-A, as required to protect the fiscal and programmatic integrity of the medical assistance programs;
7. I understand that services and/or supplies provided by me must be medically necessary and medically appropriate for each individual patient based on needs presented on the date of service that the service is provided and/or delivered;
8. I agree to charge no more for services to eligible recipients than is charged on the average for similar services to others;
9. I understand that as the provider I am held responsible for any and all claims submitted under any Louisiana Medicaid provider number issued to me;
10. I agree to maintain all records necessary for full disclosure of services provided to individuals under the program and to furnish information regarding those records as well as payments claimed/received for providing such services that the agency, the DHH Secretary, the Louisiana Attorney General, or the Medicaid Fraud Control Unit may request for five years from the date of service;
11. I agree to participate as a provider of medical services and shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted by me as a Medicaid patient. I agree to accept a client's Medicaid card as payment in full for covered services rendered. I agree to bill Medicaid for **all** services covered by Medicaid that will be provided to eligible Medicaid clients;
12. I agree to accept Medicaid payment for covered services as payment in full and not seek additional payment from any recipient for any unpaid portion of a bill, with the exception of state-funded spend-down Medically Needy recipients as indicated by the agency's form 110-MNP or any recipient co-payments as established by the DHH;
13. I agree to adhere to the published regulations of the DHH Secretary and the Bureau of Health Services Financing, including, but not limited to, those rules regarding recoupment and disclosure requirements as specified in 42 CFR 455, Subpart B;
14. I agree to adhere to the federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the federal Department of Health and Human Services, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA;

-- continued --

15. I understand the Louisiana Medicaid Program must comply with DHHS regulations promulgated under Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; and the American Disabilities Act of 1990 which require that:
    - No person in the United States shall be excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of age, color, handicap, national origin, race or sex under any program or activity receiving Federal financial assistance.

    Under these requirements, Louisiana's Department of Health and Hospitals, Bureau of Health Services Financing cannot pay for medical care or services unless such care and services are provided without discrimination based on age, color, handicap, national origin, race or sex. Written complaints of non-compliance should be directed to Secretary, Department of Health and Hospitals, PO Box 91030, Baton Rouge, LA 70821-9030 or DHHS Secretary, Washington, DC or both.

Medicaid Direct Deposit (EFT) Authorization Agreement

16. I have reviewed the Medicaid Direct Deposit (EFT) Authorization Agreement and the Medicaid Provider Requirements and Conditions as listed below and agree to this agreement:
    - I/We understand that payment and satisfaction of any claims will be from Federal and State Funds; and any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws.
    - I/We understand that DHH may revoke this authorization at any time.
    - I/We hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments that the payee has rendered for Medicaid services.
    - I/We certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature(s) below is authorized by the stated Board of Directors to enter into or change this agreement.
    - I/We agree to notify the Provider Enrollment Unit if changing financial institutions or accounts. I/We further understand that the maintenance of account information on the Louisiana Medicaid files is the provider's responsibility and failure to notify the Provider Enrollment Unit as noted may result in Medicaid payments being electronically transmitted to incorrect accounts. I understand that such changes may not be able to be accommodated if less than 15 business days notice is given.

Certification of Claims (Paper & Electronic)

17. I certify that all claims provided to Louisiana Medicaid recipients will be necessary, medically needed and will be rendered by me or under my personal supervision;
18. I understand that all claims submitted to Louisiana Medicaid 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;
19. I attest that all claims submitted under the conditions of this Agreement are certified to be true, accurate, and complete.

Print Name of Provider or Authorized Agent	Title / Position
Signature of Provider or Authorized Agent (stamps, initials not acceptable)	Date of Signature

LOUISIANA MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

(COMPLETION INSTRUCTIONS)

1.	Medicaid Provider Number:	Enter your **FULL 7-DIGIT** LA Medicaid Provider Number **(Only one provider number per form)**
2.	Provider Name:	Enter the name in which you are enrolled as a LA Medicaid Provider
3.	National Provider Identifier	Once obtained, enter the 10-digit National Provider Identifier
4.	Contact Name of Person Completing Form	Enter the name of the individual you will designate as the contact for Medicaid direct deposit issues.
5.	Contact Person's Phone Number:	Enter the phone number through which we may contact the individual listed in number 4 above.
6.	Account Type	Check the appropriate block (only one) to indicate the type of account to which your direct deposit will be transferred.
7.	Reason for Change in Account Information	Give a brief description of why the EFT information is being updated.
8.	Voided Check:	Tape a copy of a voided check showing the ABA routing number and account number. *Deposit slips are not accepted.* If a voided check is unavailable, a letter on bank letterhead identifying the ABA routing number, account number and type of account may be substituted.
9.	Signature, Title, Date	Enter your full signature, title of the person authorized to sign and date of signature. **ORIGINAL SIGNATURES ONLY; NO STAMPS OR COPIED SIGNATURES WILL BE ACCEPTED. INDIVIDUAL PROVIDERS MUST SIGN THEIR OWN FORMS.**

Please be sure to complete this form in its entirety. It will not be accepted for processing and will be returned to you if any field is incomplete.

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
MEDICAID DIRECT DEPOSIT (EFT) AUTHORIZATION AGREEMENT

1. Medicaid Provider Number (7 digits)

2. Provider Name

3. National Provdier Identifier (Once Obtained) (10 digits)

4. Contact Name of Person Completing Form:

5. Contact Person's Phone Number:

ACCOUNT INFORMATION

(All fields must be completed)

6. Account Type: *(Check One)*
☐ CHECKING ☐ SAVINGS

7. Reason for change in account information:

8. Attach Copy of Voided Check (Deposit Slips are not Acceptable)

TAPE COPY OF VOIDED CHECK HERE – NO STAPLES
DEPOSIT SLIPS ARE NOT ACCEPTED

*** To avoid interruption in payment, DO NOT close current account until a direct deposit has been processed into new account.***

If a voided check is unavailable, you may submit a letter on Bank Letterhead stating the ABA Routing Number and Account Number. The letter must be signed by a Bank Representative.

* **Attach a voided check (deposit slip not acceptable) showing complete account number and routing (ABA) number**. Original signatures required (stamped signatures or initials not accepted). If joint account, **BOTH** owners must sign this request form.

- I/We understand that payment and satisfaction of this claim will be from Federal and State Funds and that any false claims, statements or documents, or concealment of a material fact, may be prosecuted under applicable Federal and State laws. I/We understand that DHH may revoke this authorization at any time.
- I/We hereby authorize the Louisiana Department of Health and Hospitals to present credit entries into the account referenced above and depository named above. These credits will pertain **only to direct deposit transfer payments** that the payee has rendered for Medicaid services.
- I/We certify that if a Board of Directors' approval was necessary to enter into this agreement, that approval has been obtained and the signature(s) below are authorized by the stated Board of Directors to enter into or change this agreement.

9. Signature _____ Title _____ Date _____

Signature _____ Title _____ Date _____

UNISYS PROVIDER ENROLLMENT UNIT PO BOX 80159 Baton Rouge, LA 70898-0159

BE SURE THAT ALL FIELDS ARE COMPLETED

BHSF PE-DD1

Emergency Enrollment – Hurricane Katrina