Program Separation Packet Checklist

For ALL Graduating House Officers

Residents, please take action as needed

NPI / Medicaid Numbers

Licensure-CDS & DEA

Long Term Disability conversion option-American General

Credentialing & Verifications of training

Health Insurance & Retirement

Thank you,

GME Office

504-568-4006

Please visit the websites in this packet for the most updated information

This packet should be issued to ALL residents/fellowing who are completing the program in their final year

Program Separation Packet for All Outgoing House Officers

As you leave your program, there are numerous tasks and topics that you need to address and/or complete to ensure that your transition into the "real world" goes more smoothly. There is a list for those who *stay* in Louisiana and a list for those who *do not* stay in Louisiana upon graduation.

If you are planning to continue to work at LSU or in the State of Louisiana, you will need to address the following topics:

NPI and MEDICAID NUMBERS

To modify your NPI registration, you must go to the National Plan & Provider Enumeration System (https://nppes.cms.hhs.gov). Please update your new home and office address and update your registration with a new Taxonomy Code corresponding to the license that you now hold and practice type. If you originally applied for your NPI online and still know your login information, you can update it online. If you no longer have your NPI login information, complete the application available at the following website. (http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf).

To keep your Louisiana ***Medicaid number*** active, you must complete an enrollment packet (Sample Attached). The enrollment packet requires completion of two forms: 1) Basic Enrollment Packet and 2) Provider-type Specific Packet for your discipline. The enrollment packet can be found at (www.lamedicaid.com). If you have any questions, contact the Molina Provider Relations department at 1-877-598-8753.

LICENSURE

At this point in your training, you should already have your own DEA number, but if you do not, you need to apply now. You should apply for your DEA (www.deadiversion.usdoj.gov) and CDS (www.labp.com) by March, at the latest.

- First, apply for your state CDS license. Complete form 101. Physician Cost: **$45** and must be mailed.
- Once you have been approved for your state license, you can apply for a Federal DEA number. Complete Form 224. Physician Cost: **$551** – payable by credit card online, otherwise mail in your completed form with a check.

****Many employers will not finalize your credentials without these licenses.***

LONG TERM DISABILITY INSURANCE

American General is the long term disability insurance company provided by the LSU GME office for all house officers. When completing your residency, you are eligible to continue your long term disability coverage at your cost. (See attached American General Continuation of coverage/conversion packet) You have to mail in the application within 31 days after your last day of employment. Once you complete the packet please forward it to the *GME office 2020 Gravier Street, Ste 602 ATTN Kim Cannon, New Orleans La 70112* for further processing.

CREDENTIALING AND VERIFICATIONS

Be *proactive and involved* with your credentialing process. You will need all of this documentation easily accessible for your credentialing process. Start collecting copies of all of these important documents: 1) licenses (making sure all licenses are current); 2) diplomas or completion certificates; 3) Certifications (e.g., ACLS, BLS); 4) letters of recommendation; and 5) health requirement documentation including an updated TB test. In addition, if your program requires procedure logs, keep your tracking current. Be sure to retain a copy of all of these documents for your own files.

Verifications: Please provide your new employer and other parties (e.g., insurance companies) with the attached memo regarding the LSU training verification process. Your coordinator will upload your verification form to **FCVS/Federation of State Board Verification Services** (www.FCVS.org) automatically for each PGY year you complete at LSU. If your employer accepts FCVS as a primary source of verification, they can utilize this verification company. If not, they can send the verification to the LSU GME office. 2020 Gravier Str, 619, NO LA 70112 FAX 504-568-3332

MALPRACTICE INSURANCE

Louisiana Medical Mutual Insurance Company (LAMMICO) is mutual insurance company providing professional liability products and service to all eligible physicians staying to practice in Louisiana. The application process can take 2-3 months. Visit www.lammico.com for more information.

HEALTH INSURANCE and RETIREMENT

See the attached summary of details from the LSUHSC Human Resource Department. Contact number is 504-568-4226.

If you are leaving the State of Louisiana,
you will need to address the following topics:

NPI and MEDICAID NUMBERS

To modify your NPI registration, you must go to the National Plan & Provider Enumeration System (https://nppes.cms.hhs.gov). Please update your new home and office address and update your registration with a new Taxonomy Code corresponding to the license that you now hold and practice type. If you originally applied for your NPI online and still know your login information, you can update it online. If you no longer have your NPI login information, complete the application available at the following website (http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf).

Your **Louisiana Medicaid number** will be automatically cancelled upon your graduation by the LSU GME Office.

LICENSURE

If you do not have one already, you should apply for your new state DEA (www.deadiversion.usdoj.gov) and CDS (www.labp.com/ by March, at the latest. State licensure can take approximately 6 months to a year to complete, so apply early. (e.g., Texas State licensure process may take up to a year to complete).

- First, apply for your state CDS license. Cost: **$20** and must be mailed.
- Once you have been approved for your state license, you can apply for a Federal DEA number. Complete Form 224. Cost: **$551** – payable by credit card online, otherwise mail in your completed form with a check.
  ****Many employers will not finalize your credentials without these licenses***

LONG TERM DISABILITY INSURANCE

American General is the long term disability insurance company provided by the LSU GME office for all house officers. When completing your residency, you are eligible to continue your long term disability coverage at your cost. (See attached American General Continuation of coverage/conversion packet) You have to mail in the application within 31 days after your last day of employment. Once you complete the packet please forward it to the *GME office 2020 Gravier Street, Ste 602 ATTN Kim Cannon, New Orleans La 70112* for further processing.

CREDENTIALING AND VERIFICATIONS

Be *proactive and involved* with your credentialing process. You will need all of this documentation easily accessible for your credentialing process. Start collecting copies of all of these important documents: 1) licenses (making sure all licenses are current); 2) diplomas or completion certificates; 3) Certifications (e.g., ACLS, BLS); 4) letters of recommendation; and 5) health requirement documentation including an updated TB test. In addition, if your program requires procedure logs, keep your tracking current. Be sure to retain a copy of all of these documents for your own files.

Verifications: Please provide your new employer and other parties (e.g., insurance companies) with the attached memo regarding the LSU training verification process. Your coordinator will upload your verification form to **FCVS/Federation of State Board Verification Services** (www.FCVS.org) automatically for each PGY year you complete at LSU. If your employer accepts FCVS as a primary source of verification, they can utilize this verification company. If not, they can send the verification to the LSU GME office. 2020 Gravier Str, 619, NO LA 70112 FAX 504-568-3332

HEALTH INSURANCE and RETIREMENT

See the attached summary of details from the LSUHSC Human Resource Department. Contact number is 504-568-4226.

NPI & Medicaid Numbers

NPPES
National Plan & Provider Enumeration System

Help

National Plan and Provider Enumeration System (NPPES)

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the **National Plan and Provider Enumeration System (NPPES)** to assign these unique identifiers.

The website works best in Internet Explorer versions 6.0 and higher and Firefox versions 2.0 and higher. Users may experience issues with other browsers and are recommended to use the browsers listed above. It is recommended that browser windows be opened using the icon on the desktop to avoid shared browser sessions. Some browsers share sessions regardless of how the browser is opened. Please check with the browser's vendor about session management. When NPPES detects multiple browsers open within the same session, NPPES will terminate the session to protect the data in NPPES. Data entered will be lost and will need to be re-entered.

If you are a **Health Care Provider**, you must click on National Provider Identifier (NPI) to login or apply for an NPI.

A standard identifier has not yet been adopted for health plans.

Search the NPI Registry. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data. For example, users may search for a provider by the NPI or Legal Business Name. There is no charge to use the NPI Registry.

About NPPES....

CMS has contracted with Cognosante, LLC. to serve as the NPI Enumerator.

The NPI Enumerator is responsible for assisting health care providers in applying for their NPIs and updating their information in NPPES.

The NPI Enumerator may be contacted as follows:

By phone:	By e-mail at:	By mail at:
1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)	customerservice@npienumerator.com	NPI Enumerator PO Box 6059 Fargo, ND 58108-6059

CMS Centers for Medicare & Medicaid Services

Department of Health and Human Services

Form Approved
OMB No. 0938-0931

NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Use only blue or black ink. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form. Information submitted on this application (except for Social Security Number, IRS Individual Taxpayer Identification Number, and Date of Birth) may be made available on the internet.

SECTION 1 – BASIC INFORMATION

A. Reason For Submittal Of This Form (Check the appropriate box)

1. ❑ Initial Application
2. ❑ Change of Information (See instructions)
   NPI:_____
   ❑ Add Information
   ❑ Replace Information
3. ❑ Deactivation (See Instructions)
   NPI : _____
   Reason (Check one of the following)
   ❑ Death ❑ Business Dissolved
   ❑ Other, Specify: (See Instructions) _____
   _____
4. ❑ Reactivation (See Instructions)
   NPI : _____
   Reason: _____

B. Entity Type (Check only one box) (See Instructions)

1. ❑ An individual who renders health care. **(Complete Sections 2A, 3, 4A and 5 only)**
   - Is the individual a sole proprietor? (See Instructions) ❑ Yes ❑ No
2. ❑ An organization that renders health care. **(Complete Sections 2B, 3, 4B and 5 only)**
   - Is the organization a subpart? (See Instructions) ❑ Yes ❑ No
   - If yes, enter the Legal Business Name (LBN) and Taxpayer Identification Number (TIN) of the "parent" organization health care provider:
     Parent Organization LBN:_____
     Parent Organization TIN: _____

SECTION 2 – IDENTIFYING INFORMATION

A. Individuals *(includes Sole Proprietorships and Incorporated Individuals)*

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last
5. Suffix (e.g., Jr., Sr.)		6. Credential (e.g., M.D., D.O.)	

Other Name Information (If applicable. Use additional sheets of paper if necessary)

7. Prefix (e.g.,Major, Mrs.)	8. First	9. Middle	10. Last
11. Suffix (e.g., Jr., Sr.)		12. Credential (e.g., M.D., D.O.)	

13. Type of other Name
❑ Former Name ❑ Professional Name ❑ Other, specify: _____

14. Date of Birth (mm/dd/yyyy)	15. State of Birth (U.S. only)	16. Country of Birth (If other than U.S.)

17. Gender
❑ Male ❑ Female

18. Social Security Number (SSN)	19. IRS Individual Taxpayer Identification Number (ITIN) (See Instructions)

B. Organizations *(includes Groups, Corporations and Partnerships)*

1. Name (Legal Business Name)	2. Employer Identification Number (EIN) (Do not report an SSN in this field.)

3. Other Name (Use additional sheets of paper if necessary)

4. Type of Other Name
❑ Former Legal Business Name ❑ D/B/A Name ❑ Other (Describe) _____

SECTION 3 – BUSINESS ADDRESSES AND OTHER INFORMATION

A. Business Mailing Address Information *(Do not report your residential address unless it is also your Business Mailing Address.)*

1. Business Mailing Address Line 1 (Street Number and Name or P.O. Box)

2. Business Mailing Address Line 2 (Address Information; e.g., Suite Number)

3. Business City	4. Business State	5. ZIP+4 or Foreign Postal Code

6. Business Country Name (if outside U.S.)

7. Business Telephone Number (Include Area Code & Extension)	8. Business Fax Number (Include Area Code)

B. Business Practice Location Information *(Do not report your residential address unless it is also your Business Practice Location.)*

1. Business Primary Practice Location Address Line 1 (Street Number and Name – P.O. Boxes Not Acceptable)

2. Business Primary Practice Location Address Line 2 (Address Information; e.g., Suite Number)

3. Business City	4. Business State	5. ZIP+4 or Foreign Postal Code

6. Business Country Name (if outside U.S.)

7. Business Telephone Number (Include Area Code & Extension) (Required)	8. Business Fax Number (Include Area Code)

C. Other Provider Identification Numbers *(Use additional sheets of paper if necessary) Do not include SSN, ITIN, or EIN in this section.*

Issuer	Identification Number	State *(If applicable)*	*Issuer (For Other Number Type Only)*
Medicare UPIN	_____	_____	
Medicare OSCAR/Certification	_____	_____	
Medicare PIN	_____	_____	
Medicare NSC	_____	_____	
Medicaid	_____	_____ (State is required if Medicaid number is furnished.)	
Other, Specify:	_____	_____	_____

D. Provider Taxonomy Code *(Provider Type/Specialty. Enter one or more codes)* and License Number Information

Do not include SSN, ITIN, or EIN in this section.

Information on provider taxonomy codes is available at *www.wpc-edi.com/taxonomy*. Please see instructions if you plan to submit more than one taxonomy code for a Type 2 (organization) entity.

1. **Primary** Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

2. License Number (See Instructions)	3. State where issued

4. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

5. License Number (See Instructions)	6. State where issued

7. Provider Taxonomy Code or describe your specialty or provider type (e.g., chiropractor, pediatric hospital)

☐☐☐☐☐☐☐☐☐☐

8. License Number (See Instructions)	9. State where issued

PENALTIES FOR FALSIFYING INFORMATION ON THE NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to 5 years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

SECTION 4 – CERTIFICATION STATEMENT

I, the undersigned, certify to the following:

- This form is being completed by, or on behalf of, a health care provider as defined at 45 CFR 160.103.
- I have read the contents of the application and the information contained herein is true, correct and complete. If I become aware that any information in this application is not true, correct, or complete, I agree to notify the NPI Enumerator of this fact immediately.
- I authorize the NPI Enumerator to verify the information contained herein. I agree to notify the NPI Enumerator of any changes in this form within 30 days of the effective date of the change.
- I have read and understand the Penalties for Falsifying Information on the NPI Application/Update Form as printed in this application. I am aware that falsifying information will result in fines and/or imprisonment.
- I have read and understand the Privacy Act Statement.

A. Individual Practitioner's Signature

1. Applicant's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	2. Date (mm/dd/yyyy)

B. Authorized Official's Information and Signature for the Organization

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last

5. Suffix (e.g., Jr., Sr.)	6. Credential (e.g., M.D., D.O.)

7. Title/Position	8. Telephone Number (Area Code & Extension)

9. Authorized Official's Signature (First, Middle, Last, Jr., Sr., M.D., D.O., etc.)	10. Date (mm/dd/yyyy)

SECTION 5 – CONTACT PERSON

A. Contact Person's Information

❑ Check here if you are the same person identified in 2A or 4B.

If you checked the box, complete only items 8 and 9 in this section (Section 5).

1. Prefix (e.g.,Major, Mrs.)	2. First	3. Middle	4. Last

5. Suffix (e.g., Jr., Sr.)	6. Credential (e.g., M.D., D.O.)

7. Title/Position	8. E-Mail Address	9. Telephone Number

For the most efficient and fast receipt of your NPI, please use the web-based NPI process at the following address: *https://nppes.cms.hhs.gov.* NPI web is a quick and easy way for you to get your NPI.

Or send the completed signed application to:

NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

PRIVACY ACT STATEMENT

Section 1173 of the Social Security Act authorizes the adoption of a standard unique health identifier for all health care providers who conduct electronically any standard transaction adopted under 45 CFR 162. The purpose of collecting this information is to assign a standard unique health identifier, the National Provider Identifier (NPI), to each health care provider for use on standard transactions. The NPI will simplify the administrative processing of certain health information. Further, it will improve the efficiency and effectiveness of standard transactions in the Medicare and Medicaid programs and other Federal health programs and private health programs. The information collected will be entered into a new system of records called the National Provider System (NPS), HHS/HCFA/OIS No. 09-70-0008. In accordance with the NPPES Data Dissemination Notice (CMS-6060), published May 30, 2007, certain information that you furnish will be publicly disclosed. The NPPES Data Dissemination Notice can be found at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf.

Failure to provide complete and accurate information may cause the application to be returned and delay processing. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you furnished on the form. (See the instructions for completing the NPI application/update form to find the information that is voluntary or mandatory.)

Information may be disclosed under specific circumstances to:

1. The entity that contracts with HHS to perform the enumeration functions, and its agents, and the NPS for the purpose of uniquely identifying and assigning NPIs to providers.
2. Entities implementing or maintaining systems and data files necessary for compliance with standards promulgated to comply with title XI, part C, of the Social Security Act.
3. A congressional office, from the record of an individual, in response to an inquiry from the congressional office made at the request of that individual.
4. Another Federal agency for use in processing research and statistical data directly related to the administration of its programs.
5. The Department of Justice, to a court or other tribunal, or to another party before such tribunal, when
   (a) HHS, or any component thereof, or
   (b) Any HHS employee in his or her official capacity; or
   (c) Any HHS employee in his or her individual capacity, where the Department of Justice (or HHS, where it is authorized to do so) has agreed to represent the employee; or
   (d) The United States or any agency thereof where HHS determines that the litigation is likely to affect HHS or any of its components is party to litigation or has an interest in such litigation, and HHS determines that the use of such records by the Department of Justice, the tribunal, or the other party is relevant and necessary to the litigation and would help in the effective representation of the governmental party or interest, provided, however, that in each case HHS determines that such disclosure is compatible with the purpose for which the records were collected.
6. An individual or organization for a research, demonstration, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or for the purposes of determining, evaluating and/or assessing cost, effectiveness, and/or the quality of health care services provided.
7. An Agency contractor for the purpose of collating, analyzing, aggregating or otherwise refining or processing records in this system, or for developing, modifying and/or manipulating automated data processing (ADP) software. Data would also be disclosed to contractors incidental to consultation, programming, operation, user assistance, or maintenance for ADP or telecommunications systems containing or supporting records in the system.
8. An agency of a State Government, or established by State law, for purposes of determining, evaluating and/or assessing cost, effectiveness, and/or quality of health care services provided in the State.
9. Another Federal or State agency
   (a) As necessary to enable such agency to fulfill a requirement of a Federal statute or regulation, or a State statute or regulation that implements a program funded in whole or in part with Federal funds.
   (b) For the purpose of identifying health care providers for debt collection under the provisions of the Debt Collection Information Act of 1996 and the Balanced Budget Act.

INSTRUCTIONS FOR COMPLETING THE NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION/UPDATE FORM

Please PRINT or TYPE all information so it is legible. Use only blue or black ink. Do not use pencil. Failure to provide complete and accurate information may cause your application to be returned and delay processing of your application. In addition, you may experience problems being recognized by insurers if the records in their systems do not match the information you have furnished on this form. **Please note: Social Security Number (SSN) or IRS Individual Taxpayer Identification Number (ITIN) information should only be listed in block 18 or block 19 of this form. DO NOT report SSN or ITIN information in any other section of this application form.**

This application is to be completed by, or on behalf of, a health care provider or a subpart seeking to obtain an NPI. (See 45 CFR 162.408 and 162.410 (a) (1).

SECTION 1 – BASIC INFORMATION

This section is to identify the reason for submittal of this form and the type of entity seeking to obtain an NPI.

A. Reason for Submittal of this Form

This section identifies the reason the health care provider is submitting this form. *(Required)*

1. **Initial Application**
   If applying for a NPI for the first time check box #1, and complete appropriate sections as indicated in Section 1B for your entity type.
2. **Change of Information**
   If changing information, check box #2, write your NPI in the space provided, and provide the add/replace information within the appropriate section. If you are adding information, please check the 'Add Information' box and fill out the appropriate section(s) with the information you are adding. If you are replacing information, please check the 'Replace Information' box and fill out the appropriate section(s) with the replaced information. See the instructions in Section 4, then sign and date the certification statement in Section 4A or 4B. All changes must be reported to the NPI Enumerator within 30 days of the change. It is not necessary to complete sections that are not being changed; however, please ensure that your NPI is legible and correct. Complete Section 5 so that we may contact you in the event of problems processing this form. Please note that some changes, such as a change to a health care provider's date of birth, require a photocopy of the health care provider's U.S. driver's license or birth certificate to be submitted along with the form for verification purposes.
3. **Deactivation**
   If you are deactivating the NPI, check box #3. Record the NPI you want to deactivate, indicate the reason for deactivation, and complete Section 2. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for Section 4. Use additional sheets of paper if necessary. Please note that deactivations due to death must be completed and signed in Section 4 by the Power of Attorney or Executor of the Will. In addition, a copy of the death certificate or obituary must accompany the completed signed form.
4. **Reactivation**
   If you are reactivating the NPI, check box #4. Record the NPI you want to reactivate, provide the reason for reactivation, and complete Section 2. Sign and date the certification statement in Section 4A or 4B, as appropriate. See instructions for Section 4. Use additional sheets of paper if necessary.

B. Entity Type

Check only one box (*Required* for initial applications)

Entity Type 1: Individuals who render health care or furnish health care to patients; e.g., physicians, dentists, nurses, chiropractors, pharmacists, physical therapists. Incorporated individuals may obtain NPIs for themselves (Entity Type 1 Individual) if they are health care providers and may obtain NPIs for their corporations (Entity Type 2 Organization). A sole proprietorship is an Entity Type 1 (Individual). (A sole proprietorship is a form of business in which one person owns all the assets of the business and is solely liable for all the debts of the business in an individual capacity. Therefore, sole proprietorships are not organization health care providers.) Note that sole proprietorships may obtain only one NPI. Sole proprietorships must report their SSNs (not EINs even if they have EINs). Virtually any health care provider could be a sole proprietorship, including most of the examples listed in Entity Type 2.

Entity Type 2: Organizations that render health care or furnish health care supplies to patients; e.g., hospitals, home health agencies, ambulance companies, group practices, health maintenance organizations, durable medical equipment suppliers, pharmacies. Solely owned corporations that are health care providers obtain NPIs as Entity Type 2. If the organization is a subpart, check yes and furnish the Legal Business Name (LBN) and Taxpayer Identification Number (TIN) of the "parent" organization health care provider.(A subpart is a component of an organization health care provider. A subpart may be a different location or may furnish a different type of health care than the organization health care provider. For ease of reference, we refer to that organization health care provider as the "parent".)

SECTION 2 – IDENTIFYING INFORMATION

A. Individual *(includes Sole Proprietorships and Incorporated Individuals)*

NOTE: An individual may obtain only one NPI, regardless of the number of taxonomies (specialties), licenses, or business practice locations he/she may possess. SSN or ITIN information should only be listed in block 18 or block 19, respectively, of this form. DO NOT report SSN and ITIN information in any other section of this form.

A sole proprietorship is an individual.

Name Information

1–6. Provide your full legal name. (Required first and last name) Do not use initials or abbreviations. If you furnish your social security number in block 18, this name must match the name on file with the Social Security Administration (SSA). In addition, the date of birth must match that on file with SSA. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

Other name information *(Use additional sheets of paper if necessary)*

7–12. If you have used another name, including a maiden name, supply that "Other Name" in this area. (Optional) You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

13. Mark the check box to indicate the type of "Other Name" you used. (Required if 7-12 are completed)

14–16. Provide the date *(Required)*, State *(Required)*, and country *(Required, if other than U.S.)* of your birth. Do not use abbreviations other than United States (U.S.).

17. Indicate your gender. *(Required)*

18. Furnish your Social Security Number (SSN) for purposes of unique identification. *(Optional)* If you furnish your SSN, this name must match the name and date of birth on file with the Social Security Administration (SSA). If you do not furnish your SSN, processing of your application may be delayed because of the difficulty of verifying your identity via other means; you may also have difficulty establishing your proper identity with insurers from which you receive payments. If you are not eligible for an SSN, see item #19. **If you do not furnish your SSN, you must furnish 2 proofs of identity with this application form: passport, birth certificate, a photocopy of your U.S. driver's license, State issued identification, or information requested in item #19.**

19. If you do not qualify for an SSN, furnish your IRS Individual Taxpayer Identification Number (ITIN) along with a photocopy of your U.S. driver's license, State issued ID, birth certificate or passport. **You may not report an ITIN if you have an SSN. Do not enter an Employer Identification Number (EIN) in the ITIN field. Note: Your passport, birth certificate, photocopy of the U.S. driver's license or State issued identification must accompany your ITIN. If you do not furnish the information requested in blocks 18 or 19, you must furnish 2 proofs of identity with this application form: passport, birth certificate, a photocopy of your U.S. driver's license or State issued identification.**
    Examples of individuals who need ITINs include:
    - Non-resident alien filing a U.S. tax return and not eligible for an SSN;
    - U.S. resident alien *(based on days present in the United States)* filing a U.S. tax return and not eligible for an SSN;
    - Dependent or spouse of a U.S. citizen/resident alien; and
    - Dependent or spouse of a non-resident alien visa holder.

B. Organizations *(includes Groups, Corporations and Partnerships)*

1–2. Provide your organization's or group's name *(legal business name used to file tax returns with the IRS)* and Employer Identification Number *(assigned by the IRS) (Required)*

3. If your organization or group uses or previously used another name, supply that "Other Name" in this area. *(Optional)* Use additional sheets of paper if necessary.

4. Mark the check box to indicate the type of "Other Name" used by your organization. *(D/B/A Name=Doing Business As Name.) (Required if 3 is completed.)*

NOTE: A sole proprietorship does not complete this section; he/she completes Section A.

SECTION 3 – ADDRESSES AND OTHER INFORMATION

A. Business Mailing Address Information *(Required)*

This information will assist us in contacting you with any questions we may have regarding your application for an NPI or with other information regarding NPI. You must provide an address and telephone number where we can contact you directly to resolve any issues that may arise during our review of your application. Do not report your residential address in this section unless it is also your business mailing address.

B. Business Practice Location Information *(Required)*

Provide information on the address of your primary practice location. If you have more than one practice location, select one as the "primary" location. Do not furnish information about additional locations on additional sheets of paper. Do not report your residential address in this section unless it is also your business practice location.

C. Other Provider Identification Numbers *(Optional)*

To assist health plans in matching your NPI to your existing health plan assigned identification number(s), you may wish to list the provider identification number(s) you currently use that were assigned to you by health plans. If you do not have such numbers, you are not required to obtain them in order to be assigned an NPI. Organizations should only furnish other provider identification numbers that belong to the organization; do not list identification numbers that belong to health care providers who are individuals who work for the Organizations. DO NOT report SSN, ITIN, or EIN information in this section of the form.

D. Provider Taxonomy Code *(Provider Type/Specialty) (Required)*

Provide your 10-digit taxonomy code. You must select a primary taxonomy code in order to facilitate aggregate reporting of providers by classification/specialization. If you need additional taxonomy codes to describe your type/classification/specialization, you may select additional codes. Information on taxonomy codes is available at www.wpc-edi.com/taxonomy.

Furnish the provider's health care license, registration, or certificate number(s) (if applicable). If issued by a State, show the State that issued the license/certificate. The following individual practitioners are required to submit a license number *(If you are one of the following and do not have a license or certificate, you must enclose a letter to the Enumerator explaining why not)*:

Certified Registered Nurse Anesthetist	Clinical Psychologist	Nurse Practitioner	Physician/Osteopath
Chiropractor	Dentist	Optometrist	Podiatrist
Clinical Nurse Specialist	Licensed Nurse	Pharmacist	Registered Nurse

You may use the same license, registration, or certification number for multiple taxonomies; e.g., if you are a physician with several different specialties.

NOTE: A health care provider that is an organization, such as a hospital, may obtain an NPI for itself and for any subparts that it determines need to be assigned NPIs. In some cases, the subparts have Provider Taxonomy Codes that may be different from that of the hospital and of each other, and each subpart may require separate licensing by the State (e.g., General Acute Care Hospital and Psychiatric Unit). If the organization provider chooses to include these multiple Provider Taxonomy Codes in a request for a single NPI, and later determines that the subparts should have been assigned their own NPIs with their associated Provider Taxonomy Codes, the organization provider must delete from its NPPES record any Provider Taxonomy Codes that belong to the subparts who will be obtaining their own NPIs. The organization provider must do this by initiating the Change of Information option on this form.

SECTION 4 – CERTIFICATION STATEMENT *(Required)*

This section is intended for the applicant to attest that he/she is aware of the requirements that must be met and maintained in order to obtain and retain an NPI. This section also requires the signature and date of signature of the "Individual" who is the type 1 provider, or the "Authorized Official" of the type 2 organization who can legally bind the provider to the laws and regulations relating to the NPI. See below to determine who within the provider qualifies as an Authorized Official. Review these requirements carefully.

Authorized Official's Information and Signature for the Organization

By his/her signature, the authorized official binds the provider/supplier to all of the requirements listed in the Certification Statement and acknowledges that the provider may be denied a National Provider Identifier if any requirements are not met. This section is intended for organizations; not health care providers who are individuals. All signatures must be original. Stamps, faxed or photocopied signatures are unacceptable. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

An authorized official is an appointed official with the legal authority to make changes and/or updates to the provider's status (e.g., change of address, etc.) and to commit the provider to fully abide by the laws and regulations relating to the National Provider Identifier. The authorized official must be a general partner, chairman of the board, chief financial officer, chief executive officer, direct owner of 5 percent or more of the provider being enumerated, or must hold a position of similar status and authority within the provider.

Only the authorized official(s) has the authority to sign the application on behalf of the provider.

By signing this application for the National Provider Identifier, the authorized official agrees to immediately notify the NPI Enumerator if any information in the application is not true, correct, or complete. In addition, the authorized official, by his/her signature, agrees to notify the NPI Enumerator of any changes to the information contained in this form within 30 days of the effective date of the change.

SECTION 5 – CONTACT PERSON *(If the contact person is the same person identified in 2A or 4B, complete items 8 & 9 in this section.) (Required)*

To assist in the timely processing of the NPI application, provide the name and telephone number of an individual who can be reached to answer questions regarding the information furnished in this application. The contact person can be the health care provider. The contact person will receive the NPI notification once the health care provider has been assigned an NPI. Please note that if a contact person is not provided, all questions about this application will be directed to the health care provider named in Section 2 or the authorized official named in Section 4, as appropriate. You may include multiple credentials. Use additional sheets of paper for multiple credentials if necessary.

Results **1** - **10** of **49** for npi

[How do covered entities implement the **NPI** where the adopted versions of the Implementation Guides appear to allow .....]
Updated: Background Section 1173(b) of HIPAA required the Secretary to adopt "standards providing for a unique health identifier for each individual, employer, health plan, and health care provider...
Date Updated: 09/02/2011
Answer ID: 5816

[If a health care provider with an **NPI** moves to a new location, must the health care provider notify the NPPES of its new address?]
Yes. A covered health care provider must notify the NPPES of the address change within 30 days of the effective date of the change. We encourage health care providers who have been assigned NPIs, but...
Date Updated: 10/12/2011
Answer ID: 2629

[Will the National Provider Identifier (**NPI**) be used as the standard identifier for E-Prescribing transactions?]
The **NPI** will eventually be the standard identifier for e-prescribing under Part D. It already is a standard identifier that will have to be used in standard transactions after the **NPI** compliance...
Date Updated: 07/29/2011
Answer ID: 6147

[Who's National Provider Identifier (**NPI**) should be in the Attending Physician **NPI** field on claims for institutions submitting vaccine roster bills for fiscal intermediaries (FIs) or regional home health intermediaries (RHHIs) when an **NPI** isUpdated]
For claims received on or after May 23, 2007, where an **NPI** is not available for use in claims processing, institutions submitting vaccine roster bills to FIs or RHHIs must duplicate their own **NPI** in...
Date Updated: 12/20/2011
Answer ID: 8049

[If several pharmacies, each with their own **NPI**, are owned by the same covered organization, may the X12 835 payment and remittance advice for these pharmacies be consolidated and sent to the covered organization health care provider?]
Payment and remittances for multiple pharmacies, each with their own NPIs, may be consolidated when the receiving entity (payee) shares the same Taxpayer Identification Number (TIN) as those...
Date Updated: 10/20/2011
Answer ID: 8450

[What identifiers can be used in Medicare e-prescribing on an interim basis before the **NPI** is required?]
Until May 2007, entities that want to e-prescribe for Medicare beneficiaries may use other identifiers as specified by CMS in program instructions. Additional guidance can be found on our website...

Date Updated: 03/22/2011
Answer ID: 6148

[Does the National Provider identifier (**NPI**) Final Rule require individual health care providers who are also part of a group practice, to obtain and use an individual **NPI** when prescribing medications or other types of laboratory services?]
The **NPI** final rule states that **NPI** enumeration is the decision of the provider. Therefore, a provider who is an individual and a group practice has several options: S/he may obtain an individual **NPI**...
Date Updated: 08/19/2011
Answer ID: 9419

[When is an **NPI** entered in block 32 and how do I share my **NPI** with Medicare?]
Medicare does not require an **NPI** in block 32a nor a legacy number in 32b. If you are using the new CMS-1500 version 08-05, and if you previously populated boxes 17a (referring provider), 24j...
Date Updated: 11/22/2011
Answer ID: 8610

[If a health care provider deactivates its National Provider Identifier (**NPI**), will its record still be in the downloadable file and the query-only database? How will it be known that the **NPI** was deactivated?] Updated
No. Neither the downloadable file nor the query-only database will contain information about health care providers whose NPIs are deactivated. Deactivated NPIs should not be used in standard...
Date Updated: 12/20/2011
Answer ID: 8444

[What is known about the characteristics of Medicaid and CHIP service providers - e.g. name, address, National Provider Identifier (**NPI**) and other characteristics?]
Unfortunately, MSIS and MAX data do not capture detailed information on provider characteristics at this time. The only information about providers that is captured currently is the...
Date Updated: 09/16/2011
Answer ID: 10814

1 2 3 4 5 Next >

For Technical Support, call toll-free 1-877-598-8753.

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Welcome to the Louisiana Medicaid Provider Support Center

CommunityCARE Providers Invited to Participate in BAYOU HEALTH Outreach Campaign **1/6/12**

Long Term Care, ICF DD and Hospice Providers: Regular and Supplemental Billing Schedules for January through June 2012 **1/3/12**

Important Update on NCPDP D.0 and 5010 270/271 Transactions Implementation Effective January 1, 2012 **12/21/11**

Molina Office Holiday Schedule **12/21/11**

Important Update Concerning Changes to the Electronic Claims Status Inquiry (eCSI) Application **12/21/11**

Important News for CommunityCare Providers **12/12/11**

5010v of the HIPAA Electronic Transactions **12/7/11**

New Implementation Date for 5010 Compliance **12/7/11**

Fluoride Varnish Now Payable **12/6/11**

Update and Clarification of Obstetrical Services and Postpartum Care Policy **11/18/11**

Attention All Providers – Modified Payment Schedule **11/10/11**

RUM - Updated list of procedures requiring prior authorization –Effective January 1, 2012 **11/7/11**

Attention All Anesthesia Providers **11/7/11**

Update Regarding Changes to the electronic Claims Status Inquiry (eCSI) Web Application **10/26/11**

FY 2012 Community Hospital DSH / Act 540 UCC Survey **10/20/11**

Upcoming Changes to the Electronic Prior Authorization (ePA) Web Application **10/14/11**

ePrecertification Request Web Application Changes **10/14/11**

Radiopharmaceutical Diagnostic Imaging Agents **10/12/11**

DHH Schedules CCN Q & A Calls for Providers **10/7/11**

Important Provider Notice Concerning the Recent Implementation of Delayed Payment Cycles **10/4/11**

Louisiana Medicaid to Eliminate Standard Paper Remittance Advices **9/28/11**

Provider Notice for Change in Obstetric Ultrasound Service Limits **9/14/11**

Procedure Codes Payable to Optometrists **9/9/11**

Fee Schedules in Excel Format **9/6/11**

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Provider Update / Remittance Advice Index
Provider Web Account Registration Instructions
Training/Policy Updates
Useful Links

Provider Enrollment

New Enrollment and/or Change of Ownership

Applications for New Enrollments, Reactivations, and Change of Ownership

Currently Enrolled Providers

Forms to Update Existing Provider Information

CommunityCARE 2.0

Quick Facts

Modification of Louisiana Medicaid Provider ID Numbers for New Providers - Click here for more information

Out-of-State Emergency Care

The Louisiana Medicaid Program covers out-of-state emergency services provided to Louisiana Medicaid eligible recipients who are absent from the state when an emergency arises from an accident or illness, when the health of the recipient would be endangered if the recipient undertook travel to return to Louisiana, or when the health of the recipient would be endangered if medical care were postponed until the recipient returns to Louisiana. For reimbursement, the out-of-state provider must enroll as a Louisiana Medicaid Provider and must follow established timely filing guidelines in submitting claims.

Autoclosure

Providers having no billing activity in the last 18 months are subject to autoclosure of their Provider Numbers.

New Address, New Telephone

Timely reporting of a new address and/or new phone number is necessary to avoid closure of your Provider Number.

NPI

You are required to provide your NPI in order to process any transaction or correspondence with Provider Enrollment (such as change of address requests, group linkages, direct deposit, and any other correspondence). Failure to provide your NPI will result in the rejection of your request.

Provider Enrollment - Applications for New Enrollments, Reactivations, and Change of Ownership

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Louisiana Medicaid provider enrollment applications are now available online. Enrolling in Louisiana Medicaid is a two- (2) step process:

1. **Download the Basic Enrollment Packet.**

2. **Download the additional Enrollment Packet that is applicable to each provider type.**

*** It is necessary to submit forms from both packets for enrollment requests to be processed.**

Unnecessary delays may be avoided by reviewing the packets in their entirety prior to completing. Incorrect/incomplete applications will be returned to the provider for correction. A checklist has been provided in each provider specific packet identifying all required forms/documentation for enrollment. Carefully review the instructions and checklist prior to submission to ensure that all paperwork is complete. All required documentation must be submitted as one application – do not send required documentation separately as it will be rejected.

- **Basic Provider Enrollment Packet for Entities/Businesses - 07/11**
- **Basic Provider Enrollment Packet for Individuals - 07/11**
- **CommunityCARE Enrollment Packet - 07/10**
- **KIDMED Enrollment Packet (for Currently Enrolled Medicaid Providers Wanting to Add KIDMED Services) - 07/10**

Provider Type Specific Packets/Checklists

- **03 Waiver-Children's Choice**
- **04 Pediatric Day Health Facility**
- **05 Coordinated Care Network – Prepaid CCN-P**
- **06 Waiver – NOW Professional**
- **07 Case Management - Infant & Toddlers**
- **08 Office of Aging and Adult Services Case Management (Support Coordination)**
- **09 Hospice Services**
- **11 Shared Living**
- **12 Multi-Systemic Therapy**
- **13 Pre-Vocational Habilitation**
- **14 Waiver-Adult Day Habilitation**
- **15 Waiver-Environmental Accessibility Adaptations (Environmental Modifications)**
- **16 Waiver-Personal Emergency Response System**

ENROLLMENT PACKET FOR THE LOUISIANA MEDICAL ASSISTANCE PROGRAM

(Louisiana Medicaid Program)

Basic Enrollment Packet For Individuals (With Instructions)

(Common Forms for All Individual Provider Types)

(Enrollment packet is subject to change without notice)

Download complete enrollment packet at
http://www.lamedicaid.com/provweb1/Provider_Enrollment/newenrollments.htm

Provider Enrollment Specialty Change Form – Individual

Provider Number (7 digits)

National Provider Identifier – NPI (10 digits)

Provider Name:

Provider Address:

Please update my specialty on the Louisiana Medicaid Provider File to show:

See next page to choose recognized specialty and subspecialty. Forms completed with specialty or subspecialty other than those listed on the following page(s) will be returned for correction.

Specialty Code	Specialty Description

Subspecialty Code*	Subspecialty Description

*Only the following specialties may have subspecialties:

16 - OBGYN
37 - Pediatrics
41 - Internal Medicine

Provider Signature

Date

Please submit all required documentation to:
Molina Provider Enrollment Unit
PO Box 80159
Baton Rouge, LA 70898-0159

Specialties and Subspecialties For

Physicians, Doctors of Osteopathy, and Medical School Residents ONLY

01	General Practice / Emergency Room		37	Pediatrics (see subspecialty below)
1T	Emergency Medicine			Subspecialty
02	General Surgery			1A Adolescent Medicine
03	Allergy			1B Diagnostic Lab Immunology
04	Otology, Larynogology, Rhinology (ENT)			1C Neonatal Perinatal Medicine
05	Anesthesiology			1D Pediatric Cardiology
06	Cardiovascular Disease			1E Pediatric Critical Care Med.
07	Dermatology			1F Pediatric Emergency Med.
08	Family Practice			1G Pediatric Endocrinology
10	Gastroenterology			1H Pediatric Gastroenterology
13	Neurology			1I Pediatric Hematology – Oncology
14	Neurological Surgery			1J Pediatric Infectious Disease
15	Obstetrics (Osteopaths Only)			1K Pediatric Nephrology
16	Obstetrics & Gynecology (see subspecialty below) (Physicians Only)			1L Pediatric Pulmonology
	Subspecialty			1M Pediatric Rheumatology
	3A Critical Care Medicine			1N Pediatric Sports Medicine
	3B Gynecologic Oncology			1P Pediatric Surgery
	3C Maternal & Fetal Medicine		38	Geriatrics
17	Ophthalmology, Otology, Laryngology, Rhinology (Osteopaths Only)		40	Hand Surgery
18	Ophthalmology		41	Internal Medicine (see subspecialty below)
20	Orthopedic Surgery			Subspecialty
21	Pathologic Anatomy; Clinical Pathology (Osteopaths Only)			2A Cardiac Electrophysiology
22	Pathology			2B Cardiovascular Disease
23	Peripheral Vascular Disease or Surgery (Osteopaths Only)			2C Critical Care Medicine
24	Plastic Surgery			2D Diagnostic Lab Immunology
25	Physical Medicine Rehabilitation			2E Endocrinology & Metabolism
26	Psychiatry			2F Gastroenterology
27	Psychiatry; Neurology (Osteopaths Only)			2G Geriatric Medicine
28	Proctology			2H Hematology
29	Pulmonary Diseases			2I Infectious Disease
30	Radiology			2J Medical Oncology
31	Roentgenology, Radiology (Osteopaths Only)			2K Nephrology
32	Radiation Therapy (Osteopaths Only)			2L Pulmonary Disease
33	Thoracic Surgery			2M Rheumatology
34	Urology			2N Surgery – Critical Care
				2P Surgery – General Vascular

Licensure
CDS & DEA

LOUISIANA BOARD OF PHARMACY

STATE OF LOUISIANA

LOUISIANA BOARD of PHARMACY

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- FOR PHARMACY TECHNICIANS & TECHNICIAN CANDIDATES
- FOR PHARMACY INTERNS
- (CDS) CONTROLLED DANGEROUS SUBSTANCE LICENSES
- (PMP) PRESCRIPTION MONITORING PROGRAM
- LEGISLATIVE WORKGROUP ON ELECTRONIC PRESCRIBING

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January 18
Legislative Workgroup on Electronic Prescribing

January 31
Impairment Committee

February 1
Reinstatement Committee

Action Items

- **Verification of Credentials**
- **Apply For a New License**
- **Renew a License**
- **Download Forms & Applications**

Louisiana Board of Pharmacy

3388 Brentwood Drive
Baton Rouge, Louisiana 70809-1700
www.pharmacy.la.gov ~ Email: info@pharmacy.la.gov

Application Packet for a Louisiana Controlled Dangerous Substance (CDS) License

This packet contains two pages of instructions and the two paged application form. Please read the information carefully. Our experience is that many application forms are returned due to the absence of required information. Louisiana CDS Licenses are site specific for the location where the controlled dangerous substances are utilized. If you have more than one practice location where such substances are maintained, then you must submit a separate application for each location.

Due to the requirement for an original signature, the original copy of the completed application form must be delivered to the Louisiana Board of Pharmacy at the address above with the correct fee. We are unable to accept faxed application forms**.**

Section 1 – Reason for Application

- Select the reason for the application.
- For renewals of existing licenses, please enter the license number.
- For reinstatement of lapsed licenses, please enter the license number and note the additional fee.

Section 2 – Registrant Information

Please note: A post office box cannot be accepted as a practice location.

Facility Applicants:

- Enter the name of the facility, as well as the tax ID number of the business.
- Enter the office and fax numbers for the facility.
- Enter the state Board license information.
    - In the event the facility holds a credential from the Health Standards Section of the Department of Health and Hospitals, please enter that license number and expiration date.
    - If not, then enter the license number and expiration date for the facility's physician medical director.
    - In either case, please attach a legible copy of the appropriate credential.
- DEA registration information
    - Enter this number if you already hold a DEA registration number for Louisiana and are seeking reinstatement or if you currently hold a valid DEA registration number from another state and the name of the state in which it was issued. If you have never held a DEA registration number before, you may leave the space blank or write "pending" in the space.
- Controlled substance licenses issued to facilities shall be directed to the attention of the chief pharmacist, consultant pharmacist, or the physician medical director – and that person shall sign the application form.

Practitioner Applicants:

- Enter the registrant's complete name and social security number.
- Enter the office telephone and fax numbers of the registrant.
- Enter the state Board license information.
    - Enter the applicable Board license number and expiration date (this applies to all applicants who are licensed by a licensing Board) and attach a legible copy of the Board license.
    - All optometrists, physician's assistants, and APRN's shall submit a copy of their respective Board's license *plus* their Limited Prescriptive and Distributive Authority for Controlled Dangerous Substances authorization letter.

- DEA registration information.
    - Enter this number if you already hold a DEA registration number for Louisiana and are seeking reinstatement or if you currently hold a valid DEA registration number from another state and the name of the state in which it was issued. If you have never held a DEA registration number before, you may leave the space blank or write "pending" in the space.
    - Practitioners moving to Louisiana from another state and in possession of a DEA registration from that state should contact DEA for another registration for this state.
- Enter the complete physical address of the practice location (practitioners may prescribe for their patients from anywhere within the state.)

Sales Representatives:

- Enter the name of the sales representative and the name of the company.
- Enter the office and fax numbers of the registrant.
- Enter the applicable Board license number and expiration date (this applies to <u>all applicants</u> who are licensed by a licensing Board) and attach a copy of the Board license.
- DEA registration information.
    - Enter this number if you already hold a DEA registration number for Louisiana and are seeking reinstatement or if you currently hold a valid DEA registration number from another state and the name of the state in which it was issued. If you have never held a DEA registration number before, you may leave the space blank or write "pending" in the space.
    - Note: All applicants must apply for a new DEA registration number if you are moving to Louisiana from another state.
- Enter the physical address of the company's headquarters.
- You must submit a letter of verification of employment and authorization executed by the manufacturer / distributor you represent.

<u>Section 3 – Classification of License</u>

- Check the appropriate class of license sought and submit the fee amount listed with the completed application.

<u>Section 4 – Drug Schedules</u>

- Enter the schedules that you are requesting by checking the appropriate boxes.
- Permission for Schedule I substances is restricted to researchers, analytical labs, law enforcement agencies, and canine trainers.

<u>Section 5 – Certification Statements</u>

- All applicants must complete this section.
- Facility applicants for a new credential should respond only to the question for facilities.
- Practitioner applicants for a new credential should respond only to the question for practitioners.
- If the application is for renewal or reinstatement, select that question and enter the information requested.

<u>Section 6 – Applicant's Signature</u>

Read the statement, then sign and date the appropriate line.

<u>Final Notes:</u>

- Licensees are required to notify the Board of all changes of name, physical location, and mailing address no later than 10 days following such changes. Should you wish to order a duplicate credential reflecting such changes, please include the $5.00 fee for that product.
- In the event a CDS license is not renewed within 30 days after the expiration date, the Board is obligated to terminate the license, and then report that termination to the primary licensing agency as well as the U.S. Drug Enforcement Administration (DEA).
-

Louisiana Board of Pharmacy

3388 Brentwood Drive
Baton Rouge, Louisiana 70809-1700
www.pharmacy.la.gov ~ Email: info@pharmacy.la.gov

Application for a Louisiana Controlled Dangerous Substance (CDS) License

To avoid processing delays, please refer to application packet before completing this application.

Mail completed application, directed specifically to "CDS Program", at the address noted above. Faxed applications will not be accepted.

FOR BOARD OFFICE USE ONLY
CK#_____ AMT_____
Date application rec'd _____
License #_____ Date Issued: _____

SECTION 1 – Reason for Application

_____ New CDS License
_____ Renewal or Reinstatement of Existing CDS License #_____ Add $10 to renewal fee if license has been expired for more than 30 days

SECTION 2 – Registrant Information

Facilities:	Full Business or Facility Name		
	Taxpayer ID # ___ ___ - ___ ___ ___ ___ ___ ___ ___		
Practitioners:	Last Name	First Name	Middle Initial
	Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___		
Business Phone	Business Fax	Home Phone	

LA State Board License # _____	DEA Registration # _____
LA State Board License Exp. Date (mm-dd-yyyy) _____	DEA Registration Exp. Date (mm-dd-yyyy) _____

Enter Physical Address of Practice Location (Do not enter a P. O. Box)	**Mailing Address (If different than physical address)**	**Home Address**
Address Line 1	Address Line 1	Address Line 1
Address Line 2	Address Line 2	Address Line 2
City	City	City
State	State	State
Zip	Zip	Zip

For Businesses, enter name of Chief Pharmacist, Consultant Pharmacist or Physician Medical Director (must sign application)

SECTION 3 – Classification of License (Select Only One)
Submit a check or money order payable to Louisiana Board of Pharmacy in the required amount

		_____ APRN ($45)*
_____ Ambulatory Surgical Center ($50)	_____ Hospital ($50)	_____ Dentist ($45)*
_____ Animal Euthanasia Tech. ($20)	_____ Laboratory ($20)	_____ Med. Psych. ($45)*
_____ Clinic / Rural Health Clinic / Emerg. Ctr ($50)	_____ Manufacturer ($100)	_____ Optometrist ($45)*
_____ Dialysis Center ($20)	_____ Narcotic Treatment Center ($50)	_____ Physician ($45)*
_____ Drug Detection – Canine ($30)	_____ Researcher ($30)	_____ Physician Asst ($45)*
_____ EMS ($20)	_____ Sales Representative ($20)	_____ Podiatrist ($45)*
_____ Other _____ ($20)	_____ Wholesaler / Distributor ($50)	_____ Veterinarian ($20)

* Fee includes Prescription Monitoring Program (PMP) fee as authorized by La. R.S. 40:1013.

SECTION 4 – Drug Schedules
Check ALL applicable Schedules to be handled. License will be issued for those schedules checked ONLY.

_____ Schedule I (Experimental)	_____ Schedule III	_____ Schedule V
_____ Schedule II	_____ Schedule III-N (Non-narcotic)	
_____ Schedule II-N (Non-narcotic)	_____ Schedule IV	

SECTION 5 – All registrants must answer the following:
If the answer to either of the first two questions is "YES," submit a detailed statement including all circumstances along with this application.

Facility Applicants:	If the applicant is a corporation, association, or partnership has any officer, partner, stockholder or proprietor been convicted of a felony in connection with controlled substances under any State of Federal Law, or ever surrendered or had a State or Federal License revoked, suspended, or denied?	_____ **Yes** _____ **No**
Practitioner Applicants:	Has the applicant ever been convicted of a felony in connection with controlled substances under any State or Federal Law, or ever surrendered or had a State or Federal controlled dangerous substance or practitioner's license revoked, suspended, or denied?	_____ **Yes** _____ **No**
For Renewal Applications:	I certify that I have a valid practitioner's license from the appropriate Board of competent jurisdiction that expires on the following date: Expiration Date: _____ / _____ / 20_____	_____ **Yes** _____ **No**

SECTION 6 – Applicant's Signature
I hereby make application for a license to manufacture, distribute, procure, possess, prescribe, dispense, and/or to conduct research with controlled dangerous substances, as indicated above, in compliance with the requirements of Part X of Title 40 of the Louisiana Revised Statutes of 1950, as amended, as well as the rules of the Board of Pharmacy promulgated in accordance with said statute. I/We further agree that declared facilities and/or offices shall be open to inspection by the Louisiana Board of Pharmacy, its agent or designee, for the inspection of controlled dangerous substances, their storage, handling, distribution, and recordkeeping.

Facility Applicants:	Original Signature of Authorized Individual Identified in Section 2	Date _____ / _____ / 20_____
Practitioner Applicants:	Original Signature of Applicant	Date _____ / _____ / 20_____

U.S. Department of Justice Drug Enforcement Administration

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What's New

Information Regarding Carisoprodol Prescriptions

30-Day Notice of Information Collection Under Review - Agency Information Collection Activities: Proposed Collection; Comments Requested: Application for Registration and Application for Registration Renewal DEA Forms 363 and 363a (January 10, 2012)

30-Day Notice of Information Collection Under Review - Agency Information Collection Activities: Proposed Collection; Comments Requested: Application for Import Quota for Ephedrine, Pseudoephedrine, and Phenylpropanolamine DEA Form 488 (January 9, 2012)

Mylan Pharmaceuticals, Inc. (December 29, 2011)

Norac Inc. (December 29, 2011)

AMPAC Fine Chemicals LLC. (December 29, 2011)

Chemic Laboratories, Inc. (December 29, 2011)

30-Day Notice of Information Collection Under Review - Agency Information Collection Activities; Proposed Collection; Comments Requested: Application for Registration, Application for Registration Renewal, Affidavit for Chain Renewal DEA Forms 225, 225a, 225b (December 23, 2011)

Barry M. Schultz, M.D.; Decision and Order (December 19, 2011)

Controlled Substances: Established Aggregate Production Quotas for 2012 (December 15, 2011)

Schedules of Controlled Substances: Placement of Ezogabine Into Schedule V (December 15, 2011)

Halo Pharmaceutical Inc. (December 14, 2011)

Established Assessment of Annual Needs for the List I Chemicals Ephedrine, Pseudoephedrine, and Phenylpropanolamine for 2012 (December 12, 2011)

More

Registration Support

Registration Number Toll Free: 1-800-882-9539

Save time by applying for and/or renewing your DEA Registration online. Data will be entered through a **secure connection** to the **ODWIF** online web application system.

Minimum requirements:
Credit Card and a web browser that supports **128-bit encryption.**

Email Registration Questions to DEA.Registration.Help@usdoj.gov

Field Offices with Registration Specialists

More

Quick Links

- Renew Applications Online
- New Application Online
- Duplicate Certificate Request
- Registration Validation
- Registration Change Request
- Order Forms
- CSOS
- DEA Form 106: Report Theft or Loss of Controlled Substance
- Combat Meth Act 2005 (CMEA)
- Cases Against Doctors
- Mailing Addresses for Topics Related to Title 21 CFR
- Electronic Prescriptions for Controlled Substances
- Publications & Manuals
- Meetings and Events
- Drug Disposal - Got Drugs
- Chemical Control Program

FAQ

- ARCOS
- Controlled Substance Ordering System (CSOS)
- DEA Form 222 Order Forms
- Electronic Prescriptions for Controlled Substances
- General Information
- Issuance of Multiple Prescriptions for Schedule II Controlled Substances
- Locum Tenens
- Oxycodone
- Prescription Drug Monitoring Program
- Registration Procedures

Drug Enforcement Administration Home

Application for Registration Under Controlled Substance Act of 1970
(New Applicants Only)

ON-LINE REGISTRATION CONSISTS OF SIX (6) SECTIONS. Please have the following information available **before** you begin the application:

Section 1. Personal/Business Information

If you are applying for an Individual Registration (Practitioner, MLP, Researcher) you are required to provide your Full Name, Address, Social Security Number, and Phone Number. If you are applying for a Business Registration, you are required to provide the Name of the Business, Address, Tax ID, and Phone Number.

Section 2. Activity

Business Activity and Drug Schedule information. **In addition** - Certain registrants for forms 225 and 510 will need to provide specific drug codes and/or chemical codes related to their operations.

Section 3. State License(s)

Information pertaining to current State medical and/or controlled substance licenses/registrations.

Section 4. Background Information

Information pertaining to controlled substances in the applicant's background.

Section 5. Payment

Payment, via this on-line application, must be made with a Visa or MasterCard, American Express, or Discover. **Application fees are not refundable.**

Section 6. Confirmation

Applicants will confirm the entered information, make corrections if needed, and electronically submit the application and a submission confirmation will be presented. Applicants will be able to print copies for their records.

WARNING: 21 USC 843(d), states that any person who knowingly or intentionally furnishes false or fraudulent information in the application is subject to a term of imprisonment of not more than 4 years, and a fine under Title 18 of not more than $250,000, or both.

Select Your Business Category

- **Form 224 -** Practitioners(MD,DO,DDS,DMD,DVM,DPM), Mid Level Practitioners (NP, PA, OD, etc.), Pharmacies, Hospitals/Clinics, Teaching Institutions
- **Form 225 -** Manufacturers, Import/Export, Distributors, Researchers, Dog Handlers, Labs
- **Form 510 -** Chemical: Manufacturers, Import/Export, Distributors
- **Form 363 -** Treatment Clinics

Select One Business Activity

Applying for a registration with the wrong Business Category/Activity will cause either delay in processing your application or the withdrawal of your application. If you are not certain of your Business Category/Activity, please contact DEA Customer Service at 1-800-882-9539.

PRACTITIONER ($551 / 3 YRS)

Please do not use your browser's BACK and FORWARD buttons while navigating this form.

Begin

-Cancel-

Home
Registration
Reporting
Info & Legal Resources
Inside Diversion Control

Registration > ODWIF

Registration Applications

Office of Diversion Control Web Interactive Forms (ODWIF)

NEW APPLICATIONS

For Registration Help
DEA.Registration.Help@usdoj.gov
Please be sure to include your DEA Registration number in your email.

Begin Application Process	Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner, Manufacturer, Distributor, Researcher, Analytical Laboratory, Importer, Exporter, Narcotic Treatment Program, Domestic Chemical
Obtain Receipt	This link may be used ONLY if you have previously submitted an Application through this tool and need an additional receipt. You MUST have the **Tracking Number -or- Control Number**.

MINIMUM ON-LINE REQUIREMENTS

The DEA Forms listed below are for those applying to DEA for a controlled substance registration. Data will be entered through a **secure connection** to the **ODWIF** online web application system. **Your web browser must support 128-bit encryption.**

You will need to have the following information handy in order to complete the form:

- Tax ID number and/or Social Security Number
- **State Controlled Substance Registration Information**
- State Medical License Information
- Credit Card (VISA, MasterCard, Discover or American Express)

The ODWIF system can only process credit card transactions at this time. If you are paying by check, you will need to use the PDF version of the form, then print and mail the form to the address listed on the form.

To view PDF documents
Get ADOBE READER

External links included in this website should not be construed as an official endorsement of the views contained therein.

Back to Top
Drug Enforcement Administration Home

Long Term Disability

Conversion option

American General

AIG American General

AIG Life Insurance Company*
Wilmington, Delaware
A member company of American International Group, Inc.
Administrative Office: Attn: Client Services 3-A, 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583
Phone: 1-800-346-7692 Fax: 1-732-922-7604 *This company does not solicit business in New York.

Read these instructions carefully. Remove this instruction sheet prior to completing the LTD conversion application.

Notice of Conversion

If your group long term disability policy contains a conversion privilege, and your insurance under that policy ends because of your termination of employment, you may be eligible to convert your insurance. To do so, you must:

1. complete and sign the attached application; and
2. forward the signed application along with the first quarterly premium within 31 days of the date your employment terminates.

You are eligible to convert your long term disability insurance if you meet all of the following rules:

- you were insured by the group policy when your insurance terminated;
- your insurance under the group policy ceased solely because of your termination of employment; and
- you were insured for twelve consecutive months by either the group policy or a combination of the group policy and the plan of long term disability benefits replaced by the group policy.

You will not be eligible to convert if any of the following apply to you:

- the group policy terminated or your employer's participation in the group policy terminated, even if your employment terminated coincident with such termination;
- you retire;
- you are eligible to receive long term disability benefits under the group policy, or you are in the waiting period for long term disability benefits under the group policy;
- you are eligible for, or insured for, similar benefits under another group plan or an individual policy;
- your insurance under the group policy terminated for any reason other than your termination of employment; or
- you apply for coverage more than 31 days after your date of termination.

Conversion Application Instructions

On the following page you will find a summary of the conversion benefits offered and a table of conversion rates. These rates vary by age.

To convert your long term disability benefits you must:

1. Complete the Application for Conversion of Long Term Disability Insurance. Be sure that you answer all questions.

2. Check to see that your employer has completed the employer information on the Application and that an authorized representative of the employer has signed the form. *It is your responsibility to assure this information is completed and included on the Application before the Application is mailed. If the application is not complete, it will be returned to you.*

3. Determine your quarterly premium using the worksheet and the table of conversion rates on the following page.

4. Sign and date the Application. Attach your first premium payment (made payable to AIG Life Insurance Company). Mail the Application and first payment to:

AIG Life Insurance Company
Attn: Client Services 3A
3600 Route 66
P.O. Box 1583
Neptune, NJ 07754-1583

Summary of Conversion Benefits

If the benefit percentage or maximum benefit shown below is greater than the comparable provision of the group policy from which conversion is being requested, the conversion policy that will be issued will be reduced so that the benefit percentage and/or maximum benefit of the conversion policy do not exceed the group policy amounts.

	Conversion Benefits
Benefit Percentage	60%
Monthly Maximum Benefit	$2,000
Monthly Minimum Benefit	$50
Elimination Period	180 days
Maximum Benefit Period	2 years RBD

In addition, the Plan contains the following benefit provisions:

- Regular occupation definition of disability
- Full family Social Security Other Income Offset provision with cost of living freeze
- Maternity as any other disability coverage
- Three Month Survivor Benefit
- Partial Disability feature

Table of Conversion Rates

The following are the premium rates that will apply each quarter and are based upon your age and each $100 of monthly benefit. To determine your monthly benefit, and the premium that applies, use the worksheet below together with the following rate table:

Age	Table of Rates Per $100 of Monthly Benefit
Under age 35	$ .75
35 but less than 40	1.18
40 but less than 45	1.83
45 but less than 50	2.70
50 but less than 55	4.00
55 but less than 60	5.90
60 and older	10.49

Your initial rates will change effective with the first quarterly billing after the date you attain an age for which an increased rate would apply, based upon the above rate table, or the current rate table in effect.

Premium Worksheet

What is your age? _____

1. Enter your annual salary on the date your employment ended, but do not enter more than $48,000: _____.
2. Divide the figure in Step #1 by 12 and enter the answer: _____.
3. Multiply the answer in Step #2 by 0.50 and enter the answer: _____.
4. Divide the answer in Step #3 by 100 and enter the answer: _____.
5. Using the rate table above, based upon your age, enter the rate: _____.
6. Multiply the rate shown in Step #5 times the answer from Step #4 and enter the answer _____.

Your quarterly premium will be the amount in Step #6, until the rate changes because of your age change.

AIG AMERICAN GENERAL
AIG Life Insurance Company*
Wilmington, Delaware
A member company of American International Group, Inc.
Administrative Office: Attn: Client Services 3-A, 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583
Phone: 1-800-346-7692 Fax: 1-732-922-7604 *This company does not solicit business in New York.

APPLICATION FOR CONVERSION OF LONG TERM DISABILITY INSURANCE

PLEASE TYPE OR PRINT ALL INFORMATION

To Be Completed By The Terminated Employee

1. Name: _____
FIRST MIDDLE LAST

2. Home Address: _____
STREET

_____
CITY STATE ZIP CODE

3. Sex ☐ Male ☐ Female 4. Social Security Number_____ 5. Date of Birth_____

6. Name of Employer _____ 7. Group LTD Policy Number _____

8. Are you eligible for or covered by any other Group Long Term Disability Insurance other than item #7 above? ☐ Yes ☐ No

I have been informed of my option to convert to a Group Long Term Disability Conversion Policy. I understand my options, have completed the above Application for Conversion and I am enclosing the required premium payment

The statements above are true to the best of my knowledge and belief, and I agree that they shall form a part of the contract of insurance requested.

Signature of Applicant _____Date_____

NOTE: Your employer MUST complete the information on the following page of this application. Once the Employer information has been provided, you must send this application and the first premium payment to AIG Life Insurance Company at the above address. This must be done within 31 days of the date your employment with the Employer ends. AIG Life Insurance Company will not accept any application:

- that is received more than 31 days after the date your insurance ends; or
- if the first premium payment is not sent with the application.

Upon approval of this Application a Certificate of Insurance will be sent directly to you at the address provided

To Be Completed By The Employer

A) Employer (Firm Name and Division): _____

B) Address: _____
STREET

_____
CITY STATE ZIP CODE

C) Group LTD Policy Number _____ D) Maximum Benefit _____ E) Benefit Amount _____%

F) Was the individual covered under your present Group LTD Plan, or under a combination of your present and prior Group LTD Plan, for at least 12 consecutive months? ☐ Yes ☐ No

G) Date employee terminated employment _____

H) Employee's basic monthly earnings at time of termination: Commissions: $ _____ Salary:$ _____

I) Employee's occupation at time of termination _____

J) Reason for employee termination _____

K) Is the employee terminating employment as a result of retirement, leave of absence, or disability? ☐ Yes ☐ No

L) The date the conversion notice and application was given to the terminated employee _____

Employer Representative Signature _____ Date_____

Title_____ Phone Number _____

NOTE: Terminated employee MUST complete the Application and return the form to AIG Life Insurance Company.

AIG AMERICAN GENERAL

Fraud Statement

FOR RESIDENTS OF:

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEVADA: Any person who misrepresents or falsifies essential information requested on this form may, upon conviction, be subject to a fine and imprisonment under state or federal law, or both.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is unlawful for any person, knowing it to be such, to: (a) present, or cause to be presented, a false or fraudulent claim, or any proof in support of such a claim, for the payment of a loss under a contract of insurance; or (b) prepare, make, or subscribe any false or fraudulent account, certificate, affidavit, or proof of loss, or other document or writing, with intent that it be presented or used in support of such a claim.

WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF ALL OTHER STATES NOT LISTED ABOVE:

Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any facts materially thereto, commits a fraudulent insurance act, which may be a crime and subject such person to criminal and civil penalties.

Credentialing
&
Verifications of Training

LSU Health Sciences Center
NEW ORLEANS

School of Medicine
Office of Medical Education

School of Medicine
School of Dentistry
School of Nursing
School of Allied Health Professions
School of Graduate Studies
School of Public Health

January 5,2012

Please take note of our Graduate Medical Education fax number for all training verifications. This fax number is linked to a fax to email machine so all verifications can be handled more efficiently.

Medical degrees, internship, residency and fellowship verifications can be faxed to ***504-568-3332***. Please include the following information on the verification:

- **Full name** of applicant
- **Dates** of training
- **Type** of training (MD, internship, residency, fellowship, staff)
- **Department/specialty** in which training was completed
- **City** in which the training was completed. (New Orleans, Shreveport, Lafayette, Baton Rouge)
- **Signed release**

The above information is needed to allow for a 3-5 day turnaround for the verification to be completed. For those verifications for graduates in the 1960's, 70's and 80's, please allow 20-30 days. All verifications are completed by individual departments.

Thank you,

Kim Cannon
GME Coordinator
kcanno@lsuhsc.edu
504-568-2468 (Phone)

Health Insurance & Retirement

FELLOWS AND HOUSE OFFICERS

EMPLOYER SPONSERED HEALTH INSURANCE

WHEN COVERAGE ENDS

Coverage is in effect through the last day of the month in which you are employed. For example if your last day of employment is June 2nd, then coverage runs through June 30th. If your last day of employment is June 30th, coverage ends the same day.

COBRA

An extension of coverage is available under COBRA for a maximum of 18 months. You are continuing the exact same coverage as you had as an active employee so there is no difference in what the plan will cover or how it will be covered.

Premiums will rise significantly as you will now be responsible for the full cost of the plan plus 2% administration fee. As an active employee, your employer paid 75% of the premium cost and you paid 25%. You will have a 60 day window to elect the continuation of coverage. For those electing coverage, the effective date is retroactive to the termination date providing continuous coverage.

Please understand that COBRA is a retroactive enrollment. It is virtually impossible to have a COBRA policy in place for a seamless transition from active coverage. Federal law requires payment of any claims incurred during the 60 day election period once the COBRA is in place. No provider will activate COBRA coverage without payment in advance for premiums owed or while they can see active coverage in the system.

The Office of Group Benefits administers COBRA for the PPO, and Blue Cross/Blue Shield HMO plans. Ceridian Benefits is the COBRA administrator for the LSU First health plan, Option 1 and 2. The COBRA administrator issues continuation of coverage packets, collects premiums and activates coverage.

PORTABILITY

For those of you who will obtain new health coverage, federal law allows a break in coverage of up to 62 days in applying previous health coverage to reduce or eliminate pre-existing condition exclusions of a new group plan. Private health insurance companies are not required by federal law to credit you for previous coverage and are free to impose pre-existing coverage restrictions.

TRANSFER TO ANOTHER STATE AGENCY

If you are accepting employment with another state agency, please contact the Benefits Office so we can work with the receiving agency to ensure a smooth transfer of coverage.

SPOUSAL TRANSFER

If your spouse works for us or another state agency in a benefits eligible position, there are special procedures in place to allow a transfer of coverage. **Contact the Benefits Office prior to termination of employment so we can help you with the process. If you wait until coverage with us has terminated, it may be too late to avoid a break in coverage.**

STUDENT HEALTH INSURANCE

Student health insurance is not eligible for continuation of coverage through COBRA. The LSUHSC Benefits Office does not handle student insurance. Contact Michele Prudhomme with Gallagher Benefits at 225-906-1278 or 1-800-605-6102 for assistance with the student health plan.

DENTAL, VISION PLANS

Dearborn, the Dental provider and Davis, the Vision plan provider will provide COBRA packets to allow continuation of those benefits for a maximum of 18 months. You already pay the full cost of these plans; however, the COBRA administrator is allowed to impose a 2% administration fee.

HEALTH CARE/CHILD CARE FLEXIBLE SPENDING ACCOUNTS

You are not eligible to be reimbursed for expenses incurred AFTER your termination date. You have 120 days from your termination date to submit eligible claims for reimbursement.

Although it may be possible to participate in COBRA through the end of the plan year, you will lose the benefit of making pre-tax contributions.

LSU SYSTEM LIFE INSURANCE/OFFICE OF GROUP BENEFITS LIFE INSURANCE

If you wish to convert your group life insurance plan to a private policy, please contact the Benefits Office for the necessary paperwork. Conversion packets are issued only upon request.

DEFERRED COMPENSATION (GREAT WEST)

Members may leave their contributions with the Deferred Compensation plan upon termination or request a rollover or cash payout of their contributions to the plan.

Cash withdrawals are taxable income to you but are not subject to the 10% penalty.

For rollovers/payouts, members need to contact Great West at 1-800-937-7604 or visit their web site at www.louisianaDCP.com.

Members who leave the US are advised to request a wire transfer of their funds since funds are easily lost when mailed internationally.

403 (b) VOLUNTARY REITREMENT PLANS

Members may leave their contributions with the plan upon termination or request a rollover or cash payout of their contributions. Contact the vendor to obtain the necessary rollover/payout forms.

Contributions that are rolled into another qualified retirement plan or IRA are exempt from taxation or penalties. Members age 59 ½ and older or individuals who are disabled may withdraw funds without a 10% penalty the IRS normally imposes.

The Benefits office will issue a termination letter which allows the vendors to release or roll over your funds.

STATE OF LOUISIANA
OFFICE OF GROUP BENEFITS
ENROLLMENT/CHANGE FORM

Agency Number	Agency Name	Date of Hire	Annual Salary	Employee Name Changed to:

PURPOSE

☐ Waiver of Coverage ☐ Agency Transfer (Receiving Agency) ☐ New Enrollment ☐ Reinstate Coverage ☐ Re-enrollment - Previous Employment Rehired Retiree ☐ Yes ☐ No

☐ Annual Enrollment ☐ Add/Delete Dependent (s) _____ (Date) Reason for Addition/Deletion _____

☐ Surviving Spouse/Dependent ☐ Special Enrollment ☐ Late Applicant - Portability Law Applies? ☐ No ☐ Yes ☐ Retired _____ (Date)

☐ Employment Terminated _____ (Date) ☐ Deceased _____ (Date)

☐ **Cancel all coverage** (Health & Life) _____ (Reason for Cancellation) ☐ Other _____

PERSONAL INFORMATION - EMPLOYEE (Please print or type)

Name	Social Security Number	Date of Birth	
Address	**City**	**State**	**Zip Code**

Home Phone	Work Phone	Extension	Sex	Marital Status	Date of Marriage	Date of Divorce
( )	( )		1. ☐ Male 2. ☐ Female	1. ☐ Single 2. ☐ Married		

HEALTH PLAN SELECTED (Write in health plan selection)

LEVEL OF MEDICAL COVERAGE SELECTED ☐ No Coverage ☐ Employee Only ☐ Employee + Child/Children ☐ Employee + Spouse ☐ Family

Name (Last name, First, MI)	Relationship	Sex	Birth Date (mm/dd/yyyy)	Add/Delete	Social Security Number	Health	Dep. Life
Employee		☑ M ☑ F		☐ Add ☐ Delete			
Spouse		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes

Are you or family members listed above covered by any other group health insurance/HMO from another employer/organization/Medicaid? ☐ No ☐ Yes. If Yes provide the following:

Policy Holder's Name	Social Security No.	Birth Date	Policy Number	Group Number	Coverage Type	Effect. Date

Employer/Company	Insurance Company/HMO (Name/Address/Phone)	Persons Covered Under Other Policy

C.O.B.R.A.

☐ Prior F/T Terminated ☐ Divorced Spouse ☐ Dependent

_____ (Name of Original Member) _____ (Social Security Number)

MEDICARE

Employee	Spouse
☐ 1. No Coverage	☐ 1. No Coverage
☐ 2. Hospital (Part A)	☐ 2. Hospital (Part A)
☐ 3. Medical (Part B)	☐ 3. Medical (Part B)
☐ 4. Drugs (Part D)	☐ 4. Drugs (Part D)

A COPY OF MEDICARE CARD MUST BE ATTACHED

RETIREE 100

☐ Yes ☐ No ☐ Employee Only
☐ Dependent Only ☐ Employee & 1 Dependent

LIFE INSURANCE (Check only one)

☐ No Coverage Employee/Dependent

BASIC

☐ Employee/No Dependent Coverage
☐ Employee/Dependent Coverage
Eligible Spouse $1,000 Eligible Child $500
☐ Employee/Dependent Coverage
Eligible Spouse $2,000 Eligible Child $1,000

Date of Last Salary Increase _____

BASIC PLUS SUPPLEMENTAL

☐ Employee/No Dependent
☐ Employee/Dependent Coverage
Eligible Spouse $2,000 Eligible Child $1,000
☐ Employee/Dependent Coverage
Eligible Spouse $4,000 Eligible Child $2,000

Annual Salary _____
Face Life _____

WAIVER OF COVERAGE

I waive all coverage offered through the Office of Group Benefits. I understand that if I enroll at a future date, the coverage I receive will be subject to evidence of insurability for life insurance and a pre-existing condition (PEC) exclusion for health insurance, and may be conditional.

NOTE TO AGENCY REPRESENTATIVE: If the employee waives his/her right to all coverage, he/she must sign an enrollment document. A copy of this document is to be retained by the agency as evidence the employee was offered coverage within 30 days of eligibility and the employee declined. The original of this document is to be transmitted to the Office of Group Benefits.

_____ _____

EMPLOYEE SIGNATURE DATE

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, consultations, examinations, diagnosis, care, or treatment was recommended or received within the previous 6 months. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6-month period ends on the day before the waiting period begins.

The pre-existing condition exclusion does not apply to pregnancy, or to a child who is enrolled in the plan or enrolled in other creditable coverage within 30 days after birth, adoption, or placement for adoption. Effective July 1, 2011, the pre-existing condition exclusion does not apply to any employee or dependent who is under age 19.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days.

To reduce the 12-month exclusion period by your creditable coverage, you must give OGB a copy of any certificates of creditable coverage (HIPAA certificates) you have. If you do not have a certificate, but you do have prior health coverage, OGB will help you obtain a certificate from your prior plan or issuer. There are also other ways you can show that you have creditable coverage. Contact OGB if you need help demonstrating creditable coverage.

Each HIPAA certificate (or other evidence of creditable coverage) will be reviewed by OGB to determine its authenticity. Submission of a fraudulent HIPAA certificate is considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Office of Group Benefits, Eligibility Department, P. O. Box 66678, Baton Rouge, LA 70896, phone (225) 925-6934 or (toll-free) 1-800-272-8451 or (TDD) 1-800-259-6771 or fax (225) 925-6333.

ACKNOWLEDGMENT OF COVERAGE LIMITATIONS AND PRE-EXISTING CONDITION EXCLUSION

I understand that I must provide appropriate documents to OGB to verify eligibility of all covered dependents. I acknowledge that my application will be approved on a conditional basis.

I acknowledge that I have reviewed the descriptive literature about OGB health plans available to me. I apply for participation or a change in my participation in the named health plan and agree to be bound by its terms and conditions.

I authorize deductions from my earnings or retirement check to pay for insurance for myself and my dependents, if applicable.

I certify that the information provided on this form is true and correct. I understand that if I provide false information on this form, it may result in denial or recision of coverage retroactive to the initial day of coverage. A copy of my signature is as valid as the original.

I accept conditional approval for coverage and agree that this declaration will become a part of my application for coverage.

_____ _____

EMPLOYEE SIGNATURE DATE

_____ _____

AGENCY REPRESENTATIVE SIGNATURE DATE

OFFICE USE ONLY Life _____ Health _____ Specialist Int. _____ Date _____