Program Separation Packet Checklist

For All Outgoing House Officers

Residents, please take action as needed

NPI / Medicaid Numbers

Licensure

Long Term Disability Insurance

Credentialing and Verifications

Malpractice Insurance/Moonlighting

Health Insurance and Retirement

**Check with coordinator if all requirements are being met or have been met in order for you to complete the program.*

Thank you,

GME office
504-568-4006

Please visit websites in this packet, for any 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. 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.
- *These two steps can be done simultaneously.*
  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 (See the 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 to the GME office*, 2020 Gravier Street Suite 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.

MALPRACTICE INSURANCE and MOONLIGHTING

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. If you are moonlighting, makes sure you have "tail coverage" through an independent company.

HEALTH INSURANCE and RETIREMENT

See the attached summary of details from the LSUHSC Human Resource Department.

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.
- *These two steps can be done at the simultaneously.*

****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 (See the 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 to the GME office, 2020 Gravier Street Suite 602, 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.

HEALTH INSURANCE and RETIREMENT

See the attached summary of details from the LSUHSC Human Resource Department.

NPI/MEDICAID

NPPES
National Plan & Provider Enumeration System

Home Help

NPI Registry Search

Please enter data for at least one of the following fields. If searching on Practice Address State, you must enter data for at least one other field. To perform a wild card search, at least two characters must be entered before the "*". For example, to search for data beginning with "Ch", enter "Ch*". Wild card searches are only available on the Provider First Name, Provider Last Name and Practice Address City fields.

Information in the NPI Registry is updated daily.

NPI	
Provider First Name	
Provider Last Name	
Practice Address City	
Practice Address State	
Practice Address Zip	

Search Reset Back

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 Fox Systems, Inc. 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			
Other, Specify:		(State is required if Medicaid number is furnished.)	

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.

Advanced Search

npi Search

Find the answer to your question

Results **1** - **10** of **69** for npi

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...

Date Updated. 10/06/2010
Answer ID: 2629

Do I need a National Provider Identifier (NPI) to enroll in the Medicare Program?

Yes, an NPI must be included on the CMS-855 enrollment application.

Date Updated: 08/30/2010
Answer ID: 8429

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 is Updated

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: 01/04/2011
Answer ID: 8049

Do I need a National Provider Identifier (NPI) to make changes to my Medicare enrollment information?

Yes, Medicare providers must provide their NPIs when making any changes to their Medicare enrollment information.

Date Updated: 08/30/2010
Answer ID 8430

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: 07/26/2010
Answer ID: 6148

NPI and NPPES User Name and Password Information

Q: Who do I contact if I cannot remember my NPPES password? A: Contact the NPI Enumerator at 1-800-465-3203 or send an e-mail to customerservice@npienumerator.com. Q: How do I change my NPPES...
Date Updated: 11/13/2009
Answer ID: 9911

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 08/17/2010
Answer ID: 9419

I applied for my National Provider Identifier (NPI) over the web and haven't received the NPI Notification. What should I do?

The Contact Person should first check the computer's SPAM filter to ensure that the NPI Notification e-mail has not been routed to SPAM. If the NPI Notification is not in the SPAM filter and it has...
Date Updated: 09/30/2010
Answer ID: 8383

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?

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: 08/30/2010
Answer ID: 8444

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: 09/30/2010
Answer ID: 8610

1 2 3 4 5 6 Next >

LICENSURE

CDS/DEA

CDS License

Controlled Dangerous Substance Forms & Applications

101 – Application for CDS License

102 – Address Change Form

103 – Notice of Permanent Closure of CDS License at Healthcare Facility

105-L – Application for Late Renewal of CDS License for a Pharmacy for Year 2011

105-X-L – Application for Renewal of CDS License for Fee-Exempt Pharmacy for Year 2011

Print Form

Louisiana Board of Pharmacy

5615 Corporate Boulevard, 8th Floor
Baton Rouge, Louisiana 70808-2537
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 all applicants 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.

Section 3 – Classification of License

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

Section 4 – Drug Schedules

- 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.

Section 5 – Certification Statements

- 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.

Section 6 – Applicant's Signature

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

Final Notes:

- 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

5615 Corporate Boulevard, 8th Floor
Baton Rouge, Louisiana 70808-2537
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 # _____ LA State Board License Exp. Date (mm-dd-yyyy) _____	DEA Registration # _____ 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

Office of Diversion Control

Home
Registration
Reporting
Info & Legal Resources
Inside Diversion Control

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.

REGISTRATION APPLICATIONS

COMBAT METHAMPHETAMINE EPIDEMIC ACT 2005

- Required Training and Self-Certification
- Quota Applications

APPLICATIONS

- Renewal Applications
- New Applications

REGISTRATION TOOLS

- Chain Renewals
- Duplicate Certificates
- Duplicate Registration Receipts
- Online Pharmacy Modifications
- Official Order Forms
- Registration Categories and Fees
- Modifications to Registration
- Registration Procedures
- Registration Validation

RESOURCES

- Offices with Field Registration Program Specialists
- Practitioner's Manual
- Mid-Level Practitioners (MLP) Authorization by state
- Questions & Answers
- Reinstated and Retired Registrant List
- Registrant Population

Back to Top

Drug Enforcement Administration Home

Home | Registration | Reporting | Info & Legal Resources | Inside Diversion Control | Privacy Statement

U.S. Department of Justice Drug Enforcement Administration

Office of Diversion Control

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.

Registration

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

Applications

- **NEW DEA NUMBER ASSIGNMENT**
  Due to the large Type A (Practitioner) registrant population, the initial alpha letter "B" has been exhausted. DEA will begin using the new alpha letter "F" as the initial character for all new registration for Type A (Practitioner) registrations.(11092006)
- Renewal Applications
  - **DEA Form 224a** – Renewal Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner.
  - **DEA Form 225a** – Renewal Application for Manufacturer, Distributor, Researcher, Analytical Laboratory, Importer, Exporter
  - **DEA Form 363a** – Renewal Application for Narcotic Treatment Programs
  - **DEA Form 510a** – Renewal Application for Domestic Chemical
- New Applications
  - **DEA Form 224** – New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner.
  - **DEA Form 225** – New Application for Manufacturer, Distributor, Researcher, Analytical Laboratory, Importer, Exporter
  - **DEA Form 363** – New Application for Narcotic Treatment Programs
  - **DEA Form 510** – New Application for Domestic Chemical

Registration Tools

- Chain Renewals
- Duplicate Certificate
- Duplicate Receipt of Registration Application
- Online Pharmacy Modifications
  - Modify business activity from Retail Pharmacy to Retail Online Pharmacy
  - Modify business activity from Retail Online Pharmacy to Retail Pharmacy
  - Modify existing Retail Online Pharmacy Information
- Official Order Forms
  - Large Volume Order Forms
- Registration Categories and Fees
- Registration Changes
  - Address Changes
  - Drug Code Changes
  - Name Changes
  - Schedule Changes

- Registration Procedures
- Registration Validation

Resources

- Offices with Field Registration Program Specialists
  - To Apply for New Applications for Registration through the U.S. Postal Service
- Pharmacist's Manual
- Practitioner's Manual
- Mid-Level Practitioners (MLP) Authorization by State
- Questions & Answers
- **Reinstated and Retired Registrant List**
  - A complete listing of all active DEA registration numbers can be obtained from the U.S. Department of Commerce National Technical Information Service (NTIS) Web Site at http://www.ntis.gov/products/dea.aspx?. For your convenience and the most accurate information of a Registrant's status, please use the Registration Validation Tool. For further information, contact Richard.A.Boyd@usdoj.gov
- Registrant Population

Back to Top

Drug Enforcement Administration Home

Home | Registration | Reporting | Info & Legal Resources | Inside Diversion Control | Privacy Statement

U.S. Department of Justice Drug Enforcement Administration

Office of Diversion Control

Home
Registration
Reporting
Info & Legal Resources
Inside Diversion Control

Registration > ODWIF

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

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.

Back to Top

Drug Enforcement Administration Home

Home | Registration | Reporting | Info & Legal Resources | Inside Diversion Control | Privacy Statement

CREDENTIALING & VERIFICATION 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

Please give a copy of the attached memo to the hospital or group that will be credentialing you.

This letter will give them the information they need for your request for *verification of training* to be handled promptly.

Thanks.

Kim Cannon
GME Coordinator
504-568-2468

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 5,2011

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**

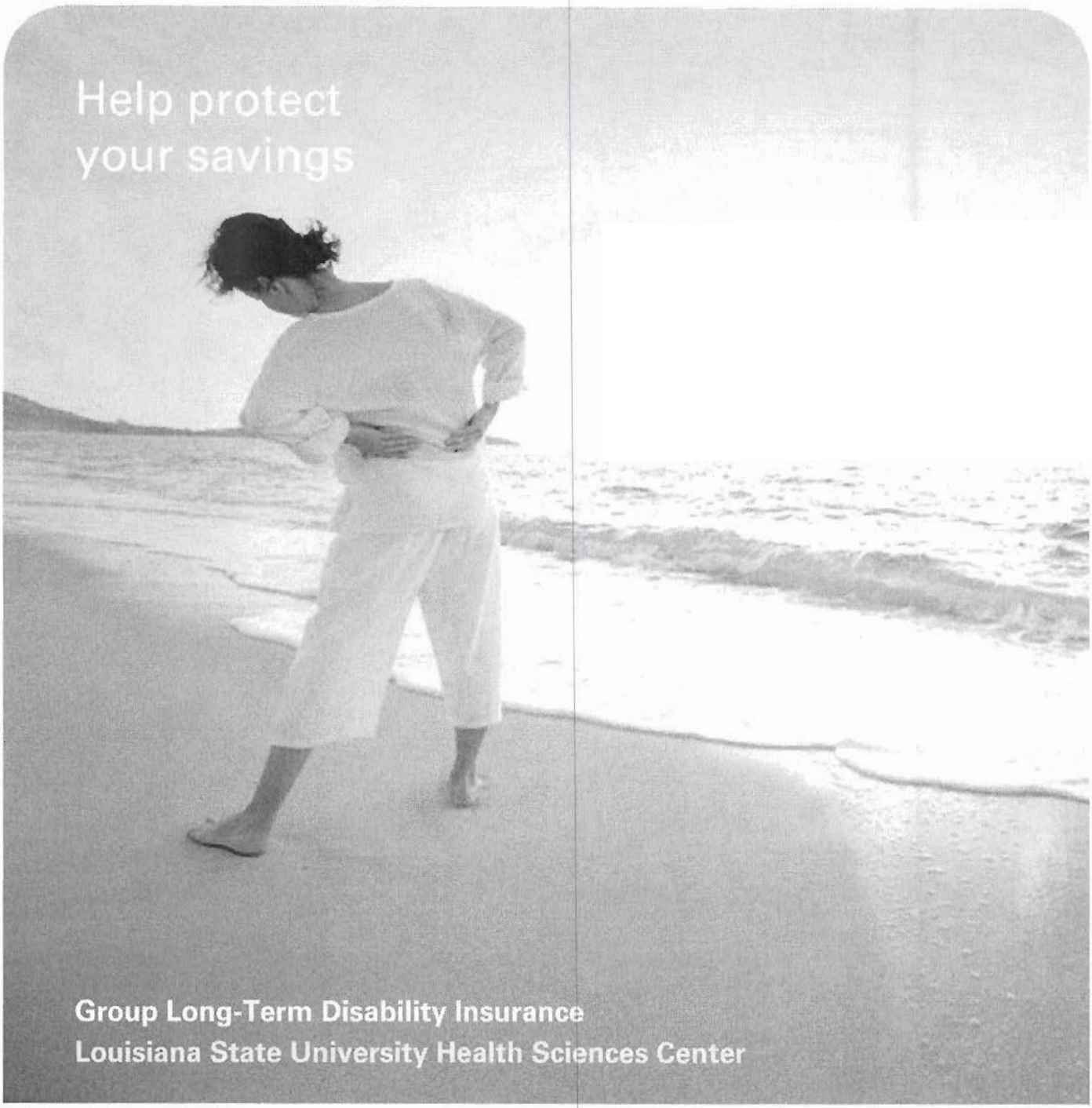
The above information is needed to allow for a 3-5 day turnaround for the verification to be completed. For those verifications for graduates in the 1960's, 70's and 80's, please allow 20-30 days. All verifications are completed by individual departments.

Thank you,

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

LONG TERM DISABILITY

American General



Group Long-Term Disability Insurance
Louisiana State University Health Sciences Center

BENEFIT SUMMARY

American General
Life Companies

Group Long-Term Disability Benefit Summary

If an illness or injury left you unable to work for an extended period of time, it could become extremely difficult to cover even your most basic expenses. Although you may have enough money in the bank to meet your short-term needs, what would happen if you were unable to work for months, or even years? The real value of disability insurance lies in its ability to protect you over the long haul.

Following is an overview of Group Long-Term Disability benefits. See the certificate for details regarding benefit descriptions, limitations and exclusions.

Benefits at a Glance

Plan Features	Plan Details
Employee Eligibility	Active, full-time eligible employees working a minimum of 30 hours per week, working and residing in the U.S.
Waiting Period	None
Benefit Percentage	60% of basic monthly earnings
Minimum Monthly Benefit	Greater of $100 or 10% of the gross monthly benefit
Maximum Monthly Benefit	$5,000
Benefit Duration	To Social Security Normal Retirement Age (SSNRA)
Elimination Period	90 days
Definition of Disability During the Elimination Period	Zero-day residual
Pre-Existing Condition Exclusion	12/12
Waiver of Disability Premium	Included
Rehabilitation Program	Included
Partial Disability Provision	Proportionate loss
Return-to-Work Incentive	Included for the first 12 months of disability
Survivor Benefit	3 times monthly disability payment after 180 days of disability
Regular Occupation Period	24 months
Mental/Nervous, Drug and Alcohol Limitation	24 months lifetime
Employee Assistance Program (EAP)*	Telephonic EAP with online Work/Life services

*Provided by Harris Rothenberg International (HRI), LLC Not an insurance product

About American General[1]

Just as your family turns to you for security and peace of mind, millions of Americans turn to American General for help protecting their families against financial hardship.

- American General's companies are collectively the top issuers of insurance by face amount in the U.S. and an industry leader in its core businesses.
- American General's companies are closely regulated by state insurance departments, with ample reserves and capital to meet the long-term obligations to policy holders.
- American General's companies have more than 11.6 million policies in force, as of 12/31/07.[2]
- American General stands ready to pay claims, making on average $24 million in claim payments every single business day.[3]
- Over the past five years, American General's companies have paid out $17.5 billion in benefits to 1.6 million families and businesses.[4]
- The general account of each insurer is primarily invested in high-quality, investment-grade bonds, in accordance with state insurance requirements and investment guidelines.
- The most prominent independent ratings agencies continue to recognize American General insurers in terms of insurer financial strength. For detailed information on specific insurer ratings, visit www.americangeneral.com/ratings.

For more information, contact
Stephanie Galendez
504-568-4008
sgalen@lsuhsc.edu

[1] Information regarding American General is for informational purposes only.
[2] Source: Statutory Annual Statements for the Domestic Life Companies, 2007.
[3] Source: Statutory Annual Statements for the Domestic Life Companies, as of June 30, 2008.
[4] Source: Statutory Annual Statements for the Domestic Life Companies, 2003 – 2007.

Pre-Existing Conditions and Exclusions (state variations may apply)

Pre-existing condition means an injury or sickness that occurred within three months just before the effective date of coverage, or the effective date of any individually elected increase under the group policy, or the effective date of an increase due to a policy amendment for which the insured:

- Incurred charges.
- Received medical treatment, consultation, care or services, including diagnostic measures.
- Took prescribed drugs or medicines.

If a disability is due to, caused by or contributed to by a pre-existing condition, and it begins in the first 12 months after the effective date of coverage, or the effective date of any individually elected increase under the group policy, or the effective date of an increase due to a policy amendment, no benefits will be paid.

Exclusions and Assumptions

- Evidence of insurability is required for all late entrants.
- The group policy does not cover any disability caused by, contributed to by or resulting from:
  - Loss of professional license, occupational license or certification.
  - Intentionally self-inflicted injuries, while sane or insane.
  - Active participation in a riot.
  - Attempting to commit a crime, or commission of a crime for which the insured has been convicted under federal or state law.
  - Insurrection, war, declared or undeclared, or any act of war.
- The company will not pay a benefit for any period of disability during which the insured is incarcerated as a result of a conviction.

Monthly benefit based on a percentage of employee earnings or flat amount, if elected. The Certificate of Insurance will provide details on benefit percentages, rates, effective date of coverage and other important coverage information. The monthly benefit will be reduced by the amount of any income the insured received or is entitled to receive that month from sources including Federal Social Security Act or the Railroad Retirement Act, the disability sickness laws of any state, workers' compensation, or a mandatory state auto reparation or indemnity act (no-fault insurance, where allowed by law). Please see the Certificate of Insurance for additional reduction sources.

Example of Long-Term Disability Reduction	Example 1	Example 2
Insured's monthly predisability earnings	$3,000	$3,000
Long-term disability benefit percentage	60%	50%
Unreduced maximum benefit	$1,800	$1,500
Less Social Security disability benefit per month	($900)	($900)
Less state disability income benefit per month	($300)	($600)
Amount of long-term disability benefit per month	**$600**	**Greater of $100 or 10% of the gross monthly benefit (plan minimum)**

Policies issued by:

American General Life Insurance Company of Delaware
Wilmington, Delaware
Policy Form Number G-DIS-41000

American International Life Assurance Company of New York
New York, New York
Policy Form Number G-DIS-31000

www.americangeneral.com/employeebenefits

06675006-2316DOD R03/10

Employer-funded plan for groups of 10-plus employees.

American General
Life Companies

MALPRACTICE

INSURANCE & MOONLIGHTING


LAMMICO
Why Choose LAMMICO
About Us
Members-Only
Insurance Products & Services
Risk Management Services
Physician Advocacy
Publications
As a leader and innovator, we build enduring partnerships.
EMail
Login
Register
Forgot Password
Arkansas Providers
Mississippi Providers
Texas Providers
Producer Login
Certificates of Insurance
Continuing Education
Contact Us
SITE SEARCH:
GO
Welcome
LAMMICO is a policyholder-owned and physician-led mutual insurance company. We provide a variety of medical professional liability products and services to health care providers and facilities. Please contact us to learn more about the benefits of being a LAMMICO policyholder.
LATEST NEWS UPDATES
NEWS ARCHIVES
CEO Address Video
Dividend Issue Form
News Article: 12/27/10
4th Dividend Awarded by LAMMICO
News Article: 12/14/10
LAMMICO Supports LSU Dental School
Quick Links
View the Letter
Office Manager's Corner
Need Facility Coverage?
Sign up for E-Communications
LAMMICO Calendar of Events
Corporate Social Responsibility
HOME
EMPLOYMENT
ONLINE RESOURCES
LEGAL NOTICE
PRIVACY POLICY
SITE MAP
EMPLOYEE LOGIN
1 GALLERIA BLVD. SUITE 700 METAIRIE, LA 70001 TOLL FREE: (800) 452-2120 FAX: (504) 841-5300 EMAIL

LAMMICO

Why Choose LAMMICO | About Us | Members-Only | Insurance Products & Services | Risk Management Services | Physician Advocacy | Publications

Why Choose LAMMICO

GO

- Consent to Settle
- Physician Advocacy
- Financially Secure Company
- Commitment to Louisiana
- Risk Management
- Personalized Claims Handling
- Aggressive Legal Defense

Advantages of LAMMICO

As a mutual insurance company, LAMMICO is policyholder-owned. LAMMICO is unique in that we seek the input of health care providers in every aspect of our operations. We understand your business, and value your needs as our top priority.

1 GALLERIA BLVD. SUITE 700 METAIRIE, LA 70001 TOLL FREE: (800) 452-2120 FAX: (504) 841-5300 EMAIL

HEALTH INSURANCE & RETIREMENT INFO

FELLOWS AND HOUSE OFFICERS

EMPLOYER SPONSORED 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 a 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 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, Options 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 are easily lost when mailed internationally.

403(b) VOLUNTARY RETIREMENT 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 and
HEALTH MAINTENANCE ORGANIZATION/HMO
ENROLLMENT/CHANGE FORM

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

A. PURPOSE

☐ Waiver of Coverage ☐ Agency Transfer (Receiving Agency) ☐ New Enrollment ☐ Reinstate Coverage ☐ Re-enrollment–Previous Employment ☐ Annual Enrollment
☐ Add/Delete Dependent(s) _____ Reason for Addition/Deletion _____
Date
☐ Surviving Spouse/Dependent ☐ Special Enrollment ☐ Late Applicant – Portability Law Applies? ☐ No ☐ Yes Retired _____
Date
☐ Employment Terminated _____ ☐ For gross misconduct ☐ Deceased _____
Date Date
☐ Cancel all coverage _____
Reason for Cancellation
☐ Primary Care Physician Change ☐ Name/Address Change ☐ Other

B. PERSONAL INFORMATION – EMPLOYEE (Please print or type)

Last Name, First, MI		Social Security Number	Date of Birth	
Name				
Address		City	State	Zip Code

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

C. HEALTH PLAN SELECTED:

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

Name (Last Name, First, MI)	Relation - ship	Sex	Birth Date (mm/dd/ccyy)	Add/Delete	Social Security Number	Health	Dep Life	HMO Requirement: Primary Care Physician Name	HMO Requirement: Previous Patient	HMO Use Only: Physician #
Employee		☐ M ☐ F		☐ Add ☐ Delete					☐ No ☐ Yes	
Spouse		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ Yes	
Dependent		☐ M ☐ F		☐ Add ☐ Delete		☐ Yes	☐ Yes		☐ No ☐ 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 Number	Birth Date	Policy Number	Group Number	Coverage Type	Effect Date

Employer/Company	Insurance Company/HMO (Name/Address/Phone)	Persons covered under other policy

E. COBRA

☐ Prior P/T Terminated ☐ Prior F/T Terminated ☐ Prior F/T – Part Time ☐ Divorced Spouse ☐ Continued Dependent

Name of original member _____ Social Security Number _____

F. MEDICARE

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

A COPY OF MEDICARE CARD MUST BE ATTACHED

G. RETIREE 100

☐ Yes ☐ No

☐ Employee Only
☐ Dependent Only
☐ Employee & 1 Dependent

H. MENTAL HEALTH RIDER

☐ Yes ☐ No

I. WAIVER OF COVERAGE

_ I waive all coverage under the Office of Group Benefits/HMO and I understand if I enroll at a future date that the coverage will be subject to the evidence of insurability for life insurance and a Pre-Existing Condition (PEC) for health insurance, and may be conditional.

NOTE TO AGENCY REPRESENTATIVE: If employee waives 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 Group Benefits.

EMPLOYEE SIGNATURE _____ DATE _____

NOTICE: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN.

I reviewed the descriptive literature about the Plans available to me. I apply for participation/change in the named health plan and agree to be bound by its terms and conditions. I authorized deductions from my earnings or retirement check to pay for insurance for myself and dependents, if applicable. I CONSENT TO THE MEDICAL RELEASE AND OTHER ENROLLMENT INFORMATION ON THE BACK OF THIS FORM. I certify that the information provided on this form is true and correct. I understand that if I provide material 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.

Employee Signature _____ Date _____

Agency Rep. _____ Date _____

OFFICE USE ONLY

Life _____ Health _____ E of I _____ Specialist Int. _____ Date _____

J. LIFE INSURANCE (Check only one)

☐ No Coverage Employee/Dependent

BASIC	BASIC PLUS SUPPLEMENTAL
☐ Employee/No Dependent Coverage	☐ Employee/No Dependent
☐ Employee/dependent Coverage Eligible Spouse $1,000 Eligible Child $500	☐ Employee/Dependent Coverage Eligible Spouse $2,000 Eligible Child $1,000
☐ Employee/Dependent Coverage Eligible Spouse $2,000 Eligible Child $1,000	☐ Employee/Dependent Coverage Eligible Spouse $4,000 Eligible Child $2,000

Annual Salary _____

Date of Last Salary Increase _____ Face Life _____

WHITE - GROUP BENEFITS CANARY – HMO PINK – AGENCY GOLDENROD – PLAN MEMEER

Medical Release

I authorize health care providers of services to me and my dependents to release information (including information related to diagnosis or treatment of mental health and/or substance abuse problems, or acquired immune deficiency syndrome) to my HMO or Office of Group Benefits and all participating providers to the extent necessary to determine responsibility for payment of claims and for utilization review and quality assurance purposes. A copy of this authorization is as valid as the original.

I understand that the names of participating providers in my HMO or PPO (health plan) may change during the plan year. The health plan does not guarantee the continuing participation of the named health care providers.

Plan Members With Enrolled Children Please Note:

IF YOU ARE DIVORCED AND HAVE CHILDREN UNDER AGE 18 AND IF A COURT ORDER HAS BEEN ISSUED ASSIGNING FINANCIAL RESPONSIBILITY, YOUR HEALTH PLAN MUST BE PROVIDED WITH A COPY.

IF THE CHILD IS OVER AGE 21, PROOF OF FULL TIME STUDENT STATUS FROM AN ACCREDITED SCHOOL MUST BE PROVIDED TO YOUR HEALTH PLAN AT THE TIME OF INITIAL ENROLLMENT AND AT THE START OF EACH SEMESTER.

New Hires and Acknowledgements

I acknowledge that my application will be approved on a conditional basis

I understand that unless the Portability Law applies, any illness, injury disease, or condition for which any treatment was received within the six months prior to the effective date of coverage will have no benefits available for the 12 months following the effective date of coverage.

I understand that any disease, illness, accident, or injury will be classified as a pre-existing condition if, during the six-month period preceding the effective date of coverage, any treatment or services were received or drugs were prescribed for such disease, illness, accident, or injury.

The term Treatment shall mean all steps taken to effect the cure of a disease, illness, accident, or injury and shall include, but not be limited to, consultations, examinations, diagnosis, and any application of remedies.

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