



Arkansas Department of Health and Human Services

Division of Medical Services



P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480

TDD: 501-682-6789 & 1-877-708-8091

Internet Website: www.medicaid.state.ar.us

TO: Arkansas Medicaid Health Care Providers

DATE: June 1, 2006

SUBJECT: Provider Manual Update Transmittal

Provider Manual	Transmittal Number
Alternatives for Adults with Physical Disabilities Waiver	35
Ambulatory Surgical Center	67
ARKids First-B	32
Certified Nurse-Midwife	71
Child Health Management Services	69
Child Health Services/Early and Periodic Screening, Diagnosis and Treatment.....	75
Children’s Services Targeted Case Management	21
Chiropractic.....	64
DDS Alternative Community Services Waiver.....	62
Dental.....	87
Developmental Day Treatment Clinic Services	71
Developmental Rehabilitation Services.....	21
Division of Youth Services and Division of Children and Family Services Targeted Case Management	13
Domiciliary Care.....	49
ElderChoices Home and Community-Based 2176 Waiver	63
Federally Qualified Health Center	58
Hearing Services.....	60
Home Health	78
Hospice	50
Hospital/End-Stage Renal Disease	93
Hyperalimentation	76
Inpatient Psychiatric Services for Under Age 21	69
Licensed Mental Health Practitioners.....	53
Living Choices Assisted Living	19
Medicare/Medicaid Crossover Only	45
Nurse Practitioner	67
Occupational, Physical, Speech Therapy Services	59
Personal Care	73
Pharmacy.....	86

Provider Manual	Transmittal Number
Physician/Independent Lab/CRNA/Radiation Therapy Center	114
Podiatrist	66
Portable X-Ray Services	55
Private Duty Nursing Services	66
Prosthetics	78
Rehabilitative Hospital.....	63
Rehabilitative Services for Persons with Mental Illness	68
Rehabilitative Services for Persons with Physical Disabilities	41
Rehabilitative Services for Youth and Children	23
Rural Health Clinic Services.....	58
School-Based Mental Health Services	26
Targeted Case Management	59
Transportation.....	78
Ventilator Equipment.....	60
Visual Care	74

REMOVE

Section	Date
DMS-652	6/05
DMS-2608	8/01

INSERT

Section	Date
DMS-652	6/06
DMS-2608	6/06

Explanation of Updates

PLEASE NOTE: The following explanations of update are revisions of the above forms and do not require you to reapply for Medicaid provider enrollment.

Form DMS-652 is included to revise the language at the bottom of the “Authorization for Automatic Deposit” page.

Form DMS-2608 is included to add that providers are exempt from the Primary Care Physician program if they are employed by an Area Health Education Center (AHEC), Federally Qualified Health Center (FQHC) or a hospital. This form is also included to revise the question about the number of beneficiaries in caseload. The age range of the beneficiaries is also asked.

Please be advised that changes to the age range of the beneficiaries can be updated via the Medicaid website at www.medicaid.state.ar.us.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8091. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

**DIVISION OF MEDICAL SERVICES
MEDICAL ASSISTANCE PROGRAM
PROVIDER APPLICATION**

As a condition for entering into or renewing a provider agreement all applicants must complete this provider application. A true, accurate and complete disclosure of all requested information is required by the Federal and State Regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State Regulations to update the information submitted on the Provider Application.

Whenever changes in this information occur, please submit the change in writing to:

**Medicaid Provider Enrollment Unit
EDS
P. O. Box 8105
Little Rock, AR 72203-8105**

All dates, except where otherwise specified, should be written in the month/day/year (MMDDYY) format. Please print all information.

This information is divided into sections. The following describes which sections are to be completed by the applicant:

- | | | |
|--------------------------|---|---|
| Section I | - | All providers |
| Section II | - | Facilities Only |
| Section III | - | Pharmacists/Registered Respiratory Therapist Only |
| Section IV | - | Provider Group Affiliations |
| Electronic Fund Transfer | | |
| Managed Care Agreement | - | Primary Care Physician |
| W-9 Tax Form | - | All Providers |
| Contract | - | All Providers |

FOR OFFICE USE ONLY

Provider Number _____	Pending _____
Specialty Code _____	Computer _____
Provider Type _____	OK to Key _____
	Keyed _____
Effective Date _____	Maintenance Checked _____

SECTION I: ALL PROVIDERS

This section **MUST** be completed by all providers.

- (1) **Date of Application:** Enter the current date in month/day/year format.

____/____/____
MM DD Year

- (2) **Last Name, First Name, Middle Initial, Title:** Enter the legal name of the applicant. The title spaces are reserved for designations such as MD, DDS, CRNA or OD. If the space is insufficient, please abbreviate.

If entering any other name such as an organization, corporation or facility, enter the full name of the entity in item 3. NOTE: Item 2 or 3 must be completed, BUT NOT BOTH.

Last Name First Name M. I. Title

- (3) **Group, Organization or Facility Name:** Enter full name of the entity.
Examples: John R. Doe, PA; Adam B. Corn, Inc.; Arkansas Emer. Phys. Group; Pulaski County Hospital; John Thompson, M. D., DBA Thompson Clinic

Corporation Name

Fictitious Name

Must submit documentation that the above Fictitious name is registered with the appropriate board within your state, (i.e., Secretary of State's, County Clerk) of the county in which the corporation's registered office is located.

- (4) **Application Type:** Circle one of the following codes which coincide with fields 2 or 3:

0 = Individual Practitioner (i.e., physician, dentist, a licensed, registered or certified practitioner)

1 = Sole Proprietorship (This includes individually owned businesses.)

2 = Government Owned

3 = Business Corporation, for profit

4 = Business Corporation, non-profit * **copy of Tax Form 501 (c) (3) must accompany this application**

5 = Private, for profit

6 = Private, non-profit * **copy of Tax Form 501 (c) (3) must accompany this application**

7 = Partnership

8 = Trust

9 = Chain

*** NOTE: IF THE TAX FORM IS NOT ATTACHED THE APPLICATION WILL BE DENIED**

(5) **Place of Service - Street Address**

(A) Enter the applicant's service location address, include suite number if applicable. THIS FIELD IS MANDATORY.

(B) Enter any additional street address. (MAY REFLECT POST OFFICE BOX IF UNDELIVERABLE TO A STREET ADDRESS)

(C) City, State, Zip Code - enter the applicant's city, state and zip code. Use the Post Office's two letter abbreviation for State. If the applicant's zip code is not the expanded nine digits enter the correct five digit zip code.

City State Zip Code

(D) Telephone Number - enter the area code and telephone number of the location in which the services are provided.

Area Code Telephone Number

(6a) **Billing Street Address:** This is the billing address where your Medicaid checks, Remittance Statements (RA) and information will be sent. Use the same format as the place of service address, P. O. Box may be entered in billing address.

City State Zip Code

Area Code Telephone Number

(6b) **Provider Manuals and Updates:** Please review Section I sub-section 101.000; 101.200; 101.300 in your Arkansas Medicaid provider manual regarding provider manuals and updates. Choose the format in which you would like to receive manuals, manual updates, and official notices. The Arkansas Medicaid website (www.medicaid.state.ar.us) is updated weekly and the Arkansas Medicaid Provider Reference CD will be distributed quarterly. Providers selecting "Internet only" or "CD with e-mail notification" will receive e-mails notifying them of applicable manual updates, official notices, and remittance advice (RA) messages available at the website; these choices require an e-mail address and Internet access. Providers selecting "CD with paper supplements" will receive the Arkansas Medicaid Provider Reference CD and applicable manual updates and official notices in the mail; these providers can find RA messages with their RAs or at the Arkansas Medicaid website. Providers selecting "paper" will receive a paper copy of the manual and receive supplementary materials on paper to maintain their manual.

_____ Internet only*

_____ CD with e-mail notification*

_____ CD with paper supplements

_____ Paper

* Selection requires an e-mail address and Internet access.

E-mail address: _____

(7a) **Medicare Number:** Enter the Medicare Number assigned to the applicant. (See attached Medicare form.)

(7b) **Unique Physician Identification Number (UPIN):** Enter the UPIN assigned (individual practitioner's only.)

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

MEDICARE VERIFICATION FORM

MUST BE COMPLETED FOR MEDICARE PROVIDERS PHYSICALLY LOCATED OUTSIDE OF THE BOUNDARIES OF ARKANSAS

Before we can enroll a provider who is not physically located in Arkansas as an Arkansas Medicaid provider, we must have verification of **CURRENT** Medicare enrollment. **If you have documentation, i.e., EOMB, Medicare letter that is not over 6 months old and reflects the Medicare number and name of the enrolling provider,** please attach a copy of the information to the application. If you do not have documentation, please submit this form to your Medicare intermediary and instruct them to complete the information requested below. After Medicare has completed the requested information and returned this form to you, you must then return this form with your completed Medicaid application. **If your application is not returned with Medicare verification, enrollment in the Arkansas Medicaid Program will be denied.**

Provider's Name _____

(1) _____
Medicare Number/UPIN Effective Date End Date

(2) _____
Social Security Number Tax I.D. Number

(3) _____
Specialty of Practice

This inquiry was completed by:

Name of Medicare Intermediary _____

Address _____

Telephone # _____

Signature of Medicare Representative _____

(Typed or Printed Name)

Date _____

(8) **County:** From the following list of codes, indicate the county that coincides with the place of service. If the services are provided in a bordering or out-of-state location, please use the county codes designated at the end of the code list.

County	County Code	County	County Code	County	County Code
Arkansas	01	Garland	26	Newton	51
Ashley	02	Grant	27	Ouachita	52
Baxter	03	Greene	28	Perry	53
Benton	04	Hempstead	29	Phillips	54
Boone	05	Hot Spring	30	Pike	55
Bradley	06	Howard	31	Poinsett	56
Calhoun	07	Independence	32	Polk	57
Carroll	08	Izard	33	Pope	58
Chicot	09	Jackson	34	Prairie	59
Clark	10	Jefferson	35	Pulaski	60
Clay	11	Johnson	36	Randolph	61
Cleburne	12	Lafayette	37	Saline	62
Cleveland	13	Lawrence	38	Scott	63
Columbia	14	Lee	39	Searcy	64
Conway	15	Lincoln	40	Sebastian	65
Craighead	16	Little River	41	Sevier	66
Crawford	17	Logan	42	Sharp	67
Crittenden	18	Lonoke	43	St. Francis	68
Cross	19	Madison	44	Stone	69
Dallas	20	Marion	45	Union	70
Desha	21	Miller	46	Van Buren	71
Drew	22	Mississippi	47	Washington	72
Faulkner	23	Monroe	48	White	73
Franklin	24	Montgomery	49	Woodruff	74
Fulton	25	Nevada	50	Yell	75

State	County Code	State	County Code	State	County Code
Louisiana	91	Oklahoma	94	Texas	96
Missouri	92	Tennessee	95	All other states	97
Mississippi	93				

(9) **Provider Category (A-C)**

Enter the two-digit **highlighted** code, from the following list, which identifies the services the applicant will be providing.

A) _____ B) _____ C) _____

Code Category Description

03	Allergy/Immunology
A8	Alternatives for Adults with Physical Disabilities (Alternative) - Environmental Adaptations
A9	Alternatives for Adults with Physical Disabilities (Alternative) - Attendant Care Services
A4	Ambulatory Surgical Center
AA	Adolescent Medicine
05	Anesthesiology
AH	Living Choices Assisted Living Agency
AL	Living Choices Assisted Living Facility—Direct Services Provider
AP	Living Choices Assisted Living Pharmacist Consultant
64	Audiologist
06	Cardiovascular Disease
C4	Child Health Management Services
35	Chiropractor
C3	CRNA
HA	DDS ACS Waiver Physical Adaptations
HB	DDS ACS Waiver Specialized Medical Supplies
HC	DDS ACS Waiver Case Management Services
HE	DDS ACS Waiver Supported Employment
H7	DDS ACS Waiver Integrated Support
H8	DDS ACS Waiver Crisis Abatement Services
H9	DDS ACS Waiver Consultation Services
HF	DDS ACS Waiver Organized HealthCare
V2	Dental
X5	Dental - Oral Surgeon
V6	Dental - Orthodontia
07	Dermatology
V3	Developmental Day Treatment Center
DR	Developmental Rehabilitation Services
V5	Domiciliary Care
E4	ElderChoices H&CB 2176 Waiver - Chore services
E5	ElderChoices H&CB 2176 Waiver - Adult foster care
E6	ElderChoices H&CB 2176 Waiver - Home maker
E7	ElderChoices H&CB 2176 Waiver - Home delivered hot meals
EC	ElderChoices H&CB 2176 Waiver - Home delivered frozen meals
E8	ElderChoices H&CB 2176 Waiver - Personal emergency response systems
E9	ElderChoices H&CB 2176 Waiver - Adult day care
EA	ElderChoices H&CB 2176 Waiver - Adult day health care
EB	ElderChoices H&CB 2176 Waiver - Respite care
E1	Emergency Medicine
E2	Endocrinology
E3	Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
F1	Family Planning
08	Family Practice
F2	Federally Qualified Health Center
10	Gastroenterology
01	General Practice
38	Geriatrics
16	Gynecology - Obstetrics
H1	Hearing Aid Dealer
H2	Hematology
H5	Hemodialysis
H3	Home Health
H6	Hospice
A5	Hospital - AR State Operating Teaching Hospital

(9) Provider Category (Continued)

Code Category Description

W6	Hospital – Inpatient
W7	Hospital - Outpatient
CH	Hospital – Critical Access
P7	Hospital - Pediatric Inpatient
P8	Hospital - Pediatric Outpatient
R7	Hospital - Rural Inpatient
H4	Hyperalimentation
V8	Immunization (Health Dept. Only)
69	Independent Lab
55	Infectious Diseases
W3	Inpatient Psychiatric - under 21
WA	Inpatient Psychiatric - Residential Treatment Unit within Inpatient Psychiatric Hospital
WB	Inpatient Psychiatric - Residential Treatment Center
WC	Inpatient Psychiatric - Sexual Offenders Program
W4	Intermediate Care Facility
W5	Intermediate Care Facility - Mentally Retarded
11	Internal Medicine
L1	Laryngology
M1	Maternity Clinic (Health Dept. Only)
M4	Medicare/Medicaid Crossover Only
WI	Mental Health Practitioner – Licensed Certified Social Worker
W2	Mental Health Practitioner – Licensed Professional Counselor
R5	Mental Health Practitioner – Licensed Marriage and Family Therapist
62	Mental Health Practitioner - Psychologist
N1	Neonatology
39	Nephrology
13	Neurology
N2	Nurse Midwife
N3	Nurse Practitioner
N4	Nurse Practitioner - OB/GYN
N6	Nurse Practitioner – Family Practice
N7	Nurse Practitioner - Gerontological
RK	Offsite Intervention Service - Outpatient Mental and Behavioral Health (ARKids ONLY)
X1	Oncology
18	Ophthalmology
X4	Optometrist
X6	Orthopedic
12	Osteopathy - Manipulative Therapy
X7	Osteopathy - Radiation Therapy
X8	Otology
X9	Otorhinolaryngology
22	Pathology
37	Pediatrics
P1	Personal Care Services
PA	Personal Care Services / Area Agency on Aging
PD	Personal Care Services / Developmental Disability Services
PE	Personal Care Services / Week-end
PG	Personal Care Services / Level I Assisted Living Facility
PH	Personal Care Services / Level II Assisted Living Facility
R3	Personal Care Services / Residential Care Facility
PS	Personal Care Services: Public School or Education Service Cooperative
P2	Pharmacy Independent
PC	Pharmacy – Chain
PM	Pharmacy – Compounding
PN	Pharmacy – Home Infusion
PR	Pharmacy – Long Term Care / Closed Door
PV	Pharmacy – Administrated Vaccines
P3	Physical Medicine
48	Podiatrist

(9) Provider Category (Continued)

Code Category Description

63	Portable X-ray Equipment
P6	Private Duty Nursing
PF	Private Duty Nursing: Public School or Education Service Cooperative
28	Proctology
P4	Prosthetic Devices
V4	Prosthetic - Durable Medical Equipment/Oxygen
Z1	Prosthetic - Orthotic Appliances
26	Psychiatry
P5	Psychiatry - Child
29	Pulmonary Diseases
R9	Radiation Therapy - Complete
RA	Radiation Therapy - Technical
30	Radiology - Diagnostic
31	Radiology - Therapeutic
R6	Rehabilitative Services for Persons with Mental Illness
RC	Rehabilitative Services for Persons with Physical Disabilities
R1	Rehabilitative Hospital
RH	Rehabilitative Hospital-extended Services
RJ	Rehabilitative Services for Youth and Children DCFS
RL	Rehabilitative Services for Youth and Children DYS
CR	Respite Care – Children’s Medical Services
R4	Rheumatology
R2	Rural Health Clinic - Provider Based
R8	Rural Health Clinic - Independent Freestanding
S7	School Based Health Clinic - Child Health Services
S8	School Based Health Clinic - Hearing Screener
S9	School Based Health Clinic - Vision Screener
SA	School Based Health clinic - Vision & Hearing Screener
VV	School Based Mental Health Clinic
S5	Skilled Nursing Facility
S6	SNF Hospital Distinct Part Bed
S1	Surgery - Cardio
S2	Surgery - Colon & Rectal
O2	Surgery - General
14	Surgery - Neurological
20	Surgery - Orthopedic
53	Surgery - Pediatric
54	Surgery - Oncology
24	Surgery - Plastic & Reconstructive
33	Surgery - Thoracic
S4	Surgery - Vascular
C5	Targeted Case Management - Ages 60 and Older
C6	Targeted Case Management - Ages 00 - 20
C7	Targeted Case Management - Ages 21 – 59
CM	Targeted Case Management – Developmental Disabilities Certification – Ages 00 - 20
T6	Therapy - Occupational
T1	Therapy - Physical
T2	Therapy - Speech Pathologist
TO	Therapy - Occupational Assistant
TP	Therapy - Physical Assistant
TS	Therapy - Speech Pathologist Assistant
A1	Transportation - Ambulance, Emergency
A2	Transportation - Ambulance, Non-emergency
A6	Transportation - Advanced Life Support with EKG
A7	Transportation - Advanced Life Support without EKG
TA	Transportation - Air Ambulance/Helicopter
TB	Transportation - Air Ambulance/Fixed Wing
TC	Transportation - Non-Emergency
T5	Transportation - Non-Public
T7	Transportation - Transportation Intra State Authority

(9) Provider Category (Continued)

Code Category Description

- T8** Transportation - Transportation Accessible Van, Intra City
- T9** Transportation - Transportation – Accessible Van, Intra State Authority
- 34** Urology
- V7** Ventilator Equipment
- ZZ** Other

(10) **SSN/FEIN Number:** Enter the Social Security Number of the applicant or the Federal Employer Identification Number of the applicant. **IF ENROLLING AN INDIVIDUAL APPLICANT THIS FIELD MUST REFLECT A SOCIAL SECURITY NUMBER.**

____ - ____ - ____ - ____ - ____ - ____
Social Security Number

NOTE: If an individual has a Federal Employee Identification Number, you will need to complete two (2) applications and two (2) contracts. One (1) as an individual and one (1) as an organization.

____ - ____ - ____ - ____ - ____ - ____
Federal Employee Identification Number

(11) **Certification Code:** This code identifies the type of provider the certification number in field 12 defines. If an entry is made in this field (11), an entry **MUST** be made in field 12 and 13 unless the entry is a 5. Please check the appropriate code.

- 0 = Mental Health
- 1 = Home Health
- 2 = CRNA
- 3 = Nursing Home
- 4 = Other
- 5 = Non-applicable

(12) **Certification Number:** If applicable, enter the certification number assigned to the applicant by the appropriate certification board/agency.

A CURRENT COPY OF THIS CERTIFICATION MUST ACCOMPANY THIS APPLICATION.

(13) **End Date:** Enter the expiration date of the applicant's current certification number in month/day/year format.

____/____/____
MM DD Year

(14) **Fiscal Year:** Enter the date of the applicant's fiscal year end. This date is in month/day format.

____/____
MM DD

- (15) **DEA Number:** If applicable, enter the number assigned to the applicant by the Federal Drug Enforcement Agency. Pharmacies must submit this information to be enrolled.

Required for Pharmacies only

A CURRENT COPY OF THIS CERTIFICATE MUST ACCOMPANY THIS APPLICATION.

- (16) **End Date:** Enter the expiration date of the current DEA Number in month/day/year format.

____/____/____
MM DD Year

- (17) **License Number:** If applicable, enter the license number assigned to the applicant by the appropriate state licensure board. If the license issued is a temporary license enter **TEMP**. If the license number is smaller than the fields allowed, leave the last spaces blank.

A CURRENT COPY OF THIS LICENSE MUST ACCOMPANY THIS APPLICATION.

- (18) **End Date:** Enter the expiration date of the applicant's current license in month/day/year format.

____/____/____
MM DD Year

- (19) **CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA):** If applicable, enter the CLIA number assigned to the applicant. **A copy of the CLIA certificate is required in order to have your laboratory test paid.**

FOR OFFICE USE ONLY

Provider Number _____	Pending _____
Provider Name _____	Computer _____
	OK to Key _____
	Keyed _____
	Maintenance Checked _____

SECTION II: FACILITIES ONLY

(20) **Special Facility Program:** Check the appropriate value to depict if the applicant's facility is indigent care, teaching facility/university or UR plan. Special facility program values include:

- | | | |
|--------|-----------------------------------|--------------------------|
| *A = | indigent care only | <input type="checkbox"/> |
| **B = | teaching facility/university only | <input type="checkbox"/> |
| ***C = | UR plan only | <input type="checkbox"/> |
| D = | A/B | <input type="checkbox"/> |
| E = | A/C | <input type="checkbox"/> |
| F = | B/C | <input type="checkbox"/> |
| G = | A/B/C | <input type="checkbox"/> |
| N = | No special program | <input type="checkbox"/> |

* Indigent Care - Indicate whether the facility is qualified for the indigent care allowance.

NOTE: Facilities which serve a disproportionate number of indigent patients (defined as exceeding 20% Medicaid days as compared to a total patient day) may qualify for an indigent care allowance. If the facility meets the above criteria, please send the appropriate excerpt from the most current cost report that reflects total Medicaid days and total patient days.

** Teaching/University Facility - Indicate whether the facility is designated as a teaching/university affiliated institution and participates in three or more residency training programs.

*** Utilization Review Plan - Does the facility have a Utilization Review Plan applicable to all Medicaid patients?

(21) **Total Beds:** Enter the total number of beds in the facility.

of Beds

FOR OFFICE USE ONLY

Provider Number _____	Pending _____
Provider Name _____	Computer _____
	OK to Key _____
	Keyed _____
	Maintenance Checked _____

SECTION III: PHARMACIST/REGISTERED RESPIRATORY THERAPIST ONLY

PHARMACIES - PLEASE INDICATE IF THIS APPLICANT IS A CHAIN-OWNED PHARMACY WITH 11 OR MORE RETAIL PHARMACIES NATIONALLY. (FRANCHISES WHICH ARE INDIVIDUALLY OWNED ARE NOT CHAIN-OWNED UNLESS ONE INDIVIDUAL OR CORPORATION OWNS 11 OR MORE RETAIL STORES.)

YES **NO**

(22) Please list each pharmacist/registered respiratory therapist name, Social Security Number, license number and effective date of employment.

Please indicate by the pharmacist name whether that pharmacist is certified to administer Vaccines. If you are providing Vaccines, the pharmacy will need to be enrolled in the Medicare program. Please include the pharmacy Medicare number in Section I item 7a.

A copy of current registered respiratory therapist is required. Subsequent renewal must be provided when issued.

NOTE: Registered Respiratory Therapists must enter registration number in license number field.

_____ Name of Pharmacist/ Registered Respiratory Therapist	_____ Social Security Number	Administering Vaccines (see above) _____ _____ yes no
--	---------------------------------	---

_____ License/Registration Number	_____ Effective Date of employment
--------------------------------------	---------------------------------------

_____ Name of Pharmacist/ Registered Respiratory Therapist	_____ Social Security Number	Administering Vaccines (see above) _____ _____ yes no
--	---------------------------------	---

_____ License/Registration Number	_____ Effective Date of employment
--------------------------------------	---------------------------------------

_____ Name of Pharmacist/ Registered Respiratory Therapist	_____ Social Security Number	Administering Vaccines (see above) _____ _____ yes no
--	---------------------------------	---

_____ License/Registration Number	_____ Effective Date of employment
--------------------------------------	---------------------------------------

_____ Name of Pharmacist/ Registered Respiratory Therapist	_____ Social Security Number	Administering Vaccines (see above) _____ _____ yes no
--	---------------------------------	---

_____ License/Registration Number	_____ Effective Date of employment
--------------------------------------	---------------------------------------

FOR OFFICE USE ONLY

Provider Number _____	Pending _____
Provider Name _____	Computer _____
	OK to Key _____
	Keyed _____
	Maintenance Checked _____

SECTION IV: PROVIDER GROUP AFFILIATIONS

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

Last Name First Name M. I. Title

Group Organization Name

Effective Date (Applicant Joined Group)

Group AR Medicaid Provider Number

Expiration Date (Applicant Left Group)

City State Zip Code

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original signature of the individual provider is mandatory (no stamped or copied signature is allowed.)

Signature Title Date

Typed or Printed Name Arkansas Medicaid Provider Number

FOR OFFICE USE ONLY

Provider Number _____	Pending _____
Provider Name _____	Computer _____
	OK to Key _____
	Keyed _____
	Maintenance Checked _____

SECTION IV: PROVIDER GROUP AFFILIATIONS (CONTINUED)

(23) If the applicant is affiliated with a group practice or an organization that is authorized to submit Medicaid claims on their behalf, the applicant must complete this section and sign the Appointment of Billing Intermediary Statement. Add extra sheets if necessary.

Last Name First Name M. I. Title

Group Practice Organization Name

Effective Date (Applicant Joined Group)

Group AR Medicaid Provider Number

Expiration Date (Applicant Left Group)

City State Zip Code

The undersigned Provider authorizes the above-listed Group Practice Organization to submit claims to the Arkansas Division of Medical Services (hereinafter the Division) on his/her/its behalf, in accordance with the applicable Division regulations. The Provider also authorizes the Division to issue payment checks on his/her/its behalf to the above listed Group Practice Organization, in accordance with applicable Division requirements.

The Provider accepts full liability to the Division for all acts committed by each Group Practice Organization listed above which relate in any manner to said Group Practice Organization's performance of duties in preparing and submitting claims on the Provider's behalf within the scope of its actual or apparent authority. Should any such acts result in the violation of any of the laws, rules or regulations governing the Medical Assistance Program or the Provider's agreement with the Division, the Provider shall be fully liable to the Division as if such acts were the Provider's own acts.

The Provider agrees to notify the Division at least ten days prior to the effective date of the revocation of this Appointment of Billing Intermediary. In such event, the Provider's liability for the acts of the Group Practice Organization shall continue until the tenth day after the Department's receipt of such notification or the effective date of the revocation, whichever date is later.

An original signature of the individual provider is mandatory (no stamped or copied signature is allowed.)

Signature Title Date

Typed or Printed Name Arkansas Medicaid Provider Number

Dear Provider:

Providers are encouraged to utilize **Electronic Fund Transfer (EFT)**. EFT allows your Medicaid payments to be directly deposited into your bank account. You will notice a difference in your cash flow with EFT because it makes your money available sooner than the actual clearance date of paper checks. Your Medicaid Remittance Advice (RA) will continue to be mailed to the mailing address listed on your enrollment application.

If you wish to have your Medicaid payment automatically deposited, please complete the Authorization for Automatic Deposit and attach a **VOIDED CHECK OR A LETTER FROM THE BANK REFLECTING THE BANK'S ABA NUMBER AND YOUR ACCOUNT NUMBER.**

If you choose not to enroll in EFT, your checks along with your Medicaid RA will be mailed to you. **Please note that since EFT is available, checks are not available for pick-up at the EDS office.**

If you have any further questions concerning this letter, please contact the EDS Provider Assistance at (501) - 376-2211 (local or out-of-state) or 1-800-457-4454 (in-state WATS).

Sincerely,

Arkansas Department of Health and Human Services

Authorization for Automatic Deposit

Name of Medicaid Provider _____ Medicaid Provider # _____

Provider Address _____ Telephone Number _____

City, State _____ Zip Code _____

Type of Authorization New Change Cancel

Checking Savings **(if not indicated will be automatically entered as checking)**

ABA Transit Number _____ Bank Account Number _____

A COPY OF A VOIDED CHECK OR A LETTER FROM THE BANK IS REQUIRED TO VERIFY THESE NUMBERS. THE NAME ON THE VOIDED CHECK OR LETTER FROM BANK MUST MATCH THE NAME OF THE MEDICAID PROVIDER STATED ABOVE. TEMPORARY CHECKS ARE INVALID IF THEY DO NOT HAVE THE PROVIDER'S NAME AND ADDRESS PRINTED BY THE BANK.

Name of Bank _____

Bank Address _____

City, State _____ Zip Code _____

I (we) hereby authorize the Arkansas Medicaid Program/Title XIX, hereinafter called Company, to initiate credit and if necessary, debit entries and adjustments for any credit entries in error to my (our) bank account as indicated above, at the depository financial institution named above and to credit or debit the same from such account. I (we) acknowledge that the authority will remain in effect until I have (or either of us) cancelled it in writing and that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law. I understand I am responsible for the validity on this form.

This authorization is to remain in full force until the Company receives written notification from me (or either of us) of its termination in such time, and in such manner as to afford Company and financial institution a reasonable opportunity to act on it. I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Provider's Original Signature (required)

Please return this form to:
Medicaid Provider Enrollment Unit
EDS
P.O. Box 8105
Little Rock, AR 72203-8105

MANAGED CARE PROGRAM

PRIMARY CARE PHYSICIAN

Family Practitioner
General Practitioner (including osteopath)
* **Internal Medicine**
* **Obstetrician**
* **Gynecologist**
Pediatrician

If your specialty of practice is listed above, you **MUST** complete the Primary Care Physician Participation Agreement and the EPSDT Agreement to participate in the Arkansas Medicaid Program. If you are employed exclusively by an Area Health Education Center (AHEC), Federally Qualified Health Center (FQHC), a Medical College Physicians Group or a hospital, you are exempt from the Primary Care Physician program. Please refer to Section I of your Arkansas Medicaid Provider manual for information concerning the Primary Care Physician Program.

* **NOTE** * Providers whose specialty is either Internal Medicine or Obstetrician/Gynecology who customarily carry a caseload of patients who are 21 years of age or older have the option of enrolling in the Child Health Services (EPSDT) program. Please review the Primary Care Physicians policy.

ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM
PRIMARY CARE PHYSICIAN PARTICIPATION AGREEMENT

This agreement is made and entered into between _____
(Please print, stamp or type physician's name)

hereafter called provider, and the Arkansas Division of Medical Services, hereafter called Medicaid.

The provider in consideration of the material benefits to be derived, and the rules and regulations of the Medicaid Program agrees as follows:

- A. To be a Medicaid enrolled Physician provider and comply with all pertinent Medicaid policies, regulations and State Plan standards.
- B. To be a Medicaid enrolled Early Periodic Screening Diagnosis and Treatment (EPSDT) provider and to comply with all pertinent Medicaid policies, regulations and State Plan standards. (Internists, Obstetricians/Gynecologists are exempt from this requirement.)
- C. To perform various services as a primary care physician under the guidelines of the Primary Care Physician Managed Care Program and to comply with all pertinent Medicaid policies, regulations and State Plan standards.
- D. To authorize their name be listed as a primary care physician and consent to release their name to interested parties.

Please indicate the maximum number of Medicaid beneficiaries you are willing to accept for primary care services, (A minimum of 1 and a maximum of 1000) and the age range of the Medicaid beneficiaries you are willing to accept for primary care services. If no age range is indicated, Medicaid beneficiaries of all ages will be accepted: _____

Please indicate all the counties in Arkansas in which you will provide primary care physician services by circling the county codes designated on the following page or by listing the county or county codes in the space that follows:

Please indicate the **Medicaid identification** number (individual or group) for payment of your management fee and inclusion on a Federal 1099 Tax Form: _____.

Physicians without hospital admitting privileges, please list the name of the enrolled PCP with admitting privileges who has agreed to be responsible for your recipient inpatient admissions: _____.
An agreement signed by the PCP and the Admitting physician is required.

Medicaid Physician Provider Number

Primary Care Physician Signature

Date

Division of Medical Services Signature

Title

Date

County Codes

County	County Code	County	County Code	County	County Code
Arkansas	01	Garland	26	Newton	51
Ashley	02	Grant	27	Ouachita	52
Baxter	03	Greene	28	Perry	53
Benton	04	Hempstead	29	Phillips	54
Boone	05	Hot Spring	30	Pike	55
Bradley	06	Howard	31	Poinsett	56
Calhoun	07	Independence	32	Polk	57
Carroll	08	Izard	33	Pope	58
Chicot	09	Jackson	34	Prairie	59
Clark	10	Jefferson	35	Pulaski	60
Clay	11	Johnson	36	Randolph	61
Cleburne	12	Lafayette	37	Saline	62
Cleveland	13	Lawrence	38	Scott	63
Columbia	14	Lee	39	Searcy	64
Conway	15	Lincoln	40	Sebastian	65
Craighead	16	Little River	41	Sevier	66
Crawford	17	Logan	42	Sharp	67
Crittenden	18	Lonoke	43	St. Francis	68
Cross	19	Madison	44	Stone	69
Dallas	20	Marion	45	Union	70
Desha	21	Miller	46	Van Buren	71
Drew	22	Mississippi	47	Washington	72
Faulkner	23	Monroe	48	White	73
Franklin	24	Montgomery	49	Woodruff	74
Fulton	25	Nevada	50	Yell	75
State	County Code	State	County Code	State	County Code
Louisiana	91	Mississippi	93	Tennessee	95
Missouri	92	Oklahoma	94	Texas	96

Please note: Per Section I, page 84, subsection 185.12, item 2 of the Arkansas Medicaid Physicians provider manual, a PCP must be physically located in the State of Arkansas or in a bordering state trade-area city. The trade-area cities are:

- **Monroe and Shreveport, Louisiana**
- **Clarksdale and Greenville, Mississippi**
- **Poplar Bluff, Missouri**
- **Poteau and Salisaw, Oklahoma**
- **Memphis, Tennessee**
- **Texarkana, Texas**

AGREEMENT

**TO PARTICIPATE AS A SCREENING PROVIDER IN THE ARKANSAS
CHILD HEALTH SERVICES EARLY AND PERIODIC SCREENING,
DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM**

This agreement made and entered into this ____ day of _____, 20__ and between _____, hereinafter called Provider, and Arkansas Division of Medical Services.

The provider, in consideration of the material benefits to be derived, and the covenants and undertakings of Arkansas Division of Medical Services agree as follows:

- A. To perform various components of the screening examination in accordance with exemplary age-specified Child Health Services (EPSDT) screening procedures:
- B. To bill for screening services only after services have been provided in accordance with the current Arkansas Child Health Services (EPSDT) medical periodicity schedule:
- C. To permit his name to be listed as a full screening provider with the Child Health Services (EPSDT) program and consent to inclusion on Child Health Services (EPSDT) provider list made available to County Human Services staff for selection by eligible clients.

In witness whereof the Parties hereto have set their hands in duplicate the day and date first written above.

Provider's Original Signature

Provider Identification Number

Authorized Representative of Arkansas
Division of Medical Services

FORM W-9

REQUEST FOR TAXPAYER

IDENTIFICATION NUMBER AND CERTIFICATION

The Department of Finance and Administration and the Department of Human Services have mandated that an IRS form W-9 be completed by all vendors doing business with the Department of Human Services.

NOTE:

TO ENSURE CORRECT PROCESSING OF THE 1099 --- PLEASE REVIEW THE FOLLOWING: WHEN BILLING FOR SERVICES UNDER CLINIC NAME AND IRS NUMBER, THE CLINIC AND EACH INDIVIDUAL PROVIDER (i.e., physician, therapist, dentist, etc.) MUST ENROLL BY COMPLETING A SEPARATE APPLICATION AND CONTRACT. A CLINIC MEDICAID NUMBER WILL BE ISSUED AND LINKED WITH EACH INDIVIDUAL'S MEDICAID NUMBER WITHIN THAT GROUP. THE CLINIC MEDICAID NUMBER MUST BE PLACED IN THE PAY TO FIELD AND THE INDIVIDUAL PROVIDER NUMBER MUST BE PLACED IN THE PERFORMING FIELD. THIS WILL ENSURE THAT THE 1099 REFLECTS THE CORRECT TAX NUMBER. PLEASE REFER TO YOUR PROVIDER MANUAL FOR CLAIMS PROCESSING INSTRUCTIONS.

Request for Taxpayer Identification Number and Certification

**Give this form
to the requester. Do
NOT send to IRS.**

Please print or type	Name (If joint names, list first and circle the name of the person or entity whose number you enter in Part I below. See instructions under "Name" if your name has changed.)	
	Address (number and street)	List account number(s) here (optional)
	City, state, and ZIP code	

Part I Taxpayer Identification Number (TIN)

Enter your taxpayer identification number in the appropriate box. For individuals and sole proprietors, this is your social security number. For other entities, it is your employer identification number. If you do not have a number, see *How to Obtain a TIN*, below.

Social security number								

OR

Employer Identification number								

Note: If the account is in more than one name, see the chart on page 2 for guidelines on whose number to enter.

Part II For Payees Exempt From Backup Withholding (See Instructions)

Requester's name and address (optional)

Certification.—Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
- (2) I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding.

Certification Instructions.—You must cross out item (2) above if you have been notified by IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item (2) does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (Also see *Signing the Certification* under *Specific Instructions*, on page 2.)

Please Sign Here

Signature ▶

Date ▶

Instructions

(Section references are to the Internal Revenue Code.)

Purpose of Form.—A person who is required to file an information return with IRS must obtain your correct taxpayer identification number (TIN) to report income paid to you, real estate transactions, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an individual retirement arrangement (IRA). Use Form W-9 to furnish your correct TIN to the requester (the person asking you to furnish your TIN), and, when applicable, (1) to certify that the TIN you are furnishing is correct (or that you are waiting for a number to be issued), (2) to certify that you are not subject to backup withholding, and (3) to claim exemption from backup withholding if you are an exempt payee. Furnishing your correct TIN and making the appropriate certifications will prevent certain payments from being subject to the 20% backup withholding.

Note: If a requester gives you a form other than a W-9 to request your TIN, you must use the requester's form.

How to Obtain a TIN.—If you do not have a TIN, apply for one immediately. To apply, get **Form SS-5**, Application for a Social Security Number Card (for individuals), from your local office of the Social Security Administration, or **Form SS-4**, Application for Employer Identification Number (for businesses and all other entities), from your local Internal Revenue Service office.

To complete Form W-9 if you do not have a TIN, write "Applied For" in the space for the TIN in Part I, sign and date the form, and give it to the requester. Generally, you will then have 60 days to obtain a TIN and furnish it to the requester. If the requester does not receive your TIN within 60 days, backup withholding, if applicable, will begin and continue until you furnish your TIN to the

requester. For reportable interest or dividend payments, the payer must exercise one of the following options concerning backup withholding during this 60-day period. Under option (1), a payer must backup withhold on any withdrawals you make from your account after 7 business days after the requester receives this form back from you. Under option (2), the payer must backup withhold on any reportable interest or dividend payments made to your account, regardless of whether you make any withdrawals. The backup withholding under option (2) must begin no later than 7 business days after the requester receives this form back. Under option (2), the payer is required to refund the amounts withheld if your certified TIN is received within the 60-day period and you were not subject to backup withholding during that period.

Note: Writing "Applied For" on the form means that you have already applied for a TIN **OR** that you intend to apply for one in the near future.

As soon as you receive your TIN, complete another Form W-9, include your TIN, sign and date the form, and give it to the requester.

What Is Backup Withholding?—Persons making certain payments to you are required to withhold and pay to IRS 20% of such payments under certain conditions. This is called "backup withholding." Payments that could be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee compensation, and certain payments from fishing boat operators, but do not include real estate transactions.

If you give the requester your correct TIN, make the appropriate certifications, and report all your taxable interest and dividends on your tax return, your payments will not be subject to backup withholding. Payments you receive will be subject to backup withholding if:

- (1) You do not furnish your TIN to the requester, or

(2) IRS notifies the requester that you furnished an incorrect TIN, or

(3) You are notified by IRS that you are subject to backup withholding because you failed to report all your interest and dividends on your tax return (for reportable interest and dividends only), or

(4) You fail to certify to the requester that you are not subject to backup withholding under (3) above (for reportable interest and dividend accounts opened after 1983 only), or

(5) You fail to certify your TIN. This applies only to reportable interest, dividend broker, or barter exchange accounts opened after 1983, or broker accounts considered inactive in 1983.

Except as explained in (5) above, other reportable payments are subject to backup withholding only if (1) or (2) above applies.

Certain payees and payments are exempt from backup withholding and information reporting. See *Payees and Payments Exempt From Backup Withholding*, below, and *Exempt Payees and Payments* under *Specific Instructions*, on page 2, if you are an exempt payee.

Payees and Payments Exempt from Backup Withholding.—The following is a list of payees exempt from backup withholding and for which no information reporting is required. For interest and dividends, all listed payees are exempt except item (9). For broker transactions, payees listed (1) through (13) and a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker are exempt. Payments subject to reporting under sections 6041 and 6041A are generally exempt from backup withholding only if made to payees described in items (1) through (7), except that a corporation that provides medical and health care services or bills and collects payments for such services is not exempt from

backup withholding or information reporting. Only payees described in items (2) through (6) are exempt from backup withholding for barter exchange transactions, patronage dividends, and payments by certain fishing boat operators.

- (1) A corporation.
- (2) An organization exempt from tax under section 501(a), or an individual retirement plan (IRA), or a custodial account under 403(b)(7).
- (3) The United States or any of its agencies or instrumentalities.
- (4) A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities.
- (5) A foreign government or any of its political subdivisions, agencies, or instrumentalities.
- (6) An international organization or any of its agencies or instrumentalities.
- (7) A foreign central bank of issue.
- (8) A dealer in securities or commodities required to register in the U.S. or a possession of the U.S.
- (9) A futures commission merchant registered with the Commodity Futures Trading Commission.
- (10) A real estate investment trust.
- (11) An entity registered at all times during the tax year under the Investment Company Act of 1940.
- (12) A common trust fund operated by a bank under section 584(a).
- (13) A financial institution.
- (14) A middleman known in the investment community as a nominee or listed in the most recent publication of the American Society of Corporate Secretaries, Inc., Nominee List.
- (15) A trust exempt from tax under section 664 or described in section 4947.

Payments of **dividends** and **patronage dividends** generally not subject to backup withholding also include the following:

- Payments to nonresident aliens subject to withholding under section 1441
- Payments to partnerships not engaged in a trade or business in the U.S. and that have at least one nonresident partner.
- Payments of patronage dividends not paid in money.
- Payments made by certain foreign organizations.

Payments of interest generally not subject to backup withholding include the following:

- Payments of interest on obligations issued by individuals. **Note:** *You may be subject to backup withholding if this interest is \$600 or more and is paid in the course of the payer's trade or business and you have not provided your correct TIN to the payer.*
- Payments of tax-exempt interest (including exempt-interest dividends under section 852).
- Payments described in section 6049(b)(5) to nonresident aliens.
- Payments on tax-free covenant bonds under section 1451.
- Payments made by certain foreign organizations.
- Mortgage interest paid by you.

Payments that are not subject to information reporting are also not subject to backup withholding. For details, see sections 6041, 6041A(a), 6042, 6044, 6045, 6049, 6050A, and 6050N, and the regulations under those sections.

Penalties

Failure to Furnish TIN.—If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil Penalty for False Information With Respect to Withholding.—If you make a false statement with no reasonable basis that results in no imposition of backup withholding, you are subject to a penalty of \$500.

Criminal Penalty for Falsifying Information.—Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Specific Instructions

Name.—If you are an individual, you must generally provide the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage, without informing the Social Security Administration of the name change, please enter your first name and both the last name shown on your social security card and your new last name.

Signing the Certification.—

(1) Interest, Dividend, and Barter Exchange Accounts Opened Before 1984 and Broker Accounts That Were Considered Active During 1983.—You are not required to sign the certification; however, you may do so. You are required to provide your correct TIN.

(2) Interest, Dividend, Broker and Barter Exchange Accounts Opened After 1983 and Broker Accounts That Were Considered Inactive During 1983.—You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item (2) in the certification before signing the form.

(3) Real Estate Transactions.—You must sign the certification. You may cross out item (2) of the certification if you wish.

(4) Other Payments.—You are required to furnish your correct TIN, but you are not required to sign the certification unless you have been notified of an incorrect TIN. Other payments include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services, payments to a nonemployee for services (including attorney and accounting fees), and payments to certain fishing boat crew members.

(5) Mortgage Interest Paid by You, Acquisition or Abandonment of Secured Property, or IRA Contribution.—You are required to furnish your correct TIN, but you are not required to sign the certification.

(6) Exempt Payees and Payments.—If you are exempt from backup withholding, you should complete this form to avoid possible erroneous backup withholding. Enter your correct TIN in Part I, write "EXEMPT" in the block in Part II, sign and date the form. If you are a nonresident alien or foreign entity not subject to backup withholding, give the requester a completed **Form W-8**, Certificate of Foreign Status.

(7) TIN "Applied For."—Follow the instructions under *How to Obtain a TIN*, on page 1, sign and date this form.

Signature.—For a joint account, only the person whose TIN is shown in Part I should sign the form.

Privacy Act Notice.—Section 6109 requires you to furnish your correct taxpayer identification number (TIN) to persons who must file information returns with IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, or contributions you made to an individual retirement arrangement (IRA). IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 20% of taxable interest, dividend, and certain other payments to a payee who does not furnish a TIN to a payer. Certain penalties may also apply.

What Name and Number to Give the Requester

For this type of account:	Give the name and SOCIAL SECURITY number of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4.a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship	The owner ³
For this type of account:	Give the name and EMPLOYER IDENTIFICATION number of:
6. A valid trust, estate, or pension trust	Legal entity (Do not furnish the identification number of the personal representative or trustee unless the legal entity itself is not designated in the account title.) ⁴
7. Corporate	The corporation
8. Association, club, religious, charitable, educational, or other tax exempt organization	The organization
9. Partnership	The partnership
10. A broker or registered nominee	The broker or nominee
11. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish.

² Circle the minor's name and furnish the minor's social security number.

³ Show the individual's name.

⁴ List first and circle the name of the legal trust, estate, or pension trust.

Note: *If no name is circled when there is more than one name, the number will be considered to be that of the first name listed.*

CONTRACT

**TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE
PROGRAM ADMINISTERED BY THE DIVISION OF MEDICAL
SERVICES UNDER TITLE XIX (MEDICAID)**

INSTRUCTIONS

Please ensure that the provider name on the front page of the contract is identical to that listed in item #2 or item #3 of the application.

If these two names do not match, your enrollment will be denied and the enrollment packet will be returned.

**CONTRACT
TO PARTICIPATE IN THE ARKANSAS MEDICAL ASSISTANCE PROGRAM
ADMINISTERED BY THE DIVISION OF MEDICAL SERVICES
TITLE XIX (MEDICAID)**

The following agreement is entered into between _____, hereinafter called Provider, and the Arkansas Department of Health and Human Services, hereafter called Department:

1. Provider, in consideration of the covenants therein, agrees to the following:
 - A. To keep all records, as set forth in the appropriate Arkansas Medicaid Provider Manual, Official Notice and Remittance Advice Message, to fully disclose the extent of services provided to individuals receiving assistance under the State Plan.
 - B. To make available all records herein specified to satisfy audit requirements under the Program, to furnish all such records for audits conducted periodically by the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or their designated agents and/or representatives. For all Medicaid beneficiaries, these records include, but are not limited to those records which are defined in Section "A" of this contract. For clients who are not Medicaid beneficiaries, the records that must be furnished are financial records of charges billed to non-Medicaid insurance to ensure that charges billed to Medicaid do not exceed charges billed to non-Medicaid insurance.
 - 1) In connection with this contract each party hereto will receive certain confidential information relating to the other party. For purposes of this contract, any information furnished or made available to one party relating to the financial condition, results of operation, business, customers, properties, assets, liabilities or information relating to the financial condition relating to beneficiaries and providers, including but not limited to protected health information as defined by the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, is collectively referred to as "Confidential Information."
 - 2) The contract shall safeguard the use and disclosure of information concerning applicants for or beneficiaries of Title XIX services in accordance with 42 CFR Part 431, Subpart F, and shall comply with 45 CFR Parts 160 and 164 and shall restrict access to and disclosure of such information in compliance with federal and state laws and regulations."
 - C. To accept assignment under Title XVIII (Medicare) in order to receive payment under Title XIX (Medicaid) for any applicable deductible or coinsurance that may be due and payable under Title XIX (Medicaid).
 - D. To bill Medicaid only after a service has been provided, or as otherwise specified in the appropriate Arkansas Medicaid Provider Manual, Official Notice, or Remittance Advice message.
 - E. To accept payment from Medicaid as payment in full for a covered service, and to make no additional charges to the beneficiary or accept any additional payment from the beneficiary except cost share (co-pay or deductible amounts) so designated by the Medicaid Program.
 - F. To take assignment and file claims with third party sources (medical or liability insurance, etc.), and if third party payment is made to the Provider, to reimburse Medicaid up to the amount Medicaid paid for the services; to make no claims against third party sources for services for which a claim has been submitted to Medicaid; and to notify Medicaid of the identity of each third party source discovered after submission of a claim or claims to Medicaid.
 - G. To make no charge to a beneficiary for a claim or a portion of a claim when a determination that the service was not medically necessary is made based on the professional opinion of appropriate and qualified medical persons on a committee that performs peer review of Medicaid cases either for the Division of Medical Services or for the Quality Improvement Organization (QIO); except that such charge may be made to the beneficiary when he/she has requested the service and has prior knowledge that he/she will be responsible for the cost of such service; and to reimburse the Division of Medical Services for all monies paid for claims for services that later were determined "not medically necessary."
 - H. To provide all services without discrimination on the grounds of race, color, national origin, or physical or mental disability within the provisions of Title VI of the Federal Civil Rights Act, Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.
 - I. To accept all changes legally made in the Program, and recognize and abide by such changes upon being notified by the Medicaid Program in the form of an update to, or an Official Notice/Remittance Advice Message pertaining to, the appropriate Arkansas Medicaid Provider Manual.
 - J. That the Department has furnished the Provider with a copy of the Arkansas Medicaid Provider Manual containing the rules, regulations and procedures pertaining to his/her profession. The Provider agrees that the terms and conditions contained therein shall be a part of this contract if the same were set out verbatim herein. The Provider states that he/she is currently licensed to practice in Arkansas or within the State where services were rendered and agrees to promptly notify the Department if his/her license is revoked or suspended. The Provider acknowledges by signature on this contract that he/she has received a copy of the appropriate Arkansas Medicaid Provider Manual.

- K. To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.
- L. To certify by original signature within 48 hours of claims being submitted by an electronic media, a claim count and dollar amount billed, that the information on the claims submitted is true, accurate and complete. The Provider agrees to maintain this certification as a matter of record for all claims submitted electronically, by any media.
- M. To notify the Department before any change of ownership or operating status. Upon change of ownership or operating status the successor owner or operator shall, as a condition of assumption of this agreement, hold the Department harmless for any rate or payment increases, decreases, or adjustments without respect to whether the increase, decrease, or adjustment relates to services delivered before the change in ownership or operating status.
- N. FOR HOSPITALS ONLY
To understand that the Quality Improvement Organization (Arkansas Foundation for Medical Care, Inc.) is responsible for the review of Medicaid admissions to inpatient hospitals, specifically for length of stay purposes, medical necessity and as otherwise specified in the Memorandum of Understanding between the individual hospital and Arkansas Foundation for Medical Care, Inc.

II. The Department, in consideration of the material benefits and the covenants and undertakings of the Provider, agrees as follows:

- A. To make payment to the above named Provider for the appropriate Medicaid covered services provided to eligible Medicaid beneficiaries in accordance with the applicable Medicaid reimbursement schedule in effect for the dates of service, and in accordance with the manual of rules, regulations and procedures that is a part of this contract.
- B. To notify the above named Provider of applicable changes in Medicaid rules and regulations as they occur.
- C. To safeguard the confidentiality of any medical records received by the Department or its fiscal intermediary, as specified in Federal and State regulations.

III. This contract may be terminated or renewed in accordance with the following provisions:

- A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party;
- B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;
- C. This contract may be terminated immediately by the Department for the following reasons:
 - 1) Sanction of provider
 - 2) Returned mail
 - 3) Death of provider
 - 4) Change of ownership
 - 5) Other reasons set out in the applicable Arkansas Medicaid Provider Manual, Official Notice or Remittance Advice message.
 - 6) Failure to conform to the terms or requirements of this contract.

If the Provider is a legal entity other than a person, the person signing this Provider Contract on behalf of the Provider warrants that he/she has legal authority to bind the Provider. The signature of the Provider or the person with the legal authority to bind the Provider on this contract certifies the Provider understands that payment and satisfaction of these claims will be made from Federal and State funds, and that any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable Federal and State laws.

By: _____
(Signature)

By: _____
(Signature)

Name: _____
(Typed Name)

Name: _____
(Typed Name)

Title: _____

Title: _____

Date: _____

Date: _____
(Effective Date of Contract)