

**FOR OFFICE USE ONLY**

Provider ID Number _____	Pending _____
Taxonomy Code _____	
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, and 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 (Doing Business As)  
**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) **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

- (6) **National Provider Identification Number (NPI) and Taxonomy Code:** Enter the National Provider Identification Number and the taxonomy code of the applicant.

\_\_\_\_\_  
National Provider Identification Number

\_\_\_\_\_  
Taxonomy Code

- (7) **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+4 Code - enter the applicant's city, state and zip+4 code. Use the Post Office's two letter abbreviation for State. Enter the complete nine digit zip code.

\_\_\_\_\_  
City State Zip Code+4

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

\_\_\_\_\_  
Area Code Telephone Number

- (E) Fax Number - enter the area code and fax number of the location in which the services are provided.

\_\_\_\_\_  
Area Code Fax Number

(8a) **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.

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_____	_____	_____
City	State	Zip Code+4
_____	_____	
Area Code	Telephone Number	
_____	_____	
Area Code	Fax Number	

(8b) **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](http://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: \_\_\_\_\_

Please make sure your e-mail address will accept e-mail from hp.com. You may need to instruct your network administrator or e-mail provider to accept e-mails from hp.com. Arkansas Medicaid sends e-mail in bulk, and some e-mail services may block bulk e-mail unless instructed otherwise.

ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL SERVICES

**MEDICARE VERIFICATION FORM**

Before we can enroll a provider 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) \_\_\_\_\_  
Provider ID Number                      Effective Date                      End Date

(2) \_\_\_\_\_  
Social Security Number                      Tax I.D. Number

(3) \_\_\_\_\_  
Specialty of Practice or Taxonomy Code

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This inquiry was completed by:

Name of Medicare Intermediary \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_

Signature of Medicare Representative \_\_\_\_\_

\_\_\_\_\_  
(Typed or Printed Name)

Date \_\_\_\_\_

- (9) **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.

---

<b>County</b>	<b>County Code</b>	<b>County</b>	<b>County Code</b>	<b>County</b>	<b>County Code</b>
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

  

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

(10) **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) \_\_\_\_\_

<b>Code</b>	<b>Category Description</b>
<b>N3</b>	Advanced Practice Nurse – Pediatrics
<b>N4</b>	Advanced Practice Nurse – Women’s Health
<b>N6</b>	Advanced Practice Nurse – Family
<b>N7</b>	Advanced Practice Nurse – Adult/Gerontological
<b>N8</b>	Advanced Practice Nurse – Psychiatric Mental Health
<b>N9</b>	Advanced Practice Nurse – Acute Care
<b>N0</b>	Advanced Practice Nurse– Nurse Practitioner - Other
<b>03</b>	Allergy/Immunology
<b>A8</b>	Alternatives for Adults with Physical Disabilities (Alternative) - Environmental Adaptations
<b>A9</b>	Alternatives for Adults with Physical Disabilities (Alternative) - Attendant Care Services
<b>A4</b>	Ambulatory Surgical Center
<b>AA</b>	Adolescent Medicine
<b>05</b>	Anesthesiology
<b>AH</b>	Living Choices Assisted Living Agency
<b>AL</b>	Living Choices Assisted Living Facility—Direct Services Provider
<b>AP</b>	Living Choices Assisted Living Pharmacist Consultant
<b>64</b>	Audiologist
<b>C1</b>	Cancer Screen (Health Dept. Only)
<b>C2</b>	Cancer Treatment (Health Dept. Only)
<b>06</b>	Cardiovascular Disease
<b>C4</b>	Child Health Management Services
<b>CF</b>	Child Health Management Services – Foster Care
<b>35</b>	Chiropractor
<b>C8</b>	Communicable Diseases (Health Dept. Only)
<b>C3</b>	CRNA
<b>HA</b>	DDS ACS Waiver Physical Adaptations
<b>HB</b>	DDS ACS Waiver Specialized Medical Supplies
<b>HC</b>	DDS ACS Waiver Case Management Services
<b>HE</b>	DDS ACS Waiver Supported Employment
<b>H7</b>	DDS ACS Waiver Supportive Living
<b>H8</b>	DDS ACS Waiver Crisis Abatement Services
<b>HG</b>	DDS ACS Waiver Crisis Center – Intervention Services
<b>H9</b>	DDS ACS Waiver Consultation Services
<b>IC</b>	DDS ACS Waiver IndependentChoices
<b>HF</b>	DDS ACS Waiver Organized HealthCare
<b>N5</b>	DDS Non-Medicaid
<b>V2</b>	Dental
<b>V1</b>	Dental Clinic (Health Dept. Only)
<b>V0</b>	Dental - Mobile Dental Facility
<b>X5</b>	Dental - Oral Surgeon
<b>V6</b>	Dental - Orthodontia
<b>07</b>	Dermatology
<b>V3</b>	Developmental Day Treatment Center
<b>DR</b>	Developmental Rehabilitation Services
<b>V5</b>	Domiciliary Care
<b>CN</b>	DYS/TCM Group
<b>CO</b>	DYS/TCM Performing
<b>E4</b>	ElderChoices H&CB 2176 Waiver - Chore services
<b>E5</b>	ElderChoices H&CB 2176 Waiver - Adult Family Homes
<b>E6</b>	ElderChoices H&CB 2176 Waiver - Home maker
<b>E7</b>	ElderChoices H&CB 2176 Waiver - Home delivered hot meals
<b>EC</b>	ElderChoices H&CB 2176 Waiver - Home delivered frozen meals
<b>E8</b>	ElderChoices H&CB 2176 Waiver - Personal emergency response systems
<b>E9</b>	ElderChoices H&CB 2176 Waiver - Adult day care
<b>EA</b>	ElderChoices H&CB 2176 Waiver - Adult day health care
<b>EB</b>	ElderChoices H&CB 2176 Waiver - Respite care
<b>E1</b>	Emergency Medicine
<b>E2</b>	Endocrinology

(10) Provider Category (Continued)

<b>Code</b>	<b>Category Description</b>
<b>E3</b>	Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
<b>F1</b>	Family Planning
<b>08</b>	Family Practice
<b>F2</b>	Federally Qualified Health Center
<b>10</b>	Gastroenterology
<b>01</b>	General Practice
<b>38</b>	Geriatrics
<b>16</b>	Gynecology - Obstetrics
<b>H1</b>	Hearing Aid Dealer
<b>H2</b>	Hematology
<b>H5</b>	Hemodialysis
<b>H3</b>	Home Health
<b>H6</b>	Hospice
<b>A5</b>	Hospital - AR State Operating Teaching Hospital
<b>W6</b>	Hospital - Inpatient
<b>W7</b>	Hospital - Outpatient
<b>CH</b>	Hospital - Critical Access
<b>IH</b>	Hospital - Indian Health Services
<b>IS</b>	Hospital - Indian Health Services Freestanding
<b>P7</b>	Hospital - Pediatric Inpatient
<b>P8</b>	Hospital - Pediatric Outpatient
<b>R7</b>	Hospital - Rural Inpatient
<b>HN</b>	Hyperalimentation Enteral Nutrition - Sole Source
<b>H4</b>	Hyperalimentation Parenteral Nutrition - Sole Source
<b>V8</b>	Immunization (Health Dept. Only)
<b>69</b>	Independent Lab
<b>55</b>	Infectious Diseases
<b>W3</b>	Inpatient Psychiatric - under 21
<b>WA</b>	Inpatient Psychiatric - Residential Treatment Unit within Inpatient Psychiatric Hospital
<b>WB</b>	Inpatient Psychiatric - Residential Treatment Center
<b>WC</b>	Inpatient Psychiatric - Sexual Offenders Program
<b>W4</b>	Intermediate Care Facility
<b>W9</b>	Intermediate Care Facility - Infant Infirmaries
<b>W5</b>	Intermediate Care Facility - Mentally Retarded
<b>11</b>	Internal Medicine
<b>L1</b>	Laryngology
<b>M1</b>	Maternity Clinic (Health Dept. Only)
<b>M4</b>	Medicare/Medicaid Crossover Only
<b>WI</b>	Mental Health Practitioner - Licensed Certified Social Worker
<b>W2</b>	Mental Health Practitioner - Licensed Professional Counselor
<b>R5</b>	Mental Health Practitioner - Licensed Marriage and Family Therapist
<b>62</b>	Mental Health Practitioner - Psychologist
<b>N1</b>	Neonatology
<b>39</b>	Nephrology
<b>13</b>	Neurology
<b>NI</b>	Nuclear Medicine
<b>N2</b>	Nurse Midwife
<b>N3</b>	Nurse Practitioner - Pediatric
<b>N4</b>	Nurse Practitioner - OB/GYN
<b>N6</b>	Nurse Practitioner - Family Practice
<b>N7</b>	Nurse Practitioner - Gerontological
<b>RK</b>	Offsite Intervention Service - Outpatient Mental and Behavioral Health (ARKids ONLY)
<b>X1</b>	Oncology
<b>18</b>	Ophthalmology
<b>X2</b>	Optical Dispensing Contractor
<b>X4</b>	Optometrist
<b>X6</b>	Orthopedic
<b>12</b>	Osteopathy - Manipulative Therapy
<b>X7</b>	Osteopathy - Radiation Therapy
<b>X8</b>	Otology
<b>X9</b>	Otorhinolaryngology



(10) Provider Category (Continued)

<b>Code</b>	<b>Category Description</b>
<b>22</b>	Pathology
<b>37</b>	Pediatrics
<b>P1</b>	Personal Care Services
<b>PA</b>	Personal Care Services / Area Agency on Aging
<b>PD</b>	Personal Care Services / Developmental Disability Services
<b>PE</b>	Personal Care Services / Week-end
<b>PG</b>	Personal Care Services / Level I Assisted Living Facility
<b>PH</b>	Personal Care Services / Level II Assisted Living Facility
<b>R3</b>	Personal Care Services / Residential Care Facility
<b>PS</b>	Personal Care Services: Public School or Education Service Cooperative
<b>P2</b>	Pharmacy Independent
<b>PC</b>	Pharmacy – Chain
<b>PM</b>	Pharmacy – Compounding
<b>PN</b>	Pharmacy – Home Infusion
<b>PR</b>	Pharmacy – Long Term Care / Closed Door
<b>PV</b>	Pharmacy – Administrated Vaccines
<b>P3</b>	Physical Medicine
<b>48</b>	Podiatrist
<b>63</b>	Portable X-ray Equipment
<b>P6</b>	Private Duty Nursing
<b>PF</b>	Private Duty Nursing: Public School or Education Service Cooperative
<b>28</b>	Proctology
<b>P4</b>	Prosthetic Devices
<b>V4</b>	Prosthetic - Durable Medical Equipment/Oxygen
<b>Z1</b>	Prosthetic - Orthotic Appliances
<b>26</b>	Psychiatry
<b>P5</b>	Psychiatry - Child
<b>29</b>	Pulmonary Diseases
<b>R9</b>	Radiation Therapy - Complete
<b>RA</b>	Radiation Therapy - Technical
<b>30</b>	Radiology - Diagnostic
<b>31</b>	Radiology - Therapeutic
<b>R6</b>	Rehabilitative Services for Persons with Mental Illness
<b>RC</b>	Rehabilitative Services for Persons with Physical Disabilities
<b>R1</b>	Rehabilitative Hospital
<b>RJ</b>	Rehabilitative Services for Youth and Children DCFS
<b>RL</b>	Rehabilitative Services for Youth and Children DYS
<b>CR</b>	Respite Care – Children’s Medical Services
<b>R4</b>	Rheumatology
<b>R2</b>	Rural Health Clinic - Provider Based
<b>R8</b>	Rural Health Clinic - Independent Freestanding
<b>S7</b>	School Based Health Clinic - Child Health Services
<b>S8</b>	School Based Health Clinic - Hearing Screener
<b>S9</b>	School Based Health Clinic - Vision Screener
<b>SA</b>	School Based Health clinic - Vision & Hearing Screener
<b>VV</b>	School Based Mental Health Clinic
<b>SO</b>	School District Outreach for ARKids
<b>S5</b>	Skilled Nursing Facility
<b>W8</b>	Skilled Nursing Facility – Special Services
<b>S6</b>	SNF Hospital Distinct Part Bed
<b>S1</b>	Surgery - Cardio
<b>S2</b>	Surgery - Colon & Rectal
<b>O2</b>	Surgery - General
<b>14</b>	Surgery - Neurological
<b>20</b>	Surgery - Orthopedic
<b>53</b>	Surgery - Pediatric
<b>54</b>	Surgery - Oncology

(10) Provider Category (Continued)

<b>Code</b>	<b>Category Description</b>
<b>24</b>	Surgery - Plastic & Reconstructive
<b>33</b>	Surgery - Thoracic
<b>S4</b>	Surgery - Vascular
<b>C5</b>	Targeted Case Management - Ages 60 and Older
<b>C6</b>	Targeted Case Management - Ages 00 - 20
<b>C7</b>	Targeted Case Management - Ages 21 – 59
<b>CM</b>	Targeted Case Management – Developmental Disabilities Certification – Ages 00 - 20
<b>T6</b>	Therapy - Occupational
<b>T1</b>	Therapy - Physical
<b>T2</b>	Therapy - Speech Pathologist
<b>TO</b>	Therapy - Occupational Assistant
<b>TP</b>	Therapy - Physical Assistant
<b>TS</b>	Therapy - Speech Pathologist Assistant
<b>A1</b>	Transportation - Ambulance, Emergency
<b>A2</b>	Transportation - Ambulance, Non-emergency
<b>A6</b>	Transportation - Advanced Life Support with EKG
<b>A7</b>	Transportation - Advanced Life Support without EKG
<b>TA</b>	Transportation - Air Ambulance/Helicopter
<b>TB</b>	Transportation - Air Ambulance/Fixed Wing
<b>TD</b>	Transportation - Broker
<b>TC</b>	Transportation - Non-Emergency
<b>TH</b>	Tuberculosis (Health Dept. Only)
<b>34</b>	Urology
<b>V7</b>	Ventilator Equipment

(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 ID Number _____	Pending _____
Taxonomy Code _____	Computer _____
Provider Name _____	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 ID Number _____	Pending _____
Taxonomy Code _____	Computer _____
Provider Name _____	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 Billing Provider ID Number on the Medicare Verification Form and attach proof of Medicare enrollment to the application. Please refer to the Medicare Verification Form for proof of Medicare requirements.**

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.

_____	_____	Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist	Social Security Number	_____      _____ yes          no
_____	_____	Effective Date of employment
License/Registration Number		
_____	_____	Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist	Social Security Number	_____      _____ yes          no
_____	_____	Effective Date of employment
License/Registration Number		
_____	_____	Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist	Social Security Number	_____      _____ yes          no
_____	_____	Effective Date of employment
License/Registration Number		
_____	_____	Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist	Social Security Number	_____      _____ yes          no
_____	_____	Effective Date of employment
License/Registration Number		

**FOR OFFICE USE ONLY**

Provider ID Number \_\_\_\_\_ Pending \_\_\_\_\_  
Taxonomy Code \_\_\_\_\_ Computer \_\_\_\_\_  
Provider Name \_\_\_\_\_ OK to Key \_\_\_\_\_  
Keyed \_\_\_\_\_  
Maintenance Checked \_\_\_\_\_

**SECTION IV: DENTAL PROVIDER ONLY**

**ORAL HEALTH PROVIDERS - PLEASE INDICATE IF YOU ARE ACCEPTING NEW CHIP OR ARKANSAS MEDICAID PATIENTS:**

**YES**       **NO**

**PLEASE INDICATE IF YOU ARE EQUIPPED TO HANDLE SPECIAL NEEDS PATIENTS:**

**YES**       **NO**

**PLEASE INDICATE THE ACCEPTED AGE RANGE (0-99):** \_\_\_\_\_

**FOR OFFICE USE ONLY**

Provider ID Number \_\_\_\_\_ Pending \_\_\_\_\_  
Taxonomy Code \_\_\_\_\_ Computer \_\_\_\_\_  
Provider Name \_\_\_\_\_ OK to Key \_\_\_\_\_  
Keyed \_\_\_\_\_  
Maintenance Checked \_\_\_\_\_

**SECTION V: 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

\_\_\_\_\_  
Group Provider ID Number Effective Date (Applicant Joined Group)

\_\_\_\_\_  
Group Taxonomy Code 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 or approved electronic signature of the individual provider is mandatory. (No stamped or copied signature is allowed; "approved electronic signature" is described at the Arkansas Medicaid website, <https://www.medicaid.state.ar.us/>.)**

\_\_\_\_\_  
Signature Title Date

\_\_\_\_\_  
Typed or Printed Name Provider ID Number

\_\_\_\_\_  
Provider Taxonomy Code

**Primary Care Physicians must complete the Primary Care Physician Agreement in order to have their managed care fees paid to a new group Provider ID Number. (See item 25)**

**FOR OFFICE USE ONLY**

Provider ID Number \_\_\_\_\_ Pending \_\_\_\_\_  
Taxonomy Code \_\_\_\_\_ Computer \_\_\_\_\_  
Provider Name \_\_\_\_\_ OK to Key \_\_\_\_\_  
Keyed \_\_\_\_\_  
Maintenance Checked \_\_\_\_\_

**SECTION V: PROVIDER GROUP AFFILIATIONS**

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Last Name First Name M. I. Title

\_\_\_\_\_  
Group Organization Name

\_\_\_\_\_  
Group Provider ID Number Effective Date (Applicant Joined Group)

\_\_\_\_\_  
Group Taxonomy Code Expiration Date (Applicant Left Group)

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Signature Title Date

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