



Division of Medical Services
Program Development & Quality Assurance



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TO: Arkansas Medicaid Health Care Providers – Dental
DATE: May 1, 2014
SUBJECT: Provider Manual Update Transmittal DENTAL-7-13

<u>REMOVE</u>		<u>INSERT</u>	
Section	Date	Section	Date
215.000	8-1-13	215.000	5-1-14
226.400	8-1-13	226.400	5-1-14
262.400	7-1-07	262.400	5-1-14

Explanation of Updates

Section 215.000 is updated to link to the new American Dental Association (ADA) claim form, ADA-J430.

Section 226.400 is updated to link to ADA-J430. It is also updated to remove Dental Unit contact information that is found in Section V of the provider manuals.

Section 262.400 is updated to link to ADA-J430. It is also updated with instructions for completing the new form.

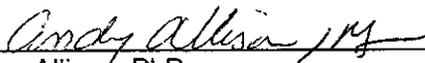
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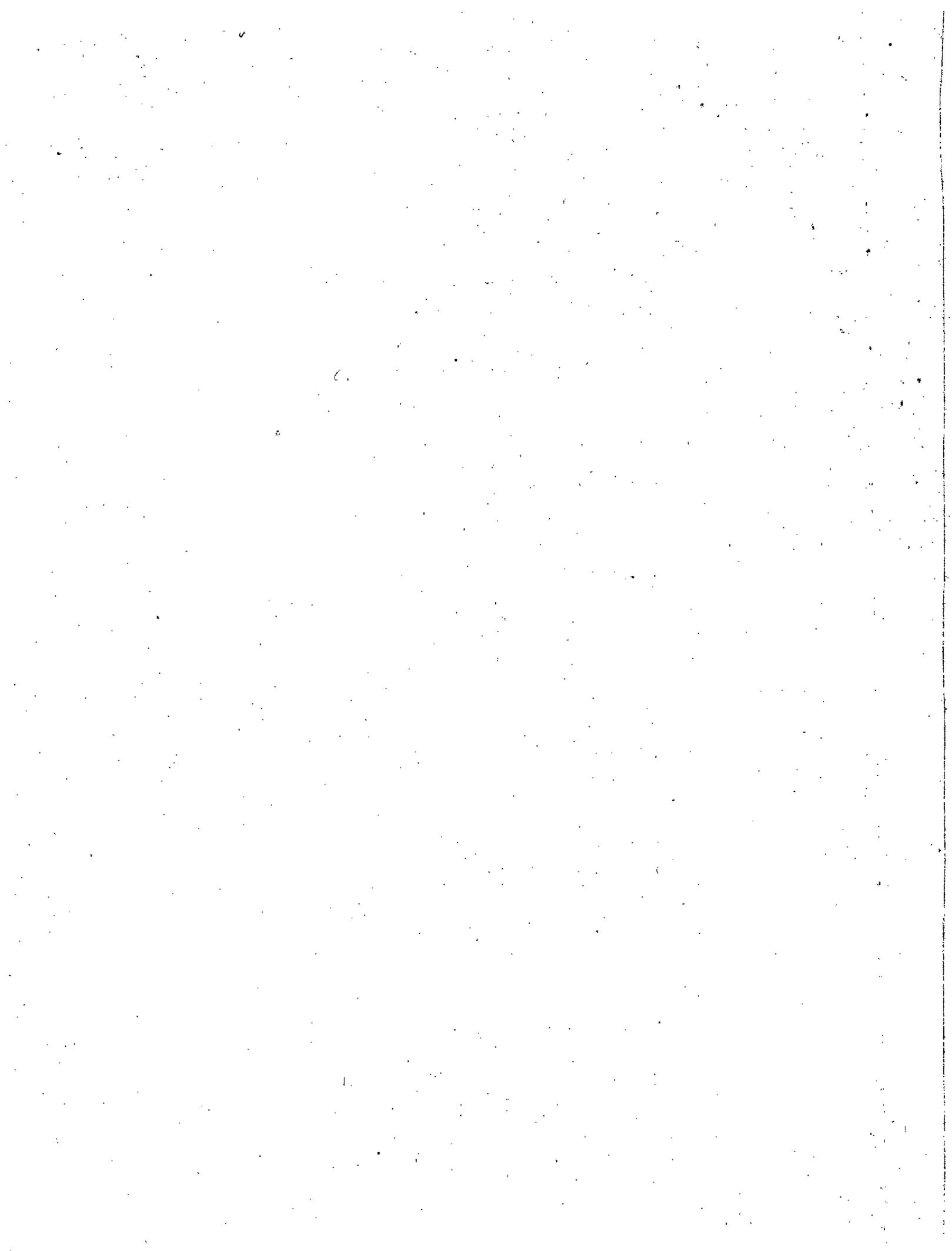
If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at 501-320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making 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.



Andrew Allison, PhD
Director



TOC not required**215.000 Child Health Services (EPSDT) Dental Screening 4-1-14**

The Child Health Services (EPSDT) periodic and interperiodic dental screening exams consist of an inspection of the oral cavity by a licensed dentist. The purpose of the dental screening exams is to check for obvious dental abnormalities and to assure access to needed dental care. Regular screening exams should be performed in accordance with the recommendations of the Child Health Services (EPSDT) periodicity schedule.

The Child Health Services (EPSDT) periodic dental screening exam is limited to two screening exams every six (6) months plus one (1) day for individuals under age 21. These benefits may be extended if documentation is provided that verifies medical necessity. See Section 262.100 to view the procedure code for periodic dental screening exams.

Individuals under age 21 enrolled in the EPSDT Program may receive an interperiodic dental screening exam twice per SFY. Extension of benefits is available in cases of medical necessity. **View or print form ADA-J430.** See Section 262.100 for the interperiodic dental screening exam procedure code.

NOTE: ARKids First-B beneficiaries may also receive an interperiodic dental screening exam twice per SFY. There is no extension of benefits for ARKids First-B beneficiaries.

Extension of benefits requests, in addition to a narrative and any supporting documentation, should be submitted to the Division of Medical Services Dental Care Unit – ATTN Dental Extension of Benefits. **View or print the Division of Medical Services Dental Care Unit contact information.**

Infant oral health care examinations must be based on the recommendations of the American Academy of Pediatric Dentistry. Essential elements of an infant oral health care visit are a thorough medical and dental history, oral examination, parental counseling, preventive health education and determination of appropriate periodic re-evaluation. See Section 201.500 for information regarding the dentist's role in the EPSDT Program.

226.400 Prior Authorization for Orthodontics 4-1-14

When requesting prior authorization for orthodontic services, the provider *must* complete and submit the Request for Orthodontic Treatment form (Form DMS-32-0), the ADA-J430 claim form for the orthodontic records and a written treatment plan along with the orthodontic records. **View or print form DMS-32-0. View or print form ADA-J430.**

Mail the requested information to the Division of Medical Services Dental Care Unit. For electronic submissions options, contact the Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

262.400 Billing Instructions - ADA Claim Form - Paper Claims Only 4-1-14

Dental providers must complete the ADA claim form when:

- A. Billing for services when using the ADA procedure codes
- B. Requesting prior authorization
- C. Approving prior authorization
- D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. **View or print the Division of Medical Services Dental Care Unit contact information.**

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the "Request for Payment for Services Provided" portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. **View or print the Division of Medical Services Dental Unit contact information.**

Completed claim forms should be forwarded to the HP Enterprise Services Claims Department. **View or print the HP Enterprise Services Claims Department contact information.**

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. **View or print form ADA-J430.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
HEADER INFORMATION	
1. Type of Transaction	Check one of the following: Statement of Actual Services EPSDT/Title XIX Request for Predetermination/Preauthorization
2. Predetermination/Preauthorization Number	If the procedure(s) being billed requires prior authorization and authorization is granted by the Medicaid Dental Program, enter the 10-digit PA control number assigned by the Medicaid Program.
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION	
3. Company/Plan Name, Address, City, State, Zip Code	Enter the carrier's name and address.
OTHER COVERAGE	
4. Dental? Medical?	Check the applicable box and complete items 5-11. If none, leave blank. (If both, complete 5-11 for dental only.)
5. Name of Policyholder/Subscriber in #4.	Enter Policyholder/Subscriber's name. Format: Last name, first name.

Field Number and Name	Instructions for Completion
6. Date of Birth	Enter Policyholder/Subscriber's date of birth. Format: MM/DD/CCYY.
7. Gender	Check M for male or F for female.
8. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
9. Plan/Group Number	Not required.
10. Patient's Relationship to Person Named in #5	Check one of the following: Self Spouse Dependent Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code	Enter the name and address of the other company providing dental or medical coverage.
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)	
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter the name and address of the policyholder/subscriber of the insurance identified in item 3.
13. Date of Birth	Enter the policyholder/subscriber's date of birth. Format: MM/DD/CCYY.
14. Gender	Check M for male or F for female.
15. Policyholder/Subscriber ID	Enter the Social Security number or ID number of the Policyholder/Subscriber.
16. Plan/Group Number	Enter the plan or group number for the insurance identified in item 3.
17. Employer Name	Not required.
PATIENT INFORMATION	
18. Relationship to Policyholder/Subscriber in #12 Above.	Check one of the following: Self Spouse Dependent Child Other
19. Reserved for Future Use	
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code	Enter last name, first name, middle initial, suffix, address, city, state and Zip code.
21. Date of Birth	Enter the patient's date of birth. Format: MM/DD/CCYY.
22. Gender	Check "M" for male or "F" for female.
23. Patient ID/Account # (Assigned by Dentist)	Enter the patient ID/Account # assigned by the dentist.

Field Number and Name	Instructions for Completion
RECORD OF SERVICES PROVIDED	
24. Procedure Date	Enter the date on which the procedure was performed. Format: MM/DD/CCYY.
25. Area of Oral Cavity	Not required.
26. Tooth System	Not required.
27. Tooth Number(s) or Letter(s)	Required if applicable. List only one tooth number per line.
28. Tooth Surface	Required if applicable. Enter one of the following: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F – Facial
29. Procedure Code	Required for Medicaid. These codes are listed in Section 262.100 for beneficiaries under age 21 or Section 262.200 for medically eligible beneficiaries age 21 and older.
29a. Diag. Pointer	Diagnosis Code Pointer. Enter A-D as applicable from item 34a.
29b. Qty.	Quantity. Indicates the number of units of the procedure code(s) listed in field 29.
30. Description	Required for Medicaid.
31. Fee	List the usual and customary fee.
31a. Other Fee(s)	Enter the total of payments previously received on this claim from any private insurance. Do not include amounts previously paid by Medicaid. Do not include in this total the automatically deducted Medicaid or ARKids First-B copayments.
32. Total Fee	Required for Medicaid. Enter the total fee charged.
33. Missing Teeth Information (Place an 'X' on each missing tooth)	Draw an X through the number of each missing tooth.
34. Diagnosis Code List Qualifier	Enter B for ICD-9-CM or AB for ICD-10-CM.
34a. Diagnosis Code(s) (Primary diagnosis in "A")	Enter up to four diagnosis codes in A-D. Enter the primary diagnosis in A.
35. Remarks	Not required.
AUTHORIZATIONS	
36. Agreement of responsibility	Patient or guardian must sign and date here.
37. Authorization of direct payment	Subscriber must sign and date here.
ANCILLARY CLAIM/TREATMENT INFORMATION	

Field Number and Name	Instructions for Completion
38. Place of Treatment (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")	Enter the two-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are: <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> 11–Office 12–Home 21–Inpatient Hospital 22–Outpatient Hospital 31–Skilled Nursing Facility 32–Nursing Facility </div> The full list is available online at http://www.cms.gov/PhysicianFeeSched/Downloads/Website POS database.pdf .
39. Enclosures (Y or N)	If there are enclosures such as radiographs, oral images or models, enter Y for Yes. If there are no enclosures, enter N for No.
40. Is Treatment for Orthodontics?	Check No or Yes. If No, skip items 41 and 42. If Yes, complete items 41 and 42.
41. Date Appliance Placed	Enter date appliance placed. Format: MM/DD/CCYY.
42. Months of Treatment Remaining	Enter months of orthodontic treatment remaining.
43. Replacement of Prosthesis	Check No or Yes. If Yes, complete item 44.
44. Date of Prior Placement	Enter the date of prior placement of the prosthesis. Format: MM/DD/CCYY.
45. Treatment Resulting from	Check one of the following, if applicable: Occupational illness/injury Auto accident Other accident If item 45 is applicable, complete item 46. If item 45 is "Auto accident," also complete item 47.
46. Date of accident	Enter date of accident. Format: MM/DD/CCYY.
47. Auto Accident State	Enter two-letter abbreviation for state in which auto accident occurred.
<i>BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)</i>	
48. Name, Address, City, State, Zip Code	Enter the name and address of the billing dentist or dental entity.
49. NPI	Not required.
50. License Number	Optional.
51. SSN or TIN	Optional.
52. Phone Number	Enter the 10-digit telephone number of the billing dentist or dental entity, beginning with area code.

Field Number and Name	Instructions for Completion
52a. Additional Provider ID	Enter the Dentist or Oral Surgeon's 9-digit Arkansas Medicaid billing provider number. The provider number should end with "08" for an individual Dentist number or "31" for a Dental group. The provider number should end in "79" for an individual Oral Surgeon number or "80" for an Oral Surgeon group.
TREATING DENTIST AND TREATMENT LOCATION INFORMATION	
53. Certification	The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
54. NPI	Not required.
55. License Number	Optional.
56. Address, City, State, Zip Code	Enter the complete address of the treating dentist.
56a. Provider Specialty Code	Indicates the type of dental professional who delivered the treatment. The general code listed as "Dentist" may be used instead of any of the other codes. For a complete list of codes, see the Provider Specialty table in the instructions accompanying the ADA-J430 claim form. View or print form ADA-J430.
57. Phone Number	Enter the 10-digit telephone number of the treating dentist, beginning with area code.
58. Additional Provider ID	If the billing provider number in Field 52a is a group or clinic ending in "31" for Dentists or "80" for Oral Surgeons, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual Dentist number or "79" for an individual Oral Surgeon number.



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TO: Arkansas Medicaid Health Care Providers – All Providers

DATE: May 1, 2014

SUBJECT: Provider Manual Update Transmittal SecV-1-13

REMOVE

Section	Date
500.000	—
ADA-J400	2006
—	—

INSERT

Section	Date
500.000	—
—	—
ADA-J430	2012

Explanation of Updates

Section 500.000 is updated to replace discontinued American Dental Association (ADA) claim form ADA-J400 with ADA-J430.

Form ADA-J400 has been discontinued.

Form ADA-J430 has been added to all provider manuals.

This transmittal and the enclosed form are for informational purposes only. **Please do not complete the enclosed form.**

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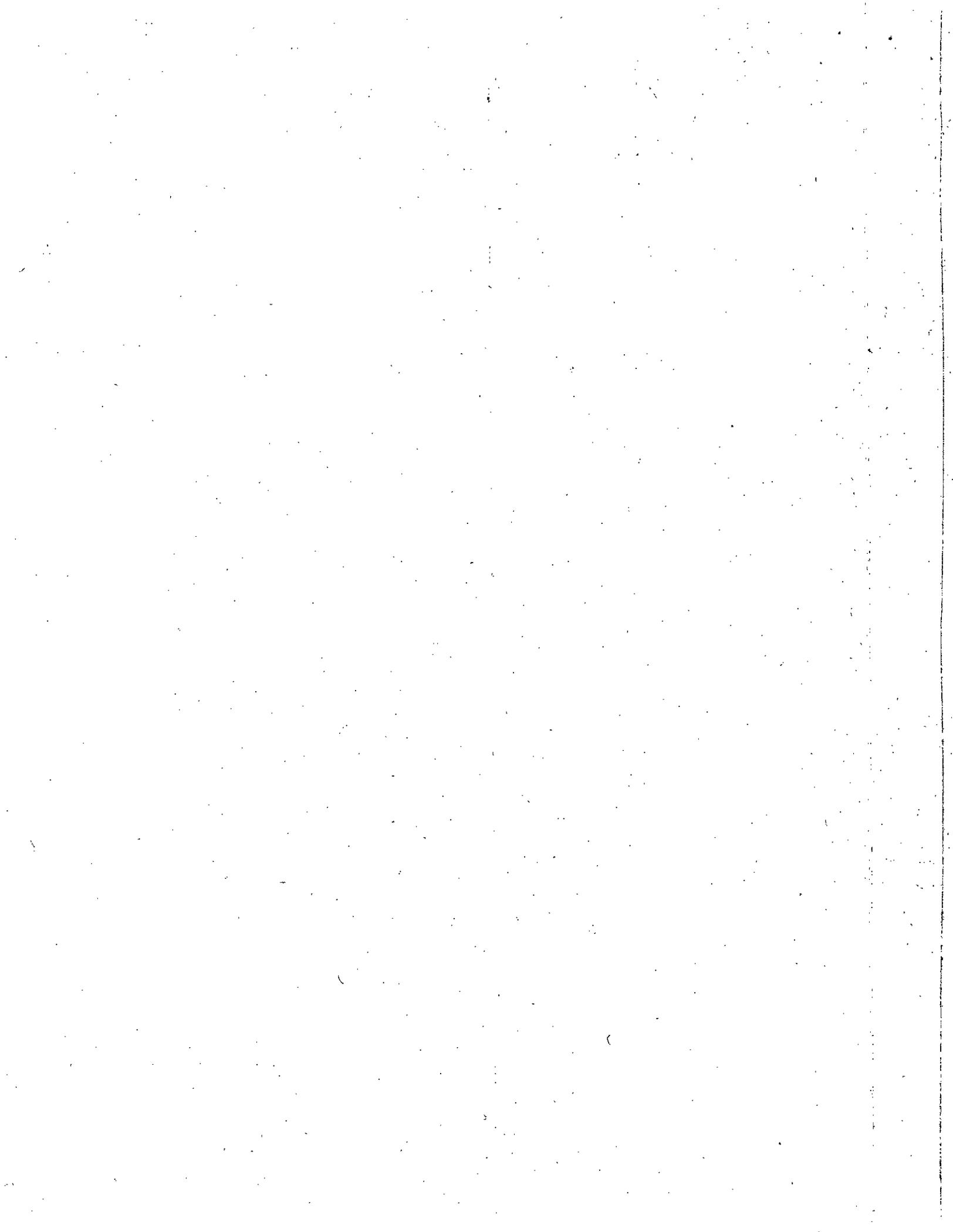
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SECTION V – FORMS**500.000****Claim Forms****Red-ink Claim Forms**

The following is a list of the red-ink claim forms required by Arkansas Medicaid. The forms below cannot be printed from this manual for use. Information about where to get the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
<u>Professional – CMS-1500</u>	Business Form Supplier
<u>Institutional – CMS-1450*</u>	Business Form Supplier
<u>Visual Care – DMS-26-V</u>	1-800-457-4454
<u>Inpatient Crossover – HP-MC-001</u>	1-800-457-4454
<u>Long Term Care Crossover – HP-MC-002</u>	1-800-457-4454
<u>Outpatient Crossover – HP-MC-003</u>	1-800-457-4454
<u>Professional Crossover – HP-MC-004</u>	1-800-457-4454

* For dates of service after 11/30/07 – ALL HOSPICE PROVIDERS USE ONLY FORM CMS-1450 (formerly UB-04) for billing.

Claim Forms

The following is a list of the non-red-ink claim forms required by Arkansas Medicaid. Information about where to get a supply of the forms and links to samples of the forms is available below. To view a sample form, click the form name.

Claim Type	Where To Get Them
<u>Alternatives Attendant Care Provider Claim Form - AAS-9559</u>	Client Employer
<u>Dental – ADA-J430</u>	Business Form Supplier

Arkansas Medicaid Forms

The forms below can be printed from this manual for use.

In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	<u>DMS-2606</u>
Address Change Form	<u>DMS-673</u>
Adjustment Request Form – Medicaid XIX	<u>HP-AR-004</u>
Adverse Effects Form	<u>DMS-2704</u>

Form Name	Form Link
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	<u>DMS-679A</u>
Amplification/Assistive Technology Recommendation Form	<u>DMS-686</u>
Application for WebRA Hardship Waiver	<u>DMS-7736</u>
Approval/Denial Codes for Inpatient Psychiatric Services	<u>DMS-2687</u>
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	<u>DDS/FS#0001.a</u>
ARKids First Mental Health Services Provider Qualification Form	<u>DMS-612</u>
Authorization for Automatic Deposit	<u>autodeposit</u>
Authorization for Payment for Services Provided	<u>MAP-8</u>
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	<u>DMS-2633</u>
Certification of Schools to Provide Comprehensive EPSDT Services	<u>CSPC-EPSDT</u>
Certification Statement for Abortion	<u>DMS-2698</u>
Change of Ownership Information	<u>DMS-0688</u>
Child Health Management Services Enrollment Orders	<u>DMS-201</u>
Child Health Management Services Discharge Notification Form	<u>DMS-202</u>
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	<u>DMS-699A</u>
CHMS Request for Prior Authorization	<u>DMS-102</u>
Claim Correction Request	<u>DMS-2647</u>
Consent for Release of Information	<u>DMS-619</u>
Contact Lens Prior Authorization Request Form	<u>DMS-0101</u>
Contract to Participate in the Arkansas Medical Assistance Program	<u>DMS-653</u>
DDTCS Transportation Log	<u>DMS-638</u>
DDTCS Transportation Survey	<u>DMS-632</u>
Dental Treatment Additional Information	<u>DMS-32-A</u>
Disclosure of Significant Business Transactions	<u>DMS-689</u>
Disproportionate Share Questionnaire	<u>DMS-628</u>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	<u>DMS-693</u>
Early Childhood Special Education Referral Form	<u>ECSE-R</u>
EPSDT Provider Agreement	<u>DMS-831</u>
Explanation of Check Refund	<u>HP-CR-002</u>
Gait Analysis Full Body	<u>DMS-647</u>
Home Health Certification and Plan of Care	<u>CMS-485</u>

Form Name	Form Link
Hospital/Physician/Certified Nurse Midwife Referral for Newborn Infant Medicaid Coverage	<u>DMS-645</u>
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	<u>DMS-2685</u>
Individual Renewal Form for School-Based Audiologists	<u>DMS-7782</u>
Lower-Limb Prosthetic Evaluation	<u>DMS-650</u>
Lower-Limb Prosthetic Prescription	<u>DMS-651</u>
Media Selection/E-Mail Address Change Form	<u>HP-MS-005</u>
Medicaid Claim Inquiry Form	<u>HP-CI-003</u>
Medicaid Form Request	<u>HP-MFR-001</u>
Medical Equipment Request for Prior Authorization & Prescription	<u>DMS-679</u>
Medical Transportation and Personal Assistant Verification	<u>DMS-616</u>
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	<u>DMS-633</u>
Notice Of Noncompliance	<u>DMS-635</u>
NPI Reporting Form	<u>DMS-683</u>
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	<u>DMS-640</u>
Ownership and Conviction Disclosure	<u>DMS-675</u>
Personal Care Assessment and Service Plan	<u>DMS-618 English</u> <u>DMS-618 Spanish</u>
Practitioner Identification Number Request Form	<u>DMS-7708</u>
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	<u>DMS-2615</u>
Primary Care Physician Managed Care Program Referral Form	<u>DMS-2610</u>
Primary Care Physician Participation Agreement	<u>DMS-2608</u>
Primary Care Physician Selection and Change Form	<u>DMS-2609</u>
Procedure Code/NDC Detail Attachment Form	<u>DMS-664</u>
Provider Application	<u>DMS-652</u>
Provider Communication Form	<u>AAS-9502</u>
Provider Data Sharing Agreement – Medicare Parts C & D	<u>DMS-652-A</u>
Provider Enrollment Application and Contract Package	<u>Application Packet</u>
Quarterly Monitoring Form	<u>AAS-9506</u>
Referral for Audiology Services – School-Based Setting	<u>DMS-7783</u>
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	<u>DMS-2634</u>
Referral for Medical Assistance	<u>DMS-630</u>

Form Name	Form Link
Request for Appeal	<u>DMS-840</u>
Request for Extension of Benefits	<u>DMS-699</u>
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	<u>DMS-671</u>
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	<u>DMS-602</u>
Request for Molecular Pathology Laboratory Services	<u>DMS-841</u>
Request For Orthodontic Treatment	<u>DMS-32-0</u>
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	<u>DMS-2692</u>
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	<u>DMS-601</u>
Research Request Form	<u>HP-0288</u>
Service Log – Personal Care Delivery and Aides Notes	<u>DMS-873</u>
Sterilization Consent Form	<u>DMS-615 English</u> <u>DMS-615 Spanish</u>
Sterilization Consent Form – Information for Men	<u>PUB-020</u>
Sterilization Consent Form – Information for Women	<u>PUB-019</u>
Upper-Limb Prosthetic Evaluation	<u>DMS-648</u>
Upper-Limb Prosthetic Prescription	<u>DMS-649</u>
Vendor Performance Report	<u>Vendorperformreport</u>
Verification of Medical Services	<u>DMS-2618</u>

In order by form number:

<u>AAS-9502</u>	<u>DMS-2618</u>	<u>DMS-618</u>	<u>DMS-664</u>	<u>ECSE-R</u>
<u>AAS-9506</u>	<u>DMS-2633</u>	<u>English</u>	<u>DMS-671</u>	<u>HP-0288</u>
<u>AAS-9559</u>	<u>DMS-2634</u>	<u>DMS-618</u>	<u>DMS-675</u>	<u>HP-AR-004</u>
<u>Address</u>	<u>DMS-2647</u>	<u>Spanish</u>	<u>DMS-673</u>	<u>HP-CI-003</u>
<u>Change</u>	<u>DMS-2685</u>	<u>DMS-619</u>	<u>DMS-679</u>	<u>HP-CR-002</u>
<u>Autodeposit</u>	<u>DMS-2687</u>	<u>DMS-628</u>	<u>DMS-679A</u>	<u>HP-MFR-001</u>
<u>CMS-485</u>	<u>DMS-2692</u>	<u>DMS-630</u>	<u>DMS-683</u>	<u>HP-MS-005</u>
<u>CSPC-EPSDT</u>	<u>DMS-2698</u>	<u>DMS-632</u>	<u>DMS-686</u>	<u>MAP-8</u>
<u>DCO-645</u>	<u>DMS-2704</u>	<u>DMS-633</u>	<u>DMS-689</u>	<u>Performance</u>
<u>DDS/FS#0001.a</u>	<u>DMS-32-A</u>	<u>DMS-635</u>	<u>DMS-693</u>	<u>Report</u>
<u>DMS-0101</u>	<u>DMS-32-0</u>	<u>DMS-638</u>	<u>DMS-699</u>	<u>Provider</u>
<u>DMS-0688</u>	<u>DMS-601</u>	<u>DMS-640</u>	<u>DMS-699A</u>	<u>Enrollment</u>
<u>DMS-102</u>	<u>DMS-602</u>	<u>DMS-647</u>	<u>DMS-7708</u>	<u>Application</u>
<u>DMS-201</u>	<u>DMS-612</u>	<u>DMS-648</u>	<u>DMS-7736</u>	<u>and Contract</u>
<u>DMS-202</u>	<u>DMS-615</u>	<u>DMS-649</u>	<u>DMS-7782</u>	<u>Package</u>
<u>DMS-2606</u>	<u>English</u>	<u>DMS-650</u>	<u>DMS-7783</u>	<u>PUB-019</u>
<u>DMS-2608</u>	<u>DMS-615</u>	<u>DMS-651</u>	<u>DMS-831</u>	<u>PUB-020</u>
<u>DMS-2609</u>	<u>Spanish</u>	<u>DMS-652</u>	<u>DMS-840</u>	
<u>DMS-2610</u>	<u>DMS-616</u>	<u>DMS-652-A</u>	<u>DMS-841</u>	
<u>DMS-2615</u>		<u>DMS-653</u>	<u>DMS-873</u>	

Arkansas Medicaid Contacts and Links

Click the link to view the information.

[American Hospital Association](#)

[Americans with Disabilities Act Coordinator](#)

[Arkansas Department of Education, Health and Nursing Services Specialist](#)

[Arkansas Department of Education, Special Education](#)

[Arkansas Department of Human Services, Division of Aging and Adult Services](#)

[Arkansas Department of Human Services, Appeals and Hearings Section](#)

[Arkansas Department of Human Services, Division of Behavioral Health Services](#)

[Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit](#)

[Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit](#)

[Arkansas Department of Human Services, Children's Services](#)

Arkansas Department of Human Services, Division of County Operations, Customer Assistance Section

Arkansas Department of Human Services, Division of Medical Services

Arkansas DHS, Division of Medical Services Director

Arkansas DHS, Division of Medical Services, Benefit Extension Requests, UR Section

Arkansas DHS, Division of Medical Services, Dental Care Unit

Arkansas DHS, Division of Medical Services, HP Enterprise Services Provider Enrollment Unit

Arkansas DHS, Division of Medical Services, Financial Activities Unit

Arkansas DHS, Division of Medical Services, Hearing Aid Consultant

Arkansas DHS, Division of Medical Services, Medical Assistance Unit

Arkansas DHS, Division of Medical Services, Medical Director for Clinical Affairs

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

Arkansas DHS, Division of Medical Services, Program Integrity Unit (PI)

Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit

Arkansas DHS, Division of Medical Services, Third-Party Liability Unit

Arkansas DHS, Division of Medical Services, UR/Home Health Extensions

Arkansas DHS, Division of Medical Services, Utilization Review Section

Arkansas DHS, Division of Medical Services, Visual Care Coordinator

Arkansas Department of Health

Arkansas Department of Health, Health Facility Services

Arkansas Department of Human Services, Accounts Receivable

Arkansas Foundation For Medical Care

Arkansas Hospital Association

ARKids First-B

ARKids First-B ID Card Example

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

CPT Ordering

Dental Contractor

HP Enterprise Services Claims Department

HP Enterprise Services EDI Support Center (formerly AEVCS Help Desk)

HP Enterprise Services Inquiry Unit

HP Enterprise Services Manual Order

HP Enterprise Services Pharmacy Help Desk

[HP Enterprise Services Provider Assistance Center \(PAC\)](#)

[HP Enterprise Services Supplied Forms](#)

[Example of Beneficiary Notification of Denied ARKids First-B Claim](#)

[Example of Beneficiary Notification of Denied Medicaid Claim](#)

[First Connections Infant & Toddler Program, Developmental Disabilities Services](#)

[Flow Chart of Intake and Prior Authorization Process For Intervention/Treatment](#)

[Health Care Declarations](#)

[ICD-9-CM, CPT, and HCPCS Reference Book Ordering](#)

[Immunizations Registry Help Desk](#)

[Medicaid ID Card Example](#)

[Medicaid Managed Care Services \(MMCS\)](#)

[Medicaid Reimbursement Unit Communications Hotline](#)

[Medicaid Tooth Numbering System](#)

[National Supplier Clearinghouse](#)

[Partners Provider Certification](#)

[Primary Care Physician \(PCP\) Enrollment Voice Response System](#)

[Provider Qualifications, Division of Behavioral Health Services](#)

[QSource of Arkansas](#)

[Select Optical](#)

[Standard Register](#)

[Table of Desirable Weights](#)

[U.S. Government Printing Office](#)

[ValueOptions](#)

[Vendor Performance Report](#)

