ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480 ·

OFFICIAL NOTICE

TO: **Health Care Provider – Dental**

DATE: **May 1, 2011**

SUBJECT: **Dental Provider Enrollment**

Children's Health Insurance Program (CHIP) legislation requires that states post information regarding dental providers' acceptance of new Medicaid or CHIP patients, dental providers' ability to handle special needs patients and the age range of patients accepted by dental providers. Arkansas Medicaid will collect this information from the provider enrollment application and disseminate this information via the web screen in the provider portal on the Medicaid Web site.

Dental providers must:

- Answer "yes" or "no" as to whether they will be accepting new Medicaid or CHIP patients. If a provider fails to answer, their response will be defaulted to "yes" at the time of enrollment.
- Answer "yes" or "no" as to whether they are equipped to handle special needs patients. If a provider fails to answer, their response will be defaulted to "yes" at the time of enrollment.
- Indicate an accepted age range of 0-99. If a provider fails to enter an age range, their response will be defaulted to 0-99 at the time of enrollment.

This information can be updated at any time through the Arkansas Medicaid Website or the provider's enrollment application.

If you have questions regarding this notice, please contact the HP Enterprise Services Provider Assistance Center at In-State WATS 1-800-457-4454, or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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

Thank you for your participation in the Arkansas Medicaid Program.

Eugene I. Gessow, Director

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501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **May 1, 2011**

SUBJECT: **Provider Manual Update Transmittal #SECV-1-11**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
DMS-652	01/11	DMS-652	05/11

Explanation of Updates

Form DMS-652 is updated to include questions regarding dental providers' acceptance of new Medicaid or CHIP patients, dental providers' ability to handle special needs patients and the age range of patients accepted by dental providers.

The paper version of this update transmittal includes revised pages that may be filed 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 have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-0593 (Local); 1-800-482-5850, extension 2-0593 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Eugene I. Gessow, 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
HP Enterprise Services
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	-	Dental Providers Only
Section V	-	Provider Group Affiliations
Electronic Fund Transfer	-	All Providers (optional)
Managed Care Agreement	-	Primary Care Physician
W-9 Tax Form	-	All Providers
Contract	-	All Providers
Ownership and Conviction Disclosure	-	All Providers
Disclosure of Significant Business Transactions	-	All Providers

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, <u>BUT NOT BOTH</u>.

_____ _____ ____ _____
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 **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
5 = Private, for profit
6 = Private, non-profit **<u>* copy of Tax Form 501 (c) (3) must accompany this application</u>**
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.

_____

_____ _____ _____
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) 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 _____

(l) _____ _____ _____
Provider ID Number Effective Date End Date

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

(3) _____
Specialty of Practice or Taxonomy Code

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.

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				

(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) _____

Code	Category Description
N3	Advanced Practice Nurse – Pediatrics
N4	Advanced Practice Nurse – Women's Health
N6	Advanced Practice Nurse – Family
N7	Advanced Practice Nurse – Adult/Gerontological
N8	Advanced Practice Nurse – Psychiatric Mental Health
N9	Advanced Practice Nurse – Acute Care
N0	Advanced Practice Nurse– Nurse Practitioner - Other
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
C1	Cancer Screen (Health Dept. Only)
C2	Cancer Treatment (Health Dept. Only)
06	Cardiovascular Disease
C4	Child Health Management Services
CF	Child Health Management Services – Foster Care
35	Chiropractor
C8	Communicable Diseases (Health Dept. Only)
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 Supportive Living
H8	DDS ACS Waiver Crisis Abatement Services
HG	DDS ACS Waiver Crisis Center – Intervention Services
H9	DDS ACS Waiver Consultation Services
IC	DDS ACS Waiver IndependentChoices
HF	DDS ACS Waiver Organized HealthCare
N5	DDS Non-Medicaid
V2	Dental
V1	Dental Clinic (Health Dept. Only)
V0	Dental - Mobile Dental Facility
X5	Dental - Oral Surgeon
V6	Dental - Orthodontia
07	Dermatology
V3	Developmental Day Treatment Center
DR	Developmental Rehabilitation Services
V5	Domiciliary Care
CN	DYS/TCM Group
CO	DYS/TCM Performing
E4	ElderChoices H&CB 2176 Waiver - Chore services
E5	ElderChoices H&CB 2176 Waiver - Adult Family Homes
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

(10) Provider Category (Continued)

Code	Category Description
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
W6	Hospital – Inpatient
W7	Hospital - Outpatient
CH	Hospital – Critical Access
IH	Hospital – Indian Health Services
IS	Hospital – Indian Health Services Freestanding
P7	Hospital - Pediatric Inpatient
P8	Hospital - Pediatric Outpatient
R7	Hospital - Rural Inpatient
HN	Hyperalimentation Enteral Nutrition – Sole Source
H4	Hyperalimentation Parenteral Nutrition – Sole Source
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
W9	Intermediate Care Facility – Infant Infirmaries
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
NI	Nuclear Medicine
N2	Nurse Midwife
N3	Nurse Practitioner – Pediatric
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
X2	Optical Dispensing Contractor
X4	Optometrist
X6	Orthopedic
12	Osteopathy - Manipulative Therapy
X7	Osteopathy - Radiation Therapy
X8	Otology
X9	Otorhinolaryngology

(10) Provider Category (Continued)

Code	Category Description
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
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
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
SO	School District Outreach for ARKids
S5	Skilled Nursing Facility
W8	Skilled Nursing Facility – Special Services
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

(10) Provider Category (Continued)

Code	Category Description
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
TD	Transportation - Broker
TC	Transportation - Non-Emergency
TH	Tuberculosis (Health Dept. Only)
34	Urology
V7	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	[]
**B	=	teaching facility/university only	[]
***C	=	UR plan only	[]
D	=	A/B	[]
E	=	A/C	[]
F	=	B/C	[]
G	=	A/B/C	[]
N	=	No special program	[]

* 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 ______________________
Taxonomy Code ______________________
Provider Name ______________________

Pending ______________________
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 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

______________________ ______________________
License/Registration Number | Effective Date of employment

______________________ ______________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist | Social Security Number | ______ yes ______ no

______________________ ______________________
License/Registration Number | Effective Date of employment

______________________ ______________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist | Social Security Number | ______ yes ______ no

______________________ ______________________
License/Registration Number | Effective Date of employment

______________________ ______________________ Administering Vaccines (see above)
Name of Pharmacist/ Registered Respiratory Therapist | Social Security Number | ______ yes ______ no

______________________ ______________________
License/Registration Number | Effective Date of employment

FOR OFFICE USE ONLY

Provider ID Number _____ Pending _____
Taxonomy Code _____ Computer _____
OK to Key _____
Provider Name _____ 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 _____
OK to Key _____
Provider Name _____ 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 _____
OK to Key _____
Provider Name _____ 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.

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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)