

**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 | - | All Providers (optional) |
| Managed Care Agreement | - | Primary Care Physician |
| W-9 Tax Form | - | All Providers |
| Contract | - | 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, 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

(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

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 Integrated Support
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 IndependentChoice
HF	DDS ACS Waiver Organized HealthCare
N5	DDS Non-Medicaid
V2	Dental
VI	Dental Clinic (Health Dept. Only)
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 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

(10) Provider Category (Continued)

Code	Category Description
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
RA	Independent X-Ray
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	Larynology
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 Medicare/Medicaid Crossover Only
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
36	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
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 | <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.

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 ID Number _____	Pending _____
Taxonomy Code _____	Computer _____
Provider Name _____	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

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

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 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.

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Group Organization Name

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Group Taxonomy Code Expiration Date (Applicant Left Group)

City State Zip Code

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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 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)

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 _____

Provider ID # _____ Taxonomy Code _____

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 hereby authorize the Arkansas Medicaid Program/Title XIX, to initiate credit entries to my bank account as indicated above and the depository named above to credit the same to such account. I understand I am responsible for the validity on this form.

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. 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 have the option of enrolling in the Child Health Services (EPSDT) program, please review the Primary Care Physicians policy **in Section I of your Arkansas Medicaid Provider manual.**

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 recipients you are willing to accept for primary care services. (a maximum of 1000): _____

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 **Provider ID Number** and **Taxonomy Code** (individual or group) for payment of your management fee and inclusion on a Federal 1099 Tax Form: _____

Provider ID Number

Taxonomy Code

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.**

Primary Care Physician Provider ID Number

Primary Care Physician Signature

Date

Primary Care Physician Taxonomy Code

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 **provider's** 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 **beneficiaries. School Based Child Health providers are excluded from this requirement as they provide services only to those beneficiaries enrolled in their individual school.**

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

Provider Original Signature

Provider Identification Number/Taxonomy Code

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 PROVIDER ID NUMBER WILL BE ISSUED AND LINKED WITH EACH INDIVIDUAL'S PROVIDER ID NUMBER WITHIN THAT GROUP. THE CLINIC PROVIDER ID NUMBER MUST BE PLACED IN THE PAY TO FIELD AND THE INDIVIDUAL PROVIDER ID 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.*

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Ownership and Conviction Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full and accurate disclosure of ownership and financial interests is required. Failure to submit **full and accurate** requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, attach the information at the end of the provider application before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. (Example: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported).

Ownership or control interest: a person or corporation that: (1) has an ownership interest totaling 5 percent or more in a disclosing entity; (2) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (3) has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity; (4) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (5) is an officer or director of a disclosing entity that is organized as a corporation; or (6) is a partner in a disclosing entity that is organized as a partnership.

Ownership Interest: equity in the capital, stock, or profits of the disclosing entity. To determine the percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in

the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. (Example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 6% and must be reported. If B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported).

Managing employee: a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/ persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either \$25,000 or 5 percent of a provider's total operating expenses.

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, address and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or control interest of 5% or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. [This applies to all Medicaid providers.]

Individuals – for each individual listed, provide date of birth and social security number

Name	Address	% of interest	DOB	SS#
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Corporations/Limited Liability Companies/Partnerships/Other legal Entities or Organizations – for each legal entity or organization listed, provide the tax identification number and submit a copy of the legal entity or organization's IRS form SS4 and the approval letter with this application.

Name	Address	% of interest	Tax ID #
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are any of the above mentioned persons related to each other as a spouse, parent, child, or sibling? Yes _____ No _____ If yes, print name and provide relationship.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Do any of the persons, legal entities or organizations with an ownership or control interest have any ownership or control interest of 5% or more in any other entity doing business with the Arkansas Medicaid Program? Yes _____ No _____ If yes, print name and give other provider name and percentage of interest.

Name	Other Provider	% of Interest
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)**

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

List the name, address, date of birth, and social security number for any person who is a managing employee of the named entity:

Name	Address	DOB	SS#
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any person who has a direct or indirect ownership or control interest in the named entity, or is an agent, or managing employee of the named entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs in any state:

Name	Offense
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List names of persons or entities with direct/indirect ownership or control interest in the named entity, or is an agent or managing employee of the named entity who, as listed in DHS Policy 1088 (Participant Exclusion Rule), has been found guilty, or pled guilty or nolo contendere, to any crime related to: (1) obtaining, attempting to obtain, or performing a public or private contract or subcontract, (2) embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, (3) dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony, (4) federal antitrust statutes, (5) the submission of bids or proposals, (6) any physical or sexual abuse or neglect when the offense is a felony.

Name	Offense
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Ownership and Conviction Disclosure
DHS Division of Medical Services, Title XIX (Medicaid)
[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Provider Statement:

“By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.”

Name: _____
(Print or Type)

Title: _____
(Print or Type)

Signature: _____

Date: _____

Disclosure of Significant Business Transactions
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Significant Business Transactions Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full, **complete** and accurate disclosure of ownership and financial interests is required. Failure to submit requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, please attach the information at the end of the application **for new enrollments, or attached to the form for updated information from existing providers**, before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program.

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either \$25,000 or 5 percent of a provider's total operating expenses.

Disclosure of Significant Business Transactions
DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, subpart B: Disclosure of Information by Providers and Fiscal Agents]

DISCLOSURE OF SIGNIFICANT BUSINESS TRANSACTIONS

Submit full, **accurate** and complete disclosure concerning the following information:

- 1) Ownership of any subcontractor with whom the named entity has had business transactions totaling more than \$25,000 during the last 12 months (12 month period ending as of the date on this application).

- 2) Any significant business transaction between the named entity and any wholly owned supplier in the last 5 years (5 year period ending as of the date of this application).

- 3) Any significant business transaction between the named entity and any subcontractor in the last 5 years (5 year period ending as of the date of this application).

Beginning on the effective date of enrollment in the Arkansas Medicaid Program, full, **accurate and complete disclosure shall be submitted concerning any significant business transaction that occurs between the named entity and any subcontractor or wholly owned supplier. This information shall be submitted within 35 days of the date the transaction takes place.**

Provider Statement:

“By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security.”

Name: _____
(Print or Type)

Title: _____
(Print or Type)

Signature: _____

Date: _____

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 Human Services, hereafter called Department:

1. Provider, in consideration of the covenants therein, agrees:
 - A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services
 - B. To make available and, upon request, furnish all records described above to 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 a designated agent or representative of any entity entitled to records. 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) established 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 a peer reviewer; 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 **without cause and/or convenience of either 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) Returned mail
 - 2) Death of provider
 - 3) Change of ownership
 - 4) **Or other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual.**

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.

Provider Name: _____
 (As inscribed on previous page of contract)

Provider

Provider Enrollment

By: _____
 (Signature Required)

By: _____
 (Signature)

Name: _____
 (Typed or Printed Name Required)

Name: _____
 (Typed Name)

Title: _____
 (Required)

Title: _____

Date: _____
 (Required)

Date: _____

Effective Date of Contract: _____