



Arkansas Department of Human Services
Division of Medical Services
EDS Provider Enrollment Unit

P.O. Box 8105
Little Rock, Arkansas 72203-8105
Telephone (501) 376-2211 FAX (501) 374-0746

INDIVIDUAL RENEWAL FORM FOR SCHOOL BASED THERAPISTS

Provider Name _____
(Please Print)

Provider Number _____

Please list the school district and provider number where services have been rendered:

School District

Provider Number

Please read the following statement:

During the past year, I have only provided services for Arkansas Medicaid Recipients in the School District listed above. I am requesting to have my provider number remain active for 2006 on the contingency that I keep my file updated with the Arkansas Medicaid Provider Enrollment Unit.

Signature _____

Date _____

Note: A photocopy or stamped signature is not acceptable and the only signature valid for an individual provider is their own.

Please return this form to:

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