FOR OFFICE USE ONLY

Provider ID Number:		Pending:	
Taxonomy Code:		Computer:	
Specialty Code:		OK to Key:	
Provider Type:		Keyed:	
		Maintenance	
Effective Date:		Checked:	

SECTION I: ALL PROVIDERS

This section **MUST** be completed by all providers.

(1) **Date of Application:** Enter the current date in month/day/year format.

_____/_____/_____
MM DD Year

(2) **Last Name, First Name, Middle Initial, and Title:** Enter the legal name of the applicant. The title spaces are reserved for designations such as MD, DDS, CRNA or OD. If the space is insufficient, please abbreviate.

If entering any other name such as an organization, corporation or facility, enter the full name of the entity in item 3. NOTE: Item 2 or 3 must be completed, BUT NOT BOTH.

Last Name First Name M.I. Title

(3) **Group, Organization or Facility Name:** Enter full name of the entity.
Examples: John R. Doe, PA; Adam B. Corn, Inc.; Arkansas Emer. Phys. Group; Pulaski County Hospital; John Thompson, M. D., DBA Thompson Clinic

Corporation Name

Fictitious Name (Doing Business As)
Must submit documentation that the above fictitious name is registered with the appropriate board within your state (i.e., Secretary of State's, County Clerk) of the county in which the corporation's registered office is located.

(4) **Application Type:** Circle one of the following codes which coincide with fields 2 or 3. Each application type listed below will be required to complete Disclosure Forms (**DMS-675** – Ownership and Conviction Disclosure and **DMS-689** – Disclosure of Significant Business Transactions.)

***NOTE: IF THE FORMS ARE NOT COMPLETED AND ATTACHED, THE APPLICATION WILL BE DENIED.**

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** School Address

(A) Enter the applicant's service location address, include suite number if applicable. THIS FIELD IS MANDATORY.

_____

(B) Enter any additional street address. (SHOULD 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

(8) **Billing Street Address** Therapist Address

(A) 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

(B) **Provider Manuals and Updates**

Please review Section I sub-section 101.000; 101.200; and 101.300 in your Arkansas Medicaid provider manual regarding provider manuals and updates. Providers will receive emails notifying them of applicable manual updates, official notices, notices of rule making and provider memos that are available on the Arkansas Medicaid website (https://medicaid.mmis.arkansas.gov/). The website is updated weekly.

Email address:_____

When providing your email address, please do the following:

- Please ensure your email address is legible.
- Use a generic email address that more than one person can access (e.g., xyzclinic@yahoo.com instead of janedoe@yahoo.com). Email addresses often become outdated when an individual leaves a practice or clinic.
- Make sure the email address will accept email from 'dxc.com'. You may have to instruct your network administrator or email provider to accept emails from 'dxc.com'. *Arkansas Medicaid* sends email in bulk and some email services block bulk email unless instructed otherwise.

If Internet access is not yet available in your area, please write "no access" in the email address field above. You will receive a paper copy of applicable manual updates, official notices, notices of rule making and provider memos in the mail.

(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
A4	Ambulatory Surgical Center
AA	Adolescent Medicine
05	Anesthesiology
AV	Autism Intensive Intervention Provider
AW	Autism Consultant
AX	Autism Lead/Line Therapist
AZ	Autism Clinical Service Specialist
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	ACS Waiver Environmental Modifications/Adaptive Equipment
HB	ACS Waiver Specialized Medical Supplies
HC	ACS Waiver Case Management/Transitional Case Management/Community Transition Services
HE	ACS Waiver Supported Employment
H7	ACS Waiver Supportive Living/Respite/Supplemental Support
HG	ACS Waiver Crisis Intervention
H9	ACS Waiver Consultation Services
IC	IndependentChoices
HF	ACS Waiver Organized HealthCare Delivery System
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	ARChoices in Homecare Waiver - Environmental Modifications
E5	ARChoices in Homecare Waiver - Adult Family Homes
E6	ARChoices in Homecare Waiver - Attendant Care
E7	ARChoices in Homecare Waiver - Home delivered hot meals
EC	ARChoices in Homecare Waiver - Home delivered frozen meals
E8	ARChoices in Homecare Waiver - Personal emergency response systems
E9	ARChoices in Homecare Waiver - Adult day care
EA	ARChoices in Homecare Waiver - Adult day health care
EB	ARChoices in Homecare Waiver - Respite care
E1	Emergency Medicine

OT - T6
COTA - TO
PT - T1
PTA - TP
SLP - T2
SLPA - TS.

(10) Provider Category (Continued)

Code	Category Description
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 fields 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 [X]

← only if speech (ASHA)

(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.

0 6 / 3 0
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 and Dental Surgeons
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**.

____ ____ ____ ____ ____ ____ ____ ____ ____ ____

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.**

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
___ – ___ – ____

Employer identification number
__ – _____

Part II 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, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, 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. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

Authorization for Electronic Funds Transfer
(Automatic Deposit)

Dear Provider:

Effective November 1, 2017, Provider Enrollment will no longer accept provider enrollment applications without a completed authorization for **Electronic Funds Transfer (EFT)**. Providers must utilize EFT, which allows your Medicaid payments to be directly deposited into your bank account. In addition to providing more secure payment and decreased administrative costs, 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. Additionally, please verify that your Remittance Advice is set to electronic delivery. Arkansas Medicaid appreciates your cooperation in allowing us to become more efficient and more environmentally friendly.

When enrolling as a Medicaid provider, you must complete the Authorization for Electronic Funds Transfer form and attach a **VOIDED CHECK OR A LETTER FROM THE BANK REFLECTING THE BANK'S ABA NUMBER AND YOUR ACCOUNT NUMBER** to have your Medicaid payment automatically deposited.

If you have any further questions concerning this letter, please contact the Provider Assistance Center at 501-376-2211 (local or out-of-state) or 1-800-457-4454 (in-state WATS).

Sincerely,

Arkansas Department of Human Services

Authorization for Electronic Funds Transfer
(Automatic Deposit)

Name of Medicaid Provider _____

Provider ID # Put NPI # if No medid. Taxonomy Code _____

Put MedId if reactivating an expired #.

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
DXC Technology
P.O. Box 8105
Little Rock, AR 72203-8105

(Rev. 11/1/17)

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, physical address and PO Box address and each location, complete Social Security Number 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 COMPLETE Social Security Number

Full Name	Date of Birth	Complete Primary Address and PO Box Address	% of Interest	Complete Social Security Number
Therapist Name	DOB	Therapist address.	100%	SSN

Corporations/Limited Liability Companies/Partnerships/Other Legal Entities or *Organizations* – for each legal entity or organization listed, provide the Tax ID Number and submit a copy of the legal entity or organization's IRS form SS4 and the approval letter with this application. Companies must include each business address location with complete addresses.

Name	Complete Primary Address and PO Box Address with Each Business Location	% of Interest	Tax ID Number
NA			

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
NA	

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?

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]

Yes_____ No ✓ If yes, print name, address and Tax ID Number and amount of % of interest they own.

Name	Complete Primary Address and PO Box Address with Each Business Location	% of Interest	Tax ID Number
N/A			

List the name, address, date of birth, and complete Social Security Number for any person who is a managing employee of the named entity. For larger corporations having more than 3 managing employees or board members, please use next page (4)*.

Name	Address	Date of Birth	Complete Social Security Number
Therapist Name	Therapist Address	DOB	SSN

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
N/A	

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
N/A	

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]

Name	Offense
NA	

***Use this sheet for multiple business managers/owners or board members.**

Name	Address	Date of Birth	Complete Social Security Number
NA			

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:_____ Title:_____

(Print or Type) (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 business transaction information is required. Upon request, the provider must furnish all records described in the provider contract within thirty-five (35) days of the date on a request by the Department, the Medicaid Fraud Control Unit, the Arkansas Office of the Medicaid Inspector General, or the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to those records, full and complete information about:

1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2) Any significant business transaction between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

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 attach 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.

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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

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).
NA

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).
NA

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).
NA

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:_____ Title:_____
(Print or Type) (Print or Type)

Signature:_____ Date:_____

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 Name, hereinafter called Provider, and the Arkansas Department of Human Services, hereafter called Department:

I. 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 make available and, upon request, furnish all records described above within thirty-five (35) days of the date on a request by the Department, the Medicaid Fraud Control Unit, the Arkansas Office of the Medicaid Inspector General, or the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to those records, full and complete information about:

1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

2) Any significant business transaction between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

D. 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).

E. 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.

F. 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.

G. 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.

H. 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."

I. 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.

J. 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.

K. 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.

L. To conform to all Medicaid requirements covered in Federal or State laws, regulations or manuals.

M. To certify by <u>original</u> 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.

N. 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.

O. 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

By: _____
(Signature Required)

Name: _____
(Typed or Printed Name Required)

Title: _____
(Required)

Date: _____
(Required)

Provider Enrollment

By: _____
(Signature)

Name: _____
(Typed Name)

Title: _____

Date: _____

Effective Date of Contract: _____