



**Division of Medical Services**  
**Program Development & Quality Assurance**

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437  
501-320-6428 · Fax: 501-404-4619  
TDD/TTY: 501-682-6789



**TO:** Arkansas Medicaid Health Care Providers – All Providers  
**EFFECTIVE DATE:** November 1, 2017  
**SUBJECT:** Provider Manual Update Transmittal Sect-2-17

**REMOVE**

Section	Effective Date
141.000	7-1-13

**INSERT**

Section	Effective Date
141.000	11-1-17

**Explanation of Updates**

Section 141.000 has been updated to include the Authorization for Electronic Funds Transfer (Automatic Deposit) as a requirement for Arkansas Medicaid Provider Enrollment.

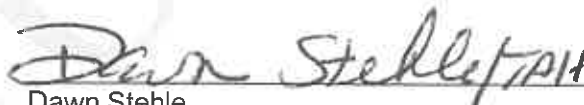
The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: [www.medicaid.state.ar.us](http://www.medicaid.state.ar.us).

Thank you for your participation in the Arkansas Medicaid Program.

  
Dawn Stehle  
Director

makeup

Section I

TOC not required

**140.000 PROVIDER PARTICIPATION**

**141.000 Provider Enrollment**

7-14311-1-  
17

Any provider of health care services must be enrolled in the Arkansas Medicaid Program before Medicaid will cover any services provided by the provider to Arkansas Medicaid beneficiaries. Enrollment as a Medicaid provider is contingent upon the provider satisfying all rules and requirements for provider participation as specified in the applicable provider manual, state and federal law. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

All providers must sign all applicable forms that require a signature and the Arkansas Medicaid Provider Contract. The signature must be an original signature or an approved electronic signature of the individual provider. The provider's authorized representative may sign the contract for a group practice, hospital, agency or other institution.

In addition to the information in Section 140.000, Section II of each program's provider manual may contain supplemental provider type specific participation requirements. The provider enrollment functions for the Arkansas Medicaid Program are performed by an independent contractor. The contractor is responsible for provider enrollment services for new providers and changes to current provider enrollment files. Potential providers must complete all appropriate portions of a provider enrollment Application Packet to execute the provider contract. They must also submit a copy of all certifications and licenses verifying compliance with enrollment criteria for the applicable provider type or discipline to be practiced and pay the application fee (if applicable). See Section 141.101 for Application Fees.

Potential providers may enroll on the Arkansas Medicaid website at <https://www.medicaid.state.ar.us>. Potential providers that are not required to pay application fees may also send the printed form to the Medicaid Provider Enrollment Unit. View or print the Provider Enrollment contact information.

Field Code Changed

All subsequent state license and certification renewals must be forwarded to the Medicaid Provider Enrollment Unit within 30 days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and FINAL 30 days to comply. Failure to timely submit verification of license or certification renewals will result in cancellation of enrollment in the Arkansas Medicaid Program. View or print the provider enrollment and contract package (Application Packet).

Field Code Changed

In addition to the submission of the Application Packet, the following forms are required and must be submitted to complete the enrollment process:

- A. W-9 Tax form (DMS-652)
- B. Medicaid Provider Contract (DMS-652)
- C. PCP Agreement, if applicable (DMS-2608. See Section 171.000 for PCP requirements.)
- D. EPSDT Agreement, if applicable (DMS-831. See Section 201.000 of the EPSDT provider manual for the EPSDT Agreement.)
- E. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.
- F. Authorization for Electronic Funds Transfer (Automatic Deposit)

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Section I

Each provider must notify the Medicaid Provider Enrollment Unit in writing immediately regarding any changes to its application or contract status, such as:

- A. Group Affiliation form, if applicable (DMS-652). This form is applicable for individual providers who choose to authorize a group to bill and receive reimbursement on their behalf.
- B. Change in Federal Employer Identification Number (FEIN) may require the completion of a new enrollment application
- C. Authorization for Electronic Funds Transfer (Automatic Deposit) Electronic Funds Transfer (EFT) Authorization for Automatic Deposit
- D. Change in practice or specialty
- E. Retirement or death of provider
- F. Name Change Form
- G. Change of Ownership Form (DMS-0688) (View or print form DMS-0688 – Provider Change of Ownership Information Form.)
- H. Address/Email Change Form (DMS-673) (View or print form DMS-673 – Address/Email Change Form.) **NOTE:** An active email address is required.
- I. Change in Ownership Control (5% or more) or Conviction of Crime (View or print form DMS-675 – Ownership and Conviction Disclosure.)
- J. Disclosure of Significant Business Transactions (View or print form DMS-689 – Disclosure of Significant Business Transactions.)

Field Code Changed

Field Code Changed

Field Code Changed

Field Code Changed

When the provider has successfully met all requirements, the Medicaid Provider Enrollment Unit will assign a unique Medicaid number to the provider. The assigned provider number is linked to the provider's tax identification number (either a Social Security Number or a Federal Employer Identification Number) and to the provider's National Provider Identifier (NPI) unless the provider is an atypical provider not required to have an NPI.



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

**EFFECTIVE DATE:** November 1, 2017

**SUBJECT:** Provider Manual Update Transmittal SecIII-1-17

**REMOVE**

Section	Effective Date
311.100	10-13-03

**INSERT**

Section	Effective Date
311.100	11-1-17

**Explanation of Updates**

Section 311.100 has been updated to add the requirement of Electronic Funds Transfer (Automatic Deposit) for Arkansas Medicaid payments to all Arkansas Medicaid providers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

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Thank you for your participation in the Arkansas Medicaid Program.

  
Dawn Stehle  
Director

TOC not required

311.100 Electronic Funds Transfer (EFT)

10-13-0311-  
1-17

Electronic Funds Transfer (EFT) allows providers to have their Medicaid payments automatically deposited instead of receiving a check. Effective 11/1/17, Arkansas Medicaid no longer mails paper checks for Medicaid payment. Providers are required to submit a completed Authorization for Electronic Funds Transfer (Automatic Deposit) form with their enrollment application. Provider Enrollment will deny applications that do not include a completed Authorization for Electronic Funds Transfer (Automatic Deposit) form. **View or print the Authorization for Electronic Funds Transfer (Automatic Deposit) form.** See Section I of the provider manual for an enrollment form and additional information regarding participation requirements.



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

**EFFECTIVE DATE:** November 1, 2017

**SUBJECT:** Provider Manual Update Transmittal SecV-3-17

**REMOVE**

Section	Effective Date
500.000	—
DMS-673	4-07
HP-MS-005	12-11
Auto Deposit	10-15-08

**INSERT**

Section	Effective Date
500.000	—
DMS-673	11-1-17
HP-MS-005	11-1-17
Auto Deposit	11-1-17

**Explanation of Updates**

Section 500.000 has been updated to change the names of Form DMS-673 and Form Auto Deposit.

Form DMS-673 has been updated to include the word “email” in the name of this form and to make submitting an email address a requirement.

Form HP-MS-005 has been updated to make submitting an email address a requirement for media selection.

Form Auto Deposit has been updated to include Electronic Funds Transfer (Automatic Deposit) requirements in the letter preceding the form and to change the name of the form.

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


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Dawn Stehle  
Director

## SECTION V – FORMS

500.000

### Claim Forms

#### Red-ink Claim Forms

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

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

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

#### Claim Forms

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

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

### Arkansas Medicaid Forms

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

#### In order by form name:

Form Name	Form Link
Acknowledgement of Hysterectomy Information	<u>DMS-2606</u>
Address/Email Change Form	<u>DMS-673</u>
Adjustment Request Form – Medicaid XIX	<u>HP-AR-004</u>
Adjustment Request Form – Medicaid XIX – Pharmacy Program	<u>DMS-802</u>

Form Name	Form Link
Adverse Effects Form	<a href="#"><u>DMS-2704</u></a>
AFMC Prescription & Prior Authorization Request for Medical Equipment Excluding Wheelchairs & Wheelchair Components	<a href="#"><u>DMS-679A</u></a>
Amplification/Assistive Technology Recommendation Form	<a href="#"><u>DMS-686</u></a>
Application for WebRA Hardship Waiver	<a href="#"><u>DMS-7736</u></a>
Approval/Denial Codes for Inpatient Psychiatric Services	<a href="#"><u>DMS-2687</u></a>
Arkansas Early Intervention Infant & Toddler Program Intake/Referral/Application for Services	<a href="#"><u>DDS/FS#0001.a</u></a>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Participation Agreement	<a href="#"><u>DMS-844</u></a>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Update/Change Request Form	<a href="#"><u>DMS-801</u></a>
Arkansas Medicaid Patient-Centered Medical Home Program Pooling Request Form	<a href="#"><u>DMS-845</u></a>
Arkansas Medicaid Patient-Centered Medical Home Program Practice Withdrawal Form	<a href="#"><u>DMS-846</u></a>
ARKids First Behavioral Health Services Provider Qualification Form	<a href="#"><u>DMS-612</u></a>
Authorization for <u>Electronic Funds Transfer (Automatic Deposit)</u>	<a href="#"><u>autodeposit</u></a>
Authorization for Payment for Services Provided	<a href="#"><u>MAP-8</u></a>
Certification of Need – Medicaid Inpatient Psychiatric Services for Under Age 21	<a href="#"><u>DMS-2633</u></a>
Certification of Schools to Provide Comprehensive EPSDT Services	<a href="#"><u>CSPC-EPSDT</u></a>
Certification Statement for Abortion	<a href="#"><u>DMS-2698</u></a>
Change of Ownership Information	<a href="#"><u>DMS-0688</u></a>
Child Health Management Services Enrollment Orders	<a href="#"><u>DMS-201</u></a>
Child Health Management Services Discharge Notification Form	<a href="#"><u>DMS-202</u></a>
CHMS Benefit Extension for Diagnosis/Evaluation Procedures	<a href="#"><u>DMS-699A</u></a>
CHMS Request for Prior Authorization	<a href="#"><u>DMS-102</u></a>
Claim Correction Request	<a href="#"><u>DMS-2647</u></a>
Consent for Release of Information	<a href="#"><u>DMS-619</u></a>
Contact Lens Prior Authorization Request Form	<a href="#"><u>DMS-0101</u></a>
Contract to Participate in the Arkansas Medical Assistance Program	<a href="#"><u>DMS-653</u></a>
DDTCS Transportation Log	<a href="#"><u>DMS-638</u></a>
DDTCS Transportation Survey	<a href="#"><u>DMS-632</u></a>
Dental Treatment Additional Information	<a href="#"><u>DMS-32-A</u></a>
Disclosure of Significant Business Transactions	<a href="#"><u>DMS-689</u></a>
Disproportionate Share Questionnaire	<a href="#"><u>DMS-628</u></a>



<b>Form Name</b>	<b>Form Link</b>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Prescription/Referral For Medically Necessary Services/Items Not Specifically Included in the Medicaid State Plan	<a href="#"><u>DMS-693</u></a>
Early Childhood Special Education Referral Form	<a href="#"><u>ECSE-R</u></a>
EPSDT Provider Agreement	<a href="#"><u>DMS-831</u></a>
Explanation of Check Refund	<a href="#"><u>HP-CR-002</u></a>
Gait Analysis Full Body	<a href="#"><u>DMS-647</u></a>
Home Health Certification and Plan of Care	<a href="#"><u>CMS-485</u></a>
Hospital/Physician/Certified Nurse-Midwife Referral for Newborn Infant Medicaid Coverage	<a href="#"><u>DCO-645</u></a>
Inpatient Psychiatric Medicaid Agency Review Team Transmittal Sheet	<a href="#"><u>DMS-2685</u></a>
Individual Renewal Form for School-Based Audiologists	<a href="#"><u>DMS-7782</u></a>
Lower-Limb Prosthetic Evaluation	<a href="#"><u>DMS-650</u></a>
Lower-Limb Prosthetic Prescription	<a href="#"><u>DMS-651</u></a>
Media Selection/E-mail Address Change Form	<a href="#"><u>HP-MS-005</u></a>
Medicaid Claim Inquiry Form	<a href="#"><u>HP-CI-003</u></a>
Medicaid Form Request	<a href="#"><u>HP-MFR-001</u></a>
Medical Equipment Request for Prior Authorization & Prescription	<a href="#"><u>DMS-679</u></a>
Medical Transportation and Personal Assistant Verification	<a href="#"><u>DMS-616</u></a>
Mental Health Services Provider Qualification Form for LCSW, LMFT and LPC	<a href="#"><u>DMS-633</u></a>
Notice Of Noncompliance	<a href="#"><u>DMS-635</u></a>
NPI Reporting Form	<a href="#"><u>DMS-683</u></a>
Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 Prescription/Referral	<a href="#"><u>DMS-640</u></a>
Ownership and Conviction Disclosure	<a href="#"><u>DMS-675</u></a>
Personal Care Assessment and Service Plan	<a href="#"><u>DMS-618 English</u></a> <a href="#"><u>DMS-618 Spanish</u></a>
Practitioner Identification Number Request Form	<a href="#"><u>DMS-7708</u></a>
Prescription & Prior Authorization Request For Nutrition Therapy & Supplies	<a href="#"><u>DMS-2615</u></a>
Primary Care Physician Managed Care Program Referral Form	<a href="#"><u>DMS-2610</u></a>
Primary Care Physician Participation Agreement	<a href="#"><u>DMS-2608</u></a>
Primary Care Physician Selection and Change Form	<a href="#"><u>DMS-2609</u></a>
Procedure Code/NDC Detail Attachment Form	<a href="#"><u>DMS-664</u></a>
Provider Application	<a href="#"><u>DMS-652</u></a>
Provider Communication Form	<a href="#"><u>AAS-9502</u></a>

Form Name	Form Link
Provider Data Sharing Agreement – Medicare Parts C & D	<a href="#"><u>DMS-652-A</u></a>
Provider Enrollment Application and Contract Package	<a href="#"><u>Application Packet</u></a>
Quarterly Monitoring Form	<a href="#"><u>AAS-9506</u></a>
Referral for Audiology Services – School-Based Setting	<a href="#"><u>DMS-7783</u></a>
Referral for Certification of Need Medicaid Inpatient Psychiatric Services for Under Age 21	<a href="#"><u>DMS-2634</u></a>
Referral for Medical Assistance	<a href="#"><u>DMS-630</u></a>
Request for Appeal	<a href="#"><u>DMS-840</u></a>
Request for Extension of Benefits	<a href="#"><u>DMS-699</u></a>
Request for Extension of Benefits for Clinical, Outpatient, Laboratory and X-Ray Services	<a href="#"><u>DMS-671</u></a>
Request for Extension of Benefits for Medical Supplies for Medicaid Beneficiaries Under Age 21	<a href="#"><u>DMS-602</u></a>
Request for Molecular Pathology Laboratory Services	<a href="#"><u>DMS-841</u></a>
Request for Orthodontic Treatment	<a href="#"><u>DMS-32-0</u></a>
Request for Prior Approval for the Special Pharmacy Therapeutic Agents and Treatments	<a href="#"><u>DMS-6</u></a>
Request for Private Duty Nursing Services Prior Authorization and Prescription – Initial Request or Recertification	<a href="#"><u>DMS-2692</u></a>
Request for Targeted Case Management Prior Authorization for Beneficiaries Under Age 21	<a href="#"><u>DMS-601</u></a>
Research Request Form	<a href="#"><u>HP-0288</u></a>
Service Log – Personal Care Delivery and Aides Notes	<a href="#"><u>DMS-873</u></a>
Sterilization Consent Form	<a href="#"><u>DMS-615 English</u></a> <a href="#"><u>DMS-615 Spanish</u></a>
Sterilization Consent Form – Information for Men	<a href="#"><u>PUB-020</u></a>
Sterilization Consent Form – Information for Women	<a href="#"><u>PUB-019</u></a>
Targeted Case Management Contact Monitoring Form	<a href="#"><u>DMS-690</u></a>
Upper-Limb Prosthetic Evaluation	<a href="#"><u>DMS-648</u></a>
Upper-Limb Prosthetic Prescription	<a href="#"><u>DMS-649</u></a>
Vendor Performance Report	<a href="#"><u>Vendorperformreport</u></a>
Verification of Medical Services	<a href="#"><u>DMS-2618</u></a>

In order by form number:

<a href="#"><u>AAS-9502</u></a>	<a href="#"><u>DMS-2633</u></a>	<a href="#"><u>DMS-618</u></a>	<a href="#"><u>DMS-673</u></a>	<a href="#"><u>DMS-846</u></a>
<a href="#"><u>AAS-9506</u></a>	<a href="#"><u>DMS-2634</u></a>	<a href="#"><u>Spanish</u></a>	<a href="#"><u>DMS-679</u></a>	<a href="#"><u>DMS-873</u></a>
<a href="#"><u>AAS-9559</u></a>	<a href="#"><u>DMS-2647</u></a>	<a href="#"><u>DMS-619</u></a>	<a href="#"><u>DMS-679A</u></a>	<a href="#"><u>ECSE-R</u></a>
<a href="#"><u>Address</u></a>	<a href="#"><u>DMS-2685</u></a>	<a href="#"><u>DMS-628</u></a>	<a href="#"><u>DMS-683</u></a>	<a href="#"><u>HP-0288</u></a>
<a href="#"><u>Change</u></a>	<a href="#"><u>DMS-2687</u></a>	<a href="#"><u>DMS-630</u></a>	<a href="#"><u>DMS-686</u></a>	<a href="#"><u>HP-AR-004</u></a>
<a href="#"><u>Autodeposit</u></a>	<a href="#"><u>DMS-2692</u></a>	<a href="#"><u>DMS-632</u></a>	<a href="#"><u>DMS-689</u></a>	<a href="#"><u>HP-CI-003</u></a>
<a href="#"><u>CMS-485</u></a>	<a href="#"><u>DMS-2698</u></a>	<a href="#"><u>DMS-633</u></a>	<a href="#"><u>DMS-690</u></a>	<a href="#"><u>HP-CR-002</u></a>
<a href="#"><u>CSPC-EPSDT</u></a>	<a href="#"><u>DMS-2704</u></a>	<a href="#"><u>DMS-635</u></a>	<a href="#"><u>DMS-693</u></a>	<a href="#"><u>HP-MFR-001</u></a>
<a href="#"><u>DCO-645</u></a>	<a href="#"><u>DMS-32-A</u></a>	<a href="#"><u>DMS-638</u></a>	<a href="#"><u>DMS-699</u></a>	<a href="#"><u>HP-MS-005</u></a>
<a href="#"><u>DDS/FS#0001.a</u></a>	<a href="#"><u>DMS-32-0</u></a>	<a href="#"><u>DMS-640</u></a>	<a href="#"><u>DMS-699A</u></a>	<a href="#"><u>MAP-8</u></a>
<a href="#"><u>DMS-0101</u></a>	<a href="#"><u>DMS-6</u></a>	<a href="#"><u>DMS-647</u></a>	<a href="#"><u>DMS-7708</u></a>	<a href="#"><u>Performance</u></a>
<a href="#"><u>DMS-0688</u></a>	<a href="#"><u>DMS-601</u></a>	<a href="#"><u>DMS-648</u></a>	<a href="#"><u>DMS-7736</u></a>	<a href="#"><u>Report</u></a>
<a href="#"><u>DMS-102</u></a>	<a href="#"><u>DMS-602</u></a>	<a href="#"><u>DMS-649</u></a>	<a href="#"><u>DMS-7782</u></a>	<a href="#"><u>Provider</u></a>
<a href="#"><u>DMS-201</u></a>	<a href="#"><u>DMS-612</u></a>	<a href="#"><u>DMS-650</u></a>	<a href="#"><u>DMS-7783</u></a>	<a href="#"><u>Enrollment</u></a>
<a href="#"><u>DMS-202</u></a>	<a href="#"><u>DMS-615</u></a>	<a href="#"><u>DMS-651</u></a>	<a href="#"><u>DMS-801</u></a>	<a href="#"><u>Application</u></a>
<a href="#"><u>DMS-2606</u></a>	<a href="#"><u>English</u></a>	<a href="#"><u>DMS-652</u></a>	<a href="#"><u>DMS-802</u></a>	<a href="#"><u>and Contract</u></a>
<a href="#"><u>DMS-2608</u></a>	<a href="#"><u>DMS-615</u></a>	<a href="#"><u>DMS-652-A</u></a>	<a href="#"><u>DMS-802</u></a>	<a href="#"><u>Package</u></a>
<a href="#"><u>DMS-2609</u></a>	<a href="#"><u>Spanish</u></a>	<a href="#"><u>DMS-653</u></a>	<a href="#"><u>DMS-831</u></a>	<a href="#"><u>PUB-019</u></a>
<a href="#"><u>DMS-2610</u></a>	<a href="#"><u>DMS-616</u></a>	<a href="#"><u>DMS-664</u></a>	<a href="#"><u>DMS-840</u></a>	<a href="#"><u>PUB-020</u></a>
<a href="#"><u>DMS-2615</u></a>	<a href="#"><u>DMS-618</u></a>	<a href="#"><u>DMS-671</u></a>	<a href="#"><u>DMS-841</u></a>	
<a href="#"><u>DMS-2618</u></a>	<a href="#"><u>English</u></a>	<a href="#"><u>DMS-675</u></a>	<a href="#"><u>DMS-844</u></a>	
			<a href="#"><u>DMS-845</u></a>	

#### Arkansas Medicaid Contacts and Links

Click the link to view the information.

[American Hospital Association](#)

[Americans with Disabilities Act Coordinator](#)

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

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

[Arkansas Department of Finance Administration, Sales and Tax Use Unit](#)

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

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

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

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

Arkansas Department of Human Services, Division of Children and Family Services, Contracts Management Unit

Arkansas Department of Human Services, Children's Services

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

Arkansas Department of Human Services, Division of Medical Services

Arkansas DHS, Division of Medical Services Director

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

Arkansas DHS, Division of Medical Services, Dental Care Unit

Arkansas DHS, Division of Medical Services, DXC Technology Provider Enrollment Unit

Arkansas DHS, Division of Medical Services, Financial Activities Unit

Arkansas DHS, Division of Medical Services, Hearing Aid Consultant

Arkansas DHS, Division of Medical Services, Medical Assistance Unit

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

Arkansas DHS, Division of Medical Services, Pharmacy Unit

Arkansas DHS, Division of Medical Services, Program Communications Unit

Arkansas DHS, Division of Medical Services, Provider Reimbursement Unit

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

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

Arkansas DHS, Division of Medical Services, Utilization Review Section

Arkansas DHS, Division of Medical Services, Visual Care Coordinator

Arkansas Department of Health

Arkansas Department of Health, Health Facility Services

Arkansas Department of Human Services, Accounts Receivable

Arkansas Foundation for Medical Care

Arkansas Foundation for Medical Care, Retrospective Review for Therapy and Prior Authorization for Personal Care for Under Age 21

Arkansas Foundation for Medical Care, Provider Relations Representative

Arkansas Hospital Association

Arkansas Office of Medicaid Inspector General (OMIG)

ARKids First-B

ARKids First-B ID Card Example

Beacon Health Options (Formerly ValueOptions)

Central Child Health Services Office (EPSDT)

ConnectCare Helpline

County Codes

Dental Contractor

[DXC Technology Claims Department](#)

[DXC Technology EDI Support Center \(formerly AEVCS Help Desk\)](#)

[DXC Technology Inquiry Unit](#)

[DXC Technology Manual Order](#)

[DXC Technology Provider Assistance Center \(PAC\)](#)

[DXC Technology Supplied Forms](#)

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

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

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

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

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

[Health Care Declarations](#)

[Immunizations Registry Help Desk](#)

[Magellan Pharmacy Call Center](#)

[Medicaid ID Card Example](#)

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

[Medicaid Reimbursement Unit Communications Hotline](#)

[Medicaid Tooth Numbering System](#)

[National Supplier Clearinghouse](#)

[Partners Provider Certification](#)

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

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

[Select Optical](#)

[Standard Register](#)

[Table of Desirable Weights](#)

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

[Vendor Performance Report](#)

**Provider Address/Email Change Form****Provider Name** \_\_\_\_\_  
(please print)**Provider ID Number/Taxonomy Code** \_\_\_\_\_**Physical Address** \_\_\_\_\_  
(Where services are provided)\_\_\_\_\_  
(Post office box allowed ONLY as an addition to a street address)**City** \_\_\_\_\_ **State** \_\_\_\_\_ **ZIP+4** \_\_\_\_\_**County** \_\_\_\_\_ **Phone Number** (Include area code) \_\_\_\_\_**Mailing/Billing  
Address**

\_\_\_\_\_

\_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **ZIP+4** \_\_\_\_\_**Phone Number** (Include area code) \_\_\_\_\_**E-mail Address (Required)** \_\_\_\_\_

**Note:** Before a change can be made in your provider file, we must have your original signature. A photo copied or stamped signature is unacceptable and the only signature valid for an individual practitioner is their own.

**Provider's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_**Mail this completed form to:**

**Medicaid Provider Enrollment Unit**  
**DXC Technology**  
**P.O. Box 8105**  
**Little Rock, AR 72203-8105**



Mail this completed form to  
**Provider Enrollment**  
DXC Technology  
P.O. Box 8036  
Little Rock, AR 72203-8036

Mockup

## Media Selection/E-mail Address Change Form

Use this form to change your media selection, your e-mail address, or both. Your provider number, name, and signature are always required.

### Required Information

**Provider Number**

--	--	--	--	--	--	--	--	--	--

**Provider Name**

(please print)

---

**Provider Signature**

---

**Date**

---

We cannot accept a photocopied or stamped signature. Only the practitioner's original signature is valid.

### Change Media Selection

If you need to change your media selection, mark your preference below (choose only one):

**Internet Only**

(requires e-mail and Internet access)

☐

E-mail:

---

**E-mail Updates**

(requires e-mail and Internet access)

☐

E-mail:

---

**Paper Updates**

☐

### Change E-mail Address

Provider Enrollment requires an active email address for each provider. If you need to change your e-mail address, enter your new address below:

**New E-mail Address**

---

Markup

**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 are encouraged to utilize **Electronic Fund Transfer (EFT)**. 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. Your Medicaid Remittance Advice (RA) will continue to be mailed to the mailing address listed on your enrollment application.

When enrolling as a Medicaid provider, you must complete the Authorization for Electronic Funds Transfer form. 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** to have your Medicaid payment automatically deposited.

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 DXC Technology office.**

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



Mockup

**Authorization for Electronic Funds Transfer**  
**(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 \_\_\_\_\_

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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**