ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
Mark Martin
500 Woodlane, Suite 026
Little Rock, Arkansas 72201-1094
(501) 682-5070
www.sos.arkansas.gov

For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Medical Services

Contact Becky Murphy E-mail becky.murphy@dhs.arkansas.gov Phone 501-320-6429

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-76-201

Rule Title: Section 1 2-17; Section III 1-17 and Section V 3-17 - Electronic Funds Transfer

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	08/14/2017
☑ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	09/12/2017
☐ Other _____ (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	
	Adopted by State Agency	11/01/2017

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy (Contact Person) becky.murphy@dhs.arkansas.gov (E-mail Address) (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Signature

(501) 371-2165 (Phone Number) rose.naff@dhs.arkansas.gov (E-mail Address)

Director (Title)

10/19/17 (Date)

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services

DIVISION Division of Medical Services

PERSON COMPLETING THIS STATEMENT Brian Jones

TELEPHONE 501-537-2064 **FAX** 501-682-3889 **EMAIL:** Brian.jones@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Section 1-2-17; Section III-1-17 and Section V-3-17

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☐ No ☒

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost:

   (b) The reason for adoption of the more costly rule:

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and:

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	$0	General Revenue	$0
Federal Funds	$0	Federal Funds	$0
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total	$0	Total	$0

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ _____

Next Fiscal Year
$ _____

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ $0

Next Fiscal Year
$ $0

These changes have no financial impact.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☒

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:

(a) the rule is achieving the statutory objectives;
(b) the benefits of the rule continue to justify its costs; and
(c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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 Secl-2-17

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
141.000	7-1-13	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.

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

TOC not required

140.000 PROVIDER PARTICIPATION

141.000 Provider Enrollment 11-1-17

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.**

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).**

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)

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)

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.**)

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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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 SecIII-1-17

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
311.100	10-13-03	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.

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.

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

TOC not required

311.100 Electronic Funds Transfer (EFT) 11-1-17

Electronic Funds Transfer (EFT) allows providers to have their Medicaid payments automatically deposited. 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 additional information regarding participation requirements.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
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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		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
500.000	—	500.000	—
DMS-673	4-07	DMS-673	11-1-17
HP-MS-005	12-11	HP-MS-005	11-1-17
Auto Deposit	10-15-08	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.**

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.

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Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
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
Professional – CMS-1500	Business Form Supplier
Institutional – CMS-1450*	Business Form Supplier
Visual Care – DMS-26-V	1-800-457-4454
Inpatient Crossover – HP-MC-001	1-800-457-4454
Long Term Care Crossover – HP-MC-002	1-800-457-4454
Outpatient Crossover – HP-MC-003	1-800-457-4454
Professional Crossover – HP-MC-004	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
Alternatives Attendant Care Provider Claim Form – AAS-9559	Client Employer
Dental – ADA-J430	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	DMS-2606
Address/Email Change Form	DMS-673
Adjustment Request Form – Medicaid XIX	HP-AR-004
Adjustment Request Form – Medicaid XIX – Pharmacy Program	DMS-802

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

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

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

In order by form number:

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

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)

Email 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

DXC.technology

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

Media Selection/Email Address Change Form

Use this form to change your media selection, your email 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 email and Internet access) Email: _____

Email Updates ☐
(requires email and Internet access) Email: _____

Paper Updates ☐

Change Email Address

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

New Email Address _____

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