

ARKANSAS MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAM
PRIMARY CARE PROVIDER DISENROLLMENT FORM

PCP Information

First Name

Last Name

9-Digit Arkansas Medicaid Provider ID

End Date

End Date (MM/DD/YYYY)

Reason for Disenrollment as a Primary Care Provider

Select at least one.

Retirement

Date

Moved out of State

Date

No longer a PCP

Date

Other

Date

Signature

*Provider Signature

Date Signed

*An original or approved electronic signature is required. Arkansas Medicaid will accept electronic signatures in compliance with Arkansas Code § 25-31-103 et seq. **Stamped or copied signatures are not accepted.**