ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Arkansas Patient-Centered Medical Home Enrollment Unit
1-866-322-4696 (in-state) or 1-501-301-8311 (local and out of state) TDD/TTY: 501-682-6789
ARKPCMH@dxc.com

Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement

Section I Primary Location

This document must be completed for each practice enrolling in the Arkansas Patient-Centered Medical Home (PCMH) program. Each PCMH must complete and submit all pages at one time before the participation agreement will be processed. All participation agreements must be submitted via email to ARKPCMH@dxc.com. PCMH's are responsible for submitting notice of any change to the information contained in this document within 30 days of the change. The program requirements are described in the PCMH Manual and Addendum located on the PCMH web page.

Patient-Centered Medical Home

Practice Name:		**Medicaid Billing ID Number:**	**National Provider Number (NPI):**
Physical Address:		**City/State:**	**Zip:**
Primary Lead Contact:	**E-mail:**	**Secondary Lead Contact:**	**E-mail:**
Phone Number:	**Title:**	**Phone Number:**	**Title:**
EHR Vendor Name:		**EHR Version Number:**	

☐ New Enrollment PCP Enrollment ☐ Update/Change Request

In this section, list all Primary Care Physicians (PCP) in your clinic. Refer to Section 200.00 in the PCMH Manual for PCP enrollment guidelines. If a PCP is associated with a satellite location, complete Section II for every satellite location. Signature is not required from a physician being removedfrom your PCMH enrollment. All signatures must be completed in ink. No e-signatures accepted. Print additional pages as needed.

First/Last Name		**First/Last Name**	
Individual Provider ID:	**NPI:**	**Individual Provider ID:**	**NPI:**
Signature of Physician:	**Status:** ☐ Enroll ☐ Withdrawal	**Signature of Physician:**	**Status:** ☐ Enroll ☐ Withdrawal
First/Last Name		**First/Last Name**	
Individual Provider ID:	**NPI:**	**Individual Provider ID:**	**NPI:**
Signature of Physician:	**Status:** ☐ Enroll ☐ Withdrawal	**Signature of Physician:**	**Status:** ☐ Enroll ☐ Withdrawal
First/Last Name		**First/Last Name**	
Individual Provider ID:	**NPI:**	**Individual Provider ID:**	**NPI:**
Signature of Physician:	**Status:** ☐ Enroll ☐ Withdrawal	**Signature of Physician:**	**Status:** ☐ Enroll ☐ Withdrawal

Practice Lead Signature:	Date:

Arkansas Medicaid Patient-Centered Medical Home Practice Participation Agreement

Section II Satellite Location

Patient-Centered Medical Home

Practice Name:	Medicaid Billing ID Number:	National Provider Number (NPI):

PCMH Satellite Location

This section should be completed for satellite locations where your participating PCP's practice. Refer to the PCMH Manual and Addendum locatedon the PCMH web page for enrollment guidelines. Please print additional pages as needed for each additional satellite location.

Practice Name:	Medicaid Billing ID Number:	National Provider Number (NPI):
Physical Address:	City/State:	Zip:

☐ New Enrollment

PCP Enrollment

☐ Update/Change Request

Complete this section for every satellite location. Refer to Section 200.00 in the PCMH Manual for PCP enrollment guidelines. Signature is not required from a physician being removed from your PCMH enrollment. All signatures must be in ink. No e-signatures accepted. Print additional pages as needed.

First/Last Name		First/Last Name	
Individual Provider ID:	NPI:	Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal	Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name		First/Last Name	
Individual Provider ID:	NPI:	Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal	Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

First/Last Name		First/Last Name	
Individual Provider ID:	NPI:	Individual Provider ID:	NPI:
Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal	Signature of Physician:	Status: ☐ Enroll ☐ Withdrawal

Practice Lead Signature:	Date: