Arkansas Medicaid Patient-Centered Medical Home Program
Pooling Request Form

Practices wishing to pool attributed beneficiaries for purposes of the PCMH program, as described in the pooling section of the Arkansas Medicaid PCMH provider manual, must submit the pooling request form.

1. Please add additional pages as required to list all practices requesting to pool their attributed beneficiaries.
2. Practices that do not voluntarily pool will, based on their number of attributed beneficiaries, be either
    a. Considered a shared savings entity independently; or
    b. Included in the default pool.

First Practice

1	Practice name (must match name on PCMH Practice Participation Agreement). Please print, stamp, or type practice name:
2	Physical address:
3	Practice Medicaid Billing ID Number:
4	National Provider Identifier:

Second Practice

5	Practice name (must match name on PCMH Practice Participation Agreement). Please print, stamp, or type practice name:
6	Physical address:
7	Practice Medicaid Billing ID Number:
8	National Provider Identifier:

Third Practice

9	Practice name (must match name on PCMH Practice Participation Agreement). Please print, stamp, or type practice name:
10	Physical address:
11	Practice Medicaid Billing ID Number:
12	National Provider Identifier:

Fourth Practice

13	Practice name (must match name on PCMH Practice Participation Agreement). Please print, stamp, or type practice name:
14	Physical address:
15	Practice Medicaid Billing ID Number:
16	National Provider Identifier:

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Pooling Request

By signing this form, _____ and
(Please print, stamp, or type first practice name)

_____ and
(Please print, stamp, or type second practice name)

_____ and
(Please print, stamp, or type third practice name)

_____
(Please print, stamp, or type fourth practice name)

hereafter called the practices, are requesting to pool their attributed beneficiaries as a common shared savings entity for purposes of the Patient-Centered Medical Home (PCMH) program as described in the Arkansas Medicaid PCMH provider manual. The practices request to have their performance measured together by aggregating performance across the practices. Specifically, performance (both for Per Beneficiary Cost of Care and Shared Savings Quality Metrics as described in the Arkansas Medicaid PCMH provider manual) is measured across the beneficiaries attributed to the practices identified above as a shared savings entity. The practices' attributed beneficiaries shall remain pooled in a shared savings entity only for the performance period in the next calendar year. In order to remain pooled, the practices must resubmit this section of the practice participation agreement annually.

_____ _____ _____
For the first practice Title Date

Practice name: _____

Phone number: _____

Email address: _____

_____ _____ _____
For the second practice Title Date

Practice name: _____

Phone number: _____

Email address: _____

_____ _____ _____
For the third practice Title Date

Practice name: _____

Phone number: _____

Email address: _____

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_____	_____	_____
For the fourth practice	Title	Date

Practice name: _____

Phone number: _____

Email address: _____

For the performance period beginning in 2015:

1. Please add additional pages as required to list all practices requesting to pool their attributed beneficiaries.
2. Practices that do not voluntarily pool will, based on their number of attributed beneficiaries, be either
    a. Considered a shared savings entity independently; or
    b. Included in the default pool.

_____	_____	_____
Division of Medical Services Signature	Title	Date