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 (234.000) 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 performance entity independently (1,000 or more beneficiaries); or
    b. Included in the default pool (less than 1,000 beneficiaries but more than 300 beneficiaries); or
    c. Included in the petite pool (less than 300 beneficiaries).

First Practice

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

Second Practice

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

Third Practice

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

Fourth Practice

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

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 performance entity for purposes of the Patient-Centered Medical Home (PCMH) program as described in Section 232.000 of the Arkansas Medicaid PCMH provider manual. The practices request to have their performance measured together by aggregating performance across the practices. Specifically, performance is measured across the beneficiaries attributed to the practices identified above as a shared performance entity (as described in Section 233.000 of the Arkansas Medicaid PCMH provider manual). The practices' attributed beneficiaries shall remain pooled in a shared performance 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: _____

_____ _____ _____

For the fourth practice Title Date

Practice name: _____

Phone number: _____

Email address: _____