ARKANSAS MEDICAID PATIENT-CENTERED MEDICAL HOME PROGRAM
PRACTICE WITHDRAWAL FORM

1	Practice name (must match Practice Participation Agreement):____ (Please print, stamp or type practice name)
2	Practice address: _________________________________ _________________________________
3	Practice Medicaid Billing ID Number:
4	National Provider Identifier:
5	Name of other practice in shared savings pool (if applicable):

Withdrawal Statement

By signing this withdrawal form, ______________________________________, hereafter called practice, is requesting to
(Please print, stamp or type practice name)

withdraw from the Arkansas Medicaid Patient-Centered Medical Home program, understanding that all potential practice support per member per month payments and shared savings payments under the Patient-Centered Medical Home program will cease immediately. This withdrawal form serves to terminate the Patient-Centered Medical Home contract that exists between Arkansas Medicaid and the practice. The practice acknowledges that the Arkansas Medicaid program may reconcile any outstanding overpayment through reduction of future Medicaid fee-for-service reimbursement.

_____________________________ _________________________________ ______________
For the practice Title Date

Phone number: ______________________

Email address: ______________________

_____________________________ _________________________________ ______________
Division of Medical Services Signature Title Date