Division of Medical Services
Arkansas Patient-Centered Medical Home Enrollment Unit
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ARKPCMH@dxc.com

Arkansas Patient-Centered Medical Home Program
Practice Withdrawal Form

PRACTICE IDENTIFICATION:

1. Practice Name: _____
2. Practice Address:_____
3. Medicaid Billing ID#: _____
4. National Provider ID#: _____
5. Name(s) of pooling partner(s):_____

(if applicable) _____

_____

_____

_____

WITHDRAWAL STATEMENT:

By signing this withdrawal form,_____ , hereafter known as "the Practice," is requesting to withdraw from the_____ configuration of the Arkansas Patient-Centered Medical Home (PCMH) Program, effective _____ , understanding that this withdrawal form serves to terminate the PCMH Program contract that exists between Arkansas Medicaid and the Practice. The Practice acknowledges that all potential payments for practice support and Shared Savings incentives under the PCMH Program will cease immediately and that any outstanding overpayment may be reconciled by Arkansas Medicaid through reduction of future Medicaid fee-for-service reimbursement.

PRACTICE AUTHORIZATION:

_____	_____	_____
Representative's Name and Title (please print)	Representative's Signature	Signature Date

Representative's Phone#: _____

Representative's Email address: _____

DMS AUTHORIZATION:

_____	_____	_____
DMS Representative's Name and Title (please print)	DMS Representative's Signature	Signature Date

NOTICE: Information included in this form is protected under HIPAA rules. The information is disclosed to the healthcare provider (covered entity) only for carrying out healthcare operations. The information must be safeguarded, used, transmitted, and disclosed only in accordance with the HIPAA rules. The information contained in this form is intended solely for use in the administration of the Medicaid program, and is neither intended nor suitable for other uses, including the selection of a health care provider. For more information, please visit the PCMH web page.