Please note as you are completing the document list your program after the ***Place of Residency*** at the bottom of the page.

Division of Medical Services Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 8105, Little Rock, AR 72203-8105
P: 501.376.2211 In state WATS: 800.457.4454 F: 501.374.0746

PRACTITIONER IDENTIFICATION NUMBER REQUEST FORM

Please select one of the following:

- ☐ Physician Assistant **NV** (Include a W9 for the Individual)
- ☐ Non-Independent Licensed Clinician (Include license) **NW**
- ☐ Certified Behavioral Analyst Paraprofessional **BP**
- ☐ Certified Peer Recovery Support Specialist BH/SU **RS**
- ☐ Resident **NU**
- ☐ QBHP **NT**
- ☐ Community Support Staff **CS**
- ☐ Personal Care Aide **NT**

Practitioner Name________________________________
(Please print)

NPI/Taxonomy Code________________________________

Social Security Number________________ **Date of Birth**________________

Physical Work Address________________________________

____
City **State** **ZIP+4**

____
County **Phone Number** (Include area code)

Mail to Address ________________________________

____
City **State** **ZIP+4**

____
Phone Number (Include area code)

Individual Email Address ________________________________

Residents Only ________________________________
Place of Residency **Effective Date of Residency**

By signing, the applicant authorizes the Arkansas Department of Human Services to conduct a State and Federal background check. Results from the background check will determine the provider enrollment status with the Arkansas Medicaid program.

Practitioner's Signature ____________________ **Date** ____________

Mail or Fax this completed form to:
Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 8105
Little Rock, AR 72203-8105
Fax Number: 501-374-0746