Division of Medical Services Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 8105, Little Rock, AR 72203-8105
P: (501) 376-2211 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 **NW** (Include license)
- ☐ Certified Behavioral Analyst Paraprofessional **BP**
- ☐ Certified Peer Recovery Support Specialist BH/SU **RS**
- ☐ Pharmacist **RX** (Include license)
- ☐ 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 Arkansas Medicaid.

_____
Practitioner's Signature **Date**

***Upload, 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

* To electronically sign this form for upload: enter required information, save the file, open using Acrobat Reader (desktop application instead of the browser window) to access the digital signature field.