



Attachment D

**Arkansas Department of Health
Provider Name and Specialty Form**

Please list each individual provider in your clinic/group or practice in space in lower half of this form. Fill in each applicable box on each provider. Please attach a copy of their medical or nursing license, DEA license if applicable and documentation of one hour of CME related to breast or cervical cancer for the past year. List their specialty, their Social Security, Medicare and NPI numbers. **If you are adding or deleting a provider to your contract, enter "A" for add "D" for delete and enter the effective date for each.** Physician/nurse groups, Community Health Centers (CHC), and hospitals should complete this form for each clinic/group practice operating under this agreement. Each individual provider must be listed for each practice with the exception of CHC's.

Clinic/Group Name: _____ Group NPI # _____

Taxpayer ID Name (if different than clinic name): _____ Email Address _____

Physical Address of Clinic: _____ City & Zip: _____ Phone #: _____

Billing Address (if different than physical add.): _____ City/State/Zip: _____

Billing Phone #: _____

| <u>BrestCare #</u> | <u>Provider Name</u> | <u>Add Delete</u> | <u>Effective Date</u> | <u>Indiv. SS #</u> | <u>Indiv. NPI #</u> | <u>Specialty</u> | <u>*PCP and/or Colposcopy P/C/B</u> | <u>Medicare #</u> | <u>AR License #</u> | <u>DEA #</u> |
|--------------------|----------------------|-------------------|-----------------------|--------------------|---------------------|------------------|-------------------------------------|-------------------|---------------------|--------------|
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| 8. | | | | | | | | | | |

*Indicate if you provide P = primary care; C = colposcopy only; or B = both primary care and colposcopy.

Make additional copies of this form, if needed.