

Application for WebRA Hardship Waiver

Submission of this application is required to opt out of BreastCare WebRA. This application must be submitted 15 days prior to the provider's assigned WebRA implementation date to be considered.

All of the information requested in the application is required. Failure to completely and accurately provide the information may result in a denial of the waiver application.

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Date of Application: _____

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Provider Name: _____ Arkansas BreastCare ID: _____ National Provider ID: _____

Street Address: _____ City: _____ State: _____ Zip: _____ Telephone Number: _____
_____ (____) _____

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Please explain why your practice is requesting to opt out of the BreastCare WebRA:

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Certification

I understand that the statements I have made on this application are subject to investigation and verification. I declare that the statements I have given on this form, to the best of my knowledge, are true and correct.

Provider Signature: _____ Date: _____

*Please refer to the WebRA provider notice for the applicable implementation date.

Mail or fax completed application to: Arkansas Department of Health, Attn: BreastCare, 4815 West Markham, Slot 11, Little Rock, AR 72205. Fax 501-661-2009

For Official Use Only

() Approved () Denied	
Reviewer: _____	Date of Decision: _____
EDI Rep: _____	Date of Update: _____