



Arkansas Department of Health

BreastCare
PROVIDER
ENROLLMENT
SYSTEM USER MANUAL

Revision Sheet

Release No.	Date	Revision Description
Rev. 0	01/31/2011	First edition in MS Word format
Rev. 1	05/26/2011	Features added/dropped
Rev. 2	05/03/2013	Features added/dropped

TABLE OF CONTENTS

<u>Topics</u>	<u>Page #</u>
<i>Overview.....</i>	<i>4</i>
<i>Begin a Provider Enrollment Application</i>	<i>5</i>
<i>Start Page.....</i>	<i>7</i>
<i>Provider Information</i>	<i>9</i>
<i>Policies and Procedures.....</i>	<i>10</i>
<i>Provider Banking Information</i>	<i>12</i>
<i>Provider W-9</i>	<i>14</i>
<i>Provider Specialty Section</i>	<i>16</i>
<i>Provider Questionnaire</i>	<i>21</i>
<i>Provider Checklist and Application Submission.....</i>	<i>22</i>
<i>Field Definitions.....</i>	<i>23</i>
<i>Basic Tips/FAQs</i>	<i>24</i>

Overview

The BreastCare Provider Enrollment System is an electronic application process designed to give providers an easier method for contracting to provide clinical services to patients enrolled in the program.

BreastCare has developed this document to guide you through the process of accessing the provider enrollment system and completing the Public Health Service Agreement (PHSA).

The BreastCare Provider Enrollment System electronic PHSA application process should take approximately 15-30 minutes to complete. Each page has fields that must be completed to continue the process. Once a page is completed, you may navigate back to it through the enrollment menu located at the top of the screen. **Do not use the browser back button as information entered may not be saved.**

There are four basic steps to completing this new enrollment process:

1. Before you start the enrollment process, please have all applicable documents ready:
 - NPIs for both group and individual providers
 - Group Tax ID number and individual providers' social security number
 - Banking Routing and Account number
 - Individual Medicare number
 - Individual provider Arkansas Medical/Nursing License number and expiration date
 - Individual provider DEA Registration number and expiration date, if applicable
2. Complete and submit your internet-based application.
3. ADH BreastCare reviews your application and emails the agreement to you for your review and signature.
4. Print, sign, date, and mail all pages of the agreement to the following address:
 - Arkansas Department of Health
 - Attention: BreastCare Provider Management
 - 4815 W Markham St, Slot 11
 - Little Rock, AR 72205

Begin a Provider Enrollment Application

A new enrollment application may be started by typing or copying and pasting the following internet address in the address bar of your browser and pressing enter;

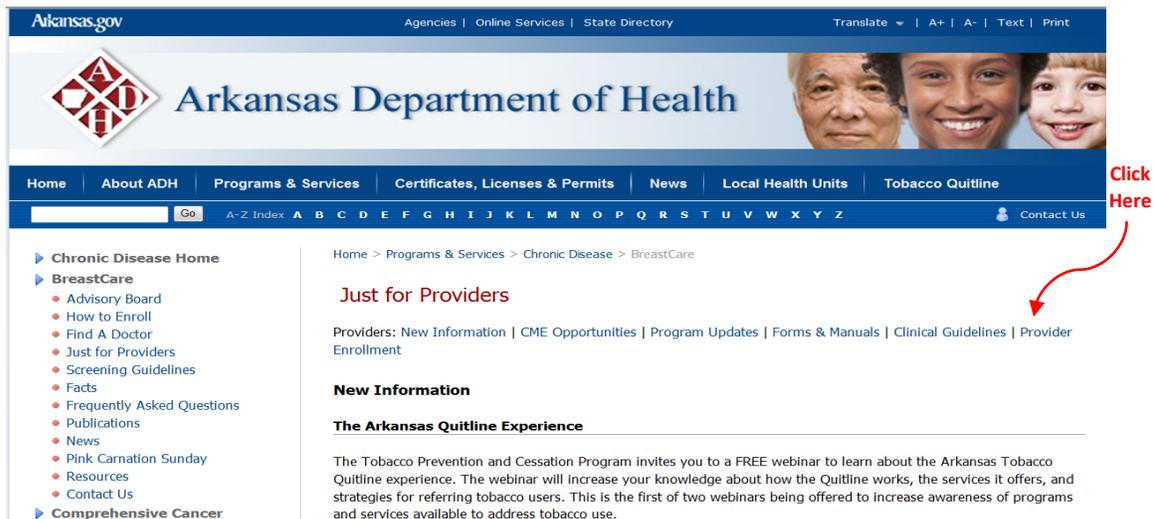
<https://health.arkansas.gov/BreastCareOnlineNew/>

or by visiting the Arkansas Department of Health website at

<http://www.healthy.arkansas.gov/programsServices/chronicDisease/ArBreastCare/Pages/default.aspx> and clicking on “Just for Providers” link on left side of webpage.



Next click on the “Provider Online Enrollment” link.



Next, click on the <https://health.arkansas.gov/BreastCareOnlineNew/> link.

The screenshot shows the Arkansas Department of Health website. The header includes the Arkansas logo and the text 'Arkansas Department of Health'. Below the header is a navigation menu with links for Home, About ADH, Programs & Services, Certificates, Licenses & Permits, News, Local Health Units, and Tobacco Quitline. A search bar and an A-Z index are also present. The main content area is titled 'Provider Enrollment Process' and contains the following text:

Home > Programs & Services > Chronic Disease > BreastCare

Provider Enrollment Process

Providers: [New Information](#) | [Professional Development](#) | [Forms & Manuals](#) | [Clinical Guidelines](#) | [Provider Enrollment](#)

Early detection and treatment are our best bets for helping Arkansas women fight breast and cervical cancer. We need more providers to accomplish this goal. During fiscal year 2011, BreastCare was able to provide mammograms and pap smears to 10,000 women out of a possible 48,000 women that are eligible for services.

It is easy to enroll. Just go to <https://health.arkansas.gov/BreastCareOnlineNew/> and complete your application, it should require only 15 minutes to complete a basic application. [Click here](#), for detailed information on the process.

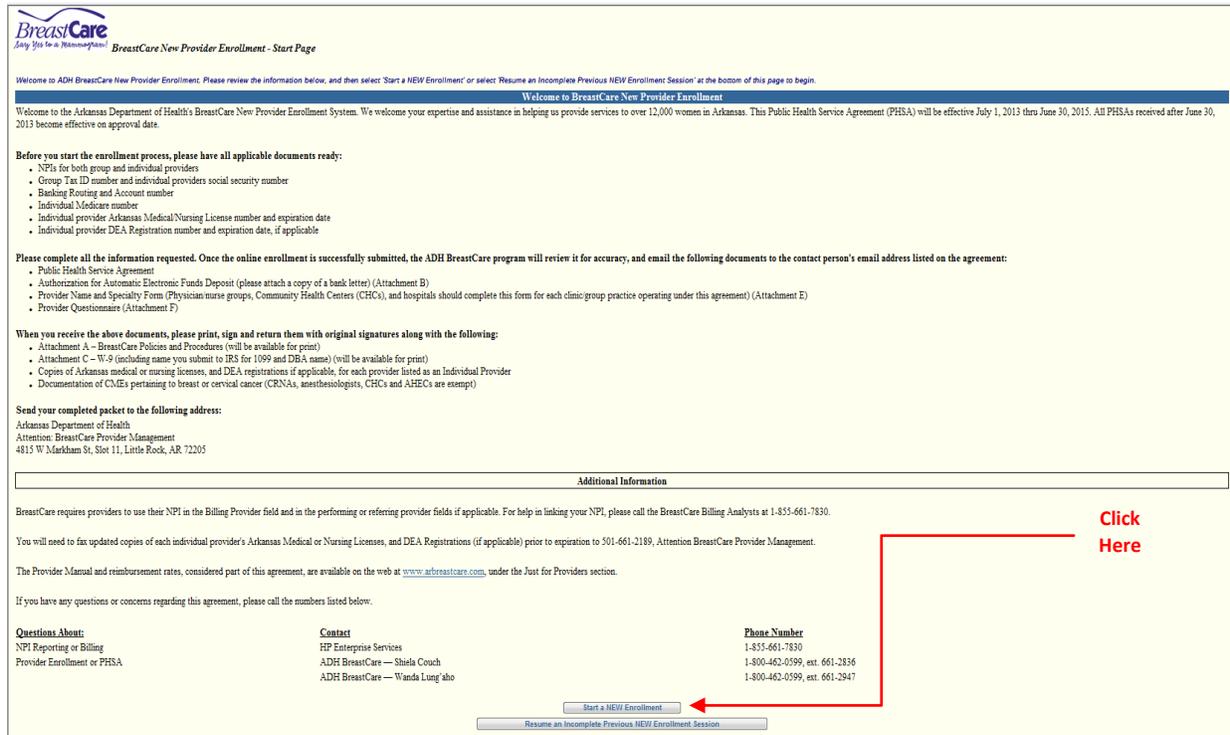
In order to enroll as a BreastCare provider you will need to complete: Provider Basic Identification, Provider Demography, Provider Banking Information, W-9 Form, Provider Specialty Form, and Questionnaire. Have all documents for the application ready and the process will move faster.

After you submit your application online, BreastCare will review it and email the Public Health Service Agreement back to you for your signature. After we receive your signed application with attachments and copy of licenses and DEA's (when applicable), it will be processed and approved.

**Click
Here**

Start Page

Read the instructions on this webpage carefully before proceeding. Click on “Start a NEW Enrollment” button at the bottom of the page to begin the application.



Welcome to BreastCare New Provider Enrollment

Welcome to the Arkansas Department of Health's BreastCare New Provider Enrollment System. We welcome your expertise and assistance in helping us provide services to over 12,000 women in Arkansas. This Public Health Service Agreement (PHSA) will be effective July 1, 2013 thru June 30, 2015. All PHSAs received after June 30, 2013 become effective on approval date.

Before you start the enrollment process, please have all applicable documents ready:

- NPIs for both group and individual providers
- Group Tax ID number and individual providers social security number
- Banking Routing and Account number
- Individual Medicare number
- Individual provider Arkansas Medical Nursing License number and expiration date
- Individual provider DEA Registration number and expiration date, if applicable

Please complete all the information requested. Once the online enrollment is successfully submitted, the ADH BreastCare program will review it for accuracy, and email the following documents to the contact person's email address listed on the agreement:

- Public Health Service Agreement
- Authorization for Automatic Electronic Funds Deposit (please attach a copy of a bank letter) (Attachment B)
- Provider Name and Specialty Form (Physician nurse groups, Community Health Centers (CHCs), and hospitals should complete this form for each clinic/group practice operating under this agreement) (Attachment E)
- Provider Questionnaire (Attachment F)

When you receive the above documents, please print, sign and return them with original signatures along with the following:

- Attachment A – BreastCare Policies and Procedures (will be available for print)
- Attachment C – W-9 (including name you submit to IRS for 1099 and DEA name) (will be available for print)
- Copies of Arkansas medical or nursing licenses, and DEA registrations if applicable, for each provider listed as an Individual Provider
- Documentation of CMEs pertaining to breast or cervical cancer (CRNAs, anesthesiologists, CHCs and AHECs are exempt)

Send your completed packet to the following address:

Arkansas Department of Health
Attention: BreastCare Provider Management
4815 W Markham St, Slot 11, Little Rock, AR 72205

Additional Information

BreastCare requires providers to use their NPI in the Billing Provider field and in the performing or referring provider fields if applicable. For help in linking your NPI, please call the BreastCare Billing Analysts at 1-855-661-7830.

You will need to fax updated copies of each individual provider's Arkansas Medical or Nursing Licenses, and DEA Registrations (if applicable) prior to expiration to 501-661-2189, Attention BreastCare Provider Management.

The Provider Manual and reimbursement rates, considered part of this agreement, are available on the web at www.arbreastcare.com, under the Just for Providers section.

If you have any questions or concerns regarding this agreement, please call the numbers listed below:

Questions About:	Contact	Phone Number
NPI Reporting or Billing	HP Enterprise Services	1-855-661-7830
Provider Enrollment or PHSA	ADH BreastCare — Shields Couch	1-800-462-0599 ext. 661-2836
	ADH BreastCare — Wanda Lung'aho	1-800-462-0599 ext. 661-2947

Enter a password so you can resume the application later if you do not complete it now. Click “Continue.”



Create a Session Password and Number

In case you do not complete your Enrollment at one sitting, please provide a 6 to 32 character Session password so you can resume later without losing any information. IMPORTANT: This is ONLY for your Enrollment session, it is NOT your BreastCare Online password that you will set later if you are given a user account for that system for the purpose of Patient Management or managing your provider information.

Session Password and Number

Enter a Password to Enable Later Resumption of This Session: * ← Enter password

(A Unique Session Number Will Be Created When You Continue)

← Click here

Write down your password and session number to resume your application later if needed. Then, click “Continue Enrollment.”

BreastCare
Say Yes to a Mammogram! Create a Session Password and Number

Your Session Password and Session Number have been created. Save them in case your Enrollment is interrupted or not completed in this browser session...

Session Password and Number

Your Session Password Is:

Your Session Number Is:

Continue Enrollment

Your password and session number is displayed

Click here

Enter your National Provider Identifier (NPI) and click “Save and Continue.”

BreastCare
Say Yes to a Mammogram! Begin New Enrollment Process

Enter the requested information and select 'Save and Continue'...

Initial

Before you start, be sure to have all necessary documents (e.g., NPIs for clinics/groups and individual providers, information for W-9, EFT Bank Routing Number and Account Number, etc.) ready.

National Provider Identifier (NPI):

Save and Continue

Enter NPI

Click here

* Required

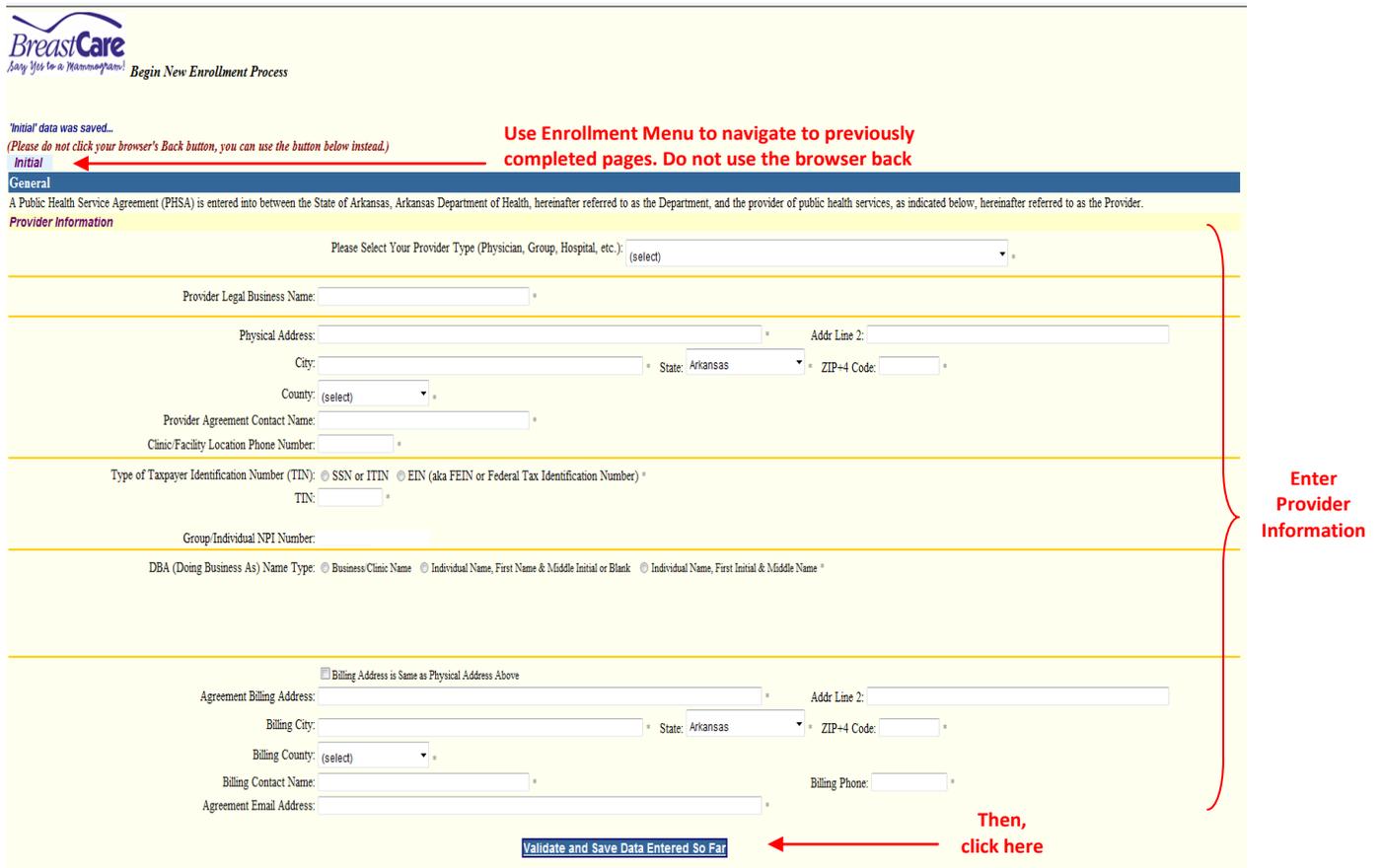
Provider Information

Once a page is completed, you may navigate back to it through the enrollment menu located at the top of the screen. **Do not use the browser back button as information entered may not be saved.**

Select your provider type from the drop down box. Enter your provider information including name, address, tax identification number and billing information (see field definitions on page 24). **Do not include dashes (-) when entering phone numbers.**

- The “Billing Address is Same as Physical Address Above” box may be checked if the provider’s physical and billing addresses are the same. The billing address fields will be copied from the physical address fields.
- It is essential that you provide a valid e-mail address in the “Agreement Email Address” field. A confirmation of your application submission will be sent to this address.

When all information is entered, click “Validate and Save Data Entered So Far.”



Initial' data was saved...
(Please do not click your browser's Back button, you can use the button below instead.)

Use Enrollment Menu to navigate to previously completed pages. Do not use the browser back

Initial

General
A Public Health Service Agreement (PHSA) is entered into between the State of Arkansas, Arkansas Department of Health, hereinafter referred to as the Department, and the provider of public health services, as indicated below, hereinafter referred to as the Provider.

Provider Information

Please Select Your Provider Type (Physician, Group, Hospital, etc.): (select) *

Provider Legal Business Name: *

Physical Address: * Addr Line 2: *

City: * State: Arkansas * ZIP+4 Code: *

Country: (select) *

Provider Agreement Contact Name: *

Clinic/Facility Location Phone Number: *

Type of Taxpayer Identification Number (TIN): SSN or ITIN EIN (aka FEIN or Federal Tax Identification Number) *

TIN: *

Group/Individual NPI Number: *

DBA (Doing Business As) Name Type: Business Clinic Name Individual Name, First Name & Middle Initial or Blank Individual Name, First Initial & Middle Name *

Billing Address is Same as Physical Address Above

Agreement Billing Address: * Addr Line 2: *

Billing City: * State: Arkansas * ZIP+4 Code: *

Billing Country: (select) *

Billing Contact Name: * Billing Phone: *

Agreement Email Address: *

Validate and Save Data Entered So Far

Then, click here

Enter Provider Information

Policies and Procedures

Click "Open, Print and Sign Policies and Procedures to Continue Enrollment"

Provider Legal Business Name: Legal Name *

Physical Address: 1234 Street Address * Addr Line 2: *

City: City * State: Arkansas * ZIP+4 Code: 72205-0000 *

County: Pulaski *

Provider Agreement Contact Name: Name *

Clinic/Facility Location Phone Number: 5011234567 *

Type of Taxpayer Identification Number (TIN): SSN - ITIN * EIN (aka FEIN or Federal Tax Identification Number) *

Social Security Number or ITIN (Individual): 123456789 *

Group/Individual NPI Number: 1477523348

DBA (Doing Business As) Name Type: Business/Clinic Name Individual Name, First Name & Middle Initial or Blank Individual Name, First Initial & Middle Name *

First Name: Legal

Middle Initial: *

Last Name: Name *

Title: MD *

Billing Address is Same as Physical Address Above

Agreement Billing Address: 1234 Street Address * Addr Line 2: *

Billing City: City * State: Arkansas * ZIP+4 Code: 72205-0000 *

Billing County: Pulaski *

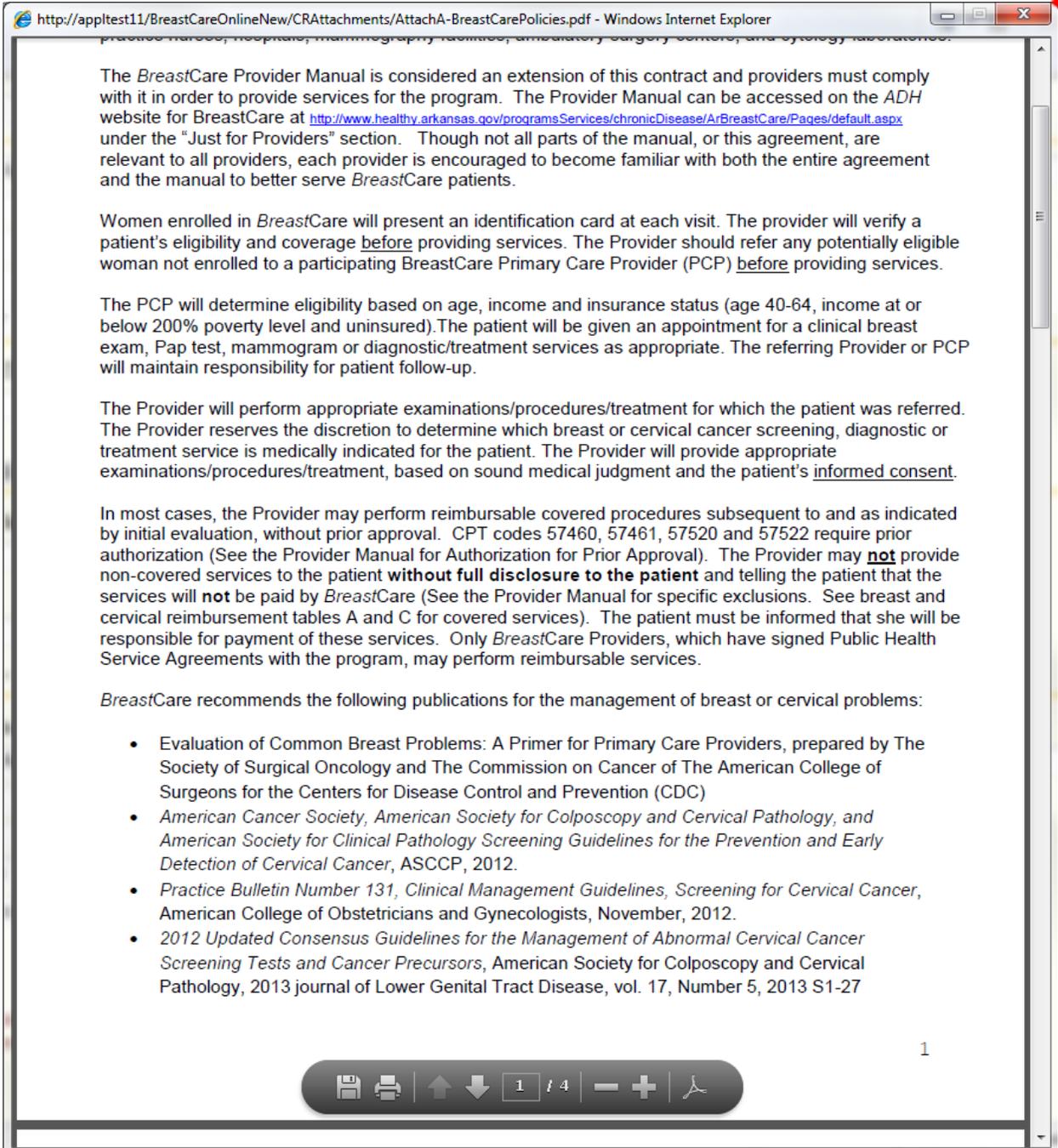
Billing Contact Name: Billing Name * Billing Phone: 5011234567 *

Agreement Email Address: email@yahoo.com *

Validate and Save Data Entered So Far

To continue, you must open and agree to the Policies and Procedures. Select [Open, Print, and Sign Policies and Procedures to Continue Enrollment](#) ← **Click here** this link to open the PDF document.

The BreastCare Program Policies and Procedures will open in a new window for you to read, print and sign. You may also save the document to your computer. Click on the red X to close the window.



http://appltst11/BreastCareOnlineNew/CRAttachments/AttachA-BreastCarePolicies.pdf - Windows Internet Explorer

The *BreastCare* Provider Manual is considered an extension of this contract and providers must comply with it in order to provide services for the program. The Provider Manual can be accessed on the ADH website for BreastCare at <http://www.healthy.arkansas.gov/programsServices/chronicDisease/ArBreastCare/Pages/default.aspx> under the "Just for Providers" section. Though not all parts of the manual, or this agreement, are relevant to all providers, each provider is encouraged to become familiar with both the entire agreement and the manual to better serve *BreastCare* patients.

Women enrolled in *BreastCare* will present an identification card at each visit. The provider will verify a patient's eligibility and coverage before providing services. The Provider should refer any potentially eligible woman not enrolled to a participating *BreastCare* Primary Care Provider (PCP) before providing services.

The PCP will determine eligibility based on age, income and insurance status (age 40-64, income at or below 200% poverty level and uninsured). The patient will be given an appointment for a clinical breast exam, Pap test, mammogram or diagnostic/treatment services as appropriate. The referring Provider or PCP will maintain responsibility for patient follow-up.

The Provider will perform appropriate examinations/procedures/treatment for which the patient was referred. The Provider reserves the discretion to determine which breast or cervical cancer screening, diagnostic or treatment service is medically indicated for the patient. The Provider will provide appropriate examinations/procedures/treatment, based on sound medical judgment and the patient's informed consent.

In most cases, the Provider may perform reimbursable covered procedures subsequent to and as indicated by initial evaluation, without prior approval. CPT codes 57460, 57461, 57520 and 57522 require prior authorization (See the Provider Manual for Authorization for Prior Approval). The Provider may **not** provide non-covered services to the patient **without full disclosure to the patient** and telling the patient that the services will **not** be paid by *BreastCare* (See the Provider Manual for specific exclusions. See breast and cervical reimbursement tables A and C for covered services). The patient must be informed that she will be responsible for payment of these services. Only *BreastCare* Providers, which have signed Public Health Service Agreements with the program, may perform reimbursable services.

BreastCare recommends the following publications for the management of breast or cervical problems:

- Evaluation of Common Breast Problems: A Primer for Primary Care Providers, prepared by The Society of Surgical Oncology and The Commission on Cancer of The American College of Surgeons for the Centers for Disease Control and Prevention (CDC)
- *American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology Screening Guidelines for the Prevention and Early Detection of Cervical Cancer*, ASCCP, 2012.
- *Practice Bulletin Number 131, Clinical Management Guidelines, Screening for Cervical Cancer*, American College of Obstetricians and Gynecologists, November, 2012.
- *2012 Updated Consensus Guidelines for the Management of Abnormal Cervical Cancer Screening Tests and Cancer Precursors*, American Society for Colposcopy and Cervical Pathology, 2013 journal of Lower Genital Tract Disease, vol. 17, Number 5, 2013 S1-27

1

PDF viewer controls: Save, Print, Previous, Next, Page 1 of 4, Zoom In, Zoom Out, Refresh

Check the box “I have read and agreed to the terms in the Policies and Procedures.”

Provider Legal Business Name: Legal Name *

Physical Address: 1234 Street Address * Addr Line 2: *

City: City * State: Arkansas * ZIP+4 Code: 72205-0000 *

County: Pulaski *

Provider Agreement Contact Name: Name *

Clinic/Facility Location Phone Number: 5011234567 *

Type of Taxpayer Identification Number (TIN): SSN or ITIN EIN (aka FEIN or Federal Tax Identification Number) *

Social Security Number or ITIN (Individual): 123456789 *

Group/Individual NPI Number: 1477523348

DBA (Doing Business As) Name Type: Business/Clinic Name Individual Name, First Name & Middle Initial or Blank Individual Name, First Initial & Middle Name *

First Name: Legal *

Middle Initial: *

Last Name: Name *

Title: MD *

Billing Address is Same as Physical Address Above

Agreement Billing Address: 1234 Street Address * Addr Line 2: *

Billing City: City * State: Arkansas * ZIP+4 Code: 72205-0000 *

Billing County: Pulaski *

Billing Contact Name: Billing Name * Billing Phone: 5011234567 *

Agreement Email Address: email@yahoo.com *

Validate and Save Data Entered So Far

To continue, you must open and agree to the Policies and Procedures. Select this link to open the PDF document: [Open, Print, and Sign Policies and Procedures to Continue Enrollment](#)

I have read and agreed to the terms in the Policies and Procedures ← Check box

Click “Continue.”

Provider Legal Business Name: Legal Name *

Physical Address: 1234 Street Address * Addr Line 2: *

City: City * State: Arkansas * ZIP+4 Code: 72205-0000 *

County: Pulaski *

Provider Agreement Contact Name: Name *

Clinic/Facility Location Phone Number: 5011234567 *

Type of Taxpayer Identification Number (TIN): SSN or ITIN EIN (aka FEIN or Federal Tax Identification Number) *

Social Security Number or ITIN (Individual): 123456789 *

Group/Individual NPI Number: 1477523348

DBA (Doing Business As) Name Type: Business/Clinic Name Individual Name, First Name & Middle Initial or Blank Individual Name, First Initial & Middle Name *

First Name: Legal *

Middle Initial: *

Last Name: Name *

Title: MD *

Billing Address is Same as Physical Address Above

Agreement Billing Address: 1234 Street Address * Addr Line 2: *

Billing City: City * State: Arkansas * ZIP+4 Code: 72205-0000 *

Billing County: Pulaski *

Billing Contact Name: Billing Name * Billing Phone: 5011234567 *

Agreement Email Address: email@yahoo.com *

Validate and Save Data Entered So Far

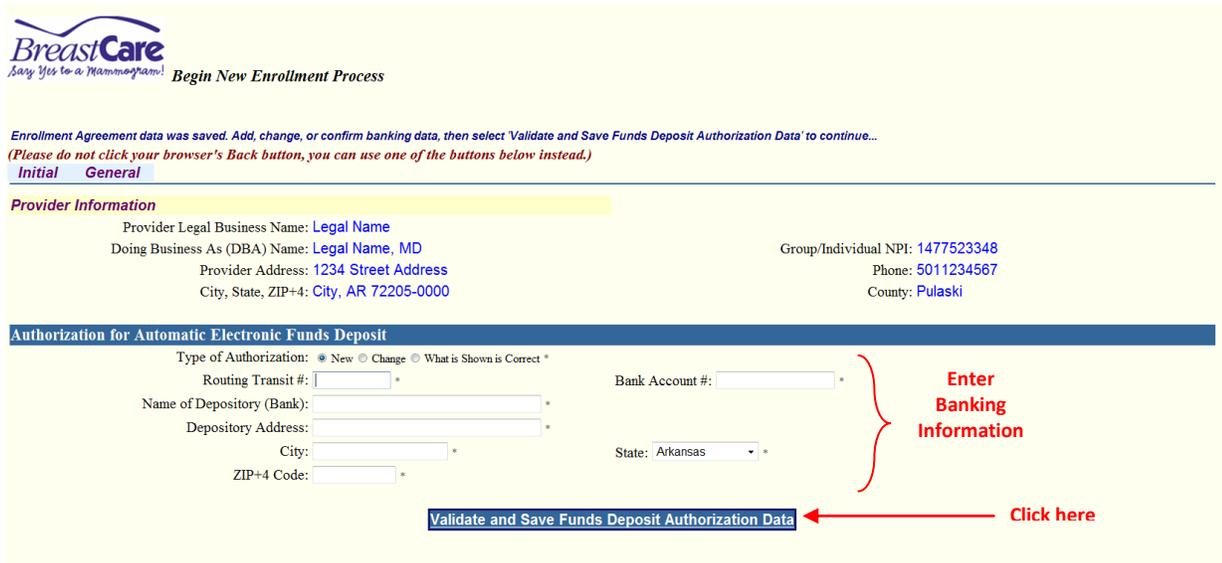
To continue, you must open and agree to the Policies and Procedures. Select this link to open the PDF document: [Open, Print, and Sign Policies and Procedures to Continue Enrollment](#)

I have read and agreed to the terms in the Policies and Procedures

[Continue](#) ← Click here

Provider Banking Information

Enter your banking information in the appropriate fields. Then, click “Validate and Save Funds Deposit Authorization Data.”



BreastCare
Say Yes to a Mammogram! *Begin New Enrollment Process*

*Enrollment Agreement data was saved. Add, change, or confirm banking data, then select 'Validate and Save Funds Deposit Authorization Data' to continue...
(Please do not click your browser's Back button, you can use one of the buttons below instead.)*

Initial **General**

Provider Information

Provider Legal Business Name: **Legal Name**
 Doing Business As (DBA) Name: **Legal Name, MD**
 Provider Address: **1234 Street Address**
 City, State, ZIP+4: **City, AR 72205-0000**

Group/Individual NPI: **1477523348**
 Phone: **5011234567**
 County: **Pulaski**

Authorization for Automatic Electronic Funds Deposit

Type of Authorization: New Change What is Shown is Correct *

Routing Transit #: *

Name of Depository (Bank): *

Depository Address: *

City: *

ZIP+4 Code: *

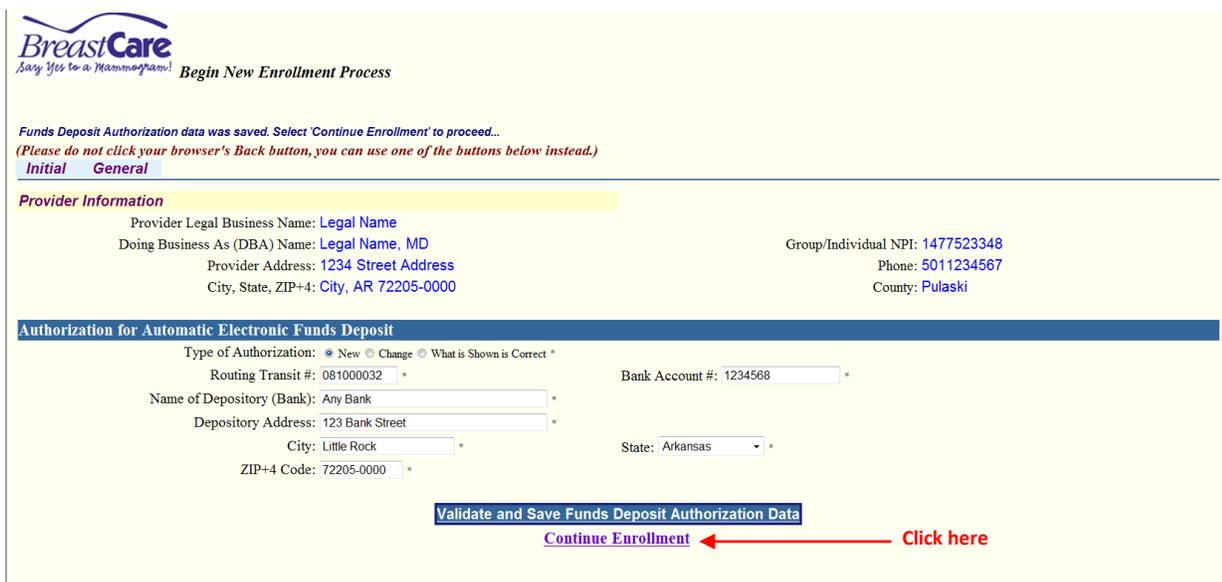
Bank Account #: *

State: **Arkansas** *

Enter Banking Information

Validate and Save Funds Deposit Authorization Data ← **Click here**

Then, click “Continue Enrollment.”



BreastCare
Say Yes to a Mammogram! *Begin New Enrollment Process*

*Funds Deposit Authorization data was saved. Select 'Continue Enrollment' to proceed...
(Please do not click your browser's Back button, you can use one of the buttons below instead.)*

Initial **General**

Provider Information

Provider Legal Business Name: **Legal Name**
 Doing Business As (DBA) Name: **Legal Name, MD**
 Provider Address: **1234 Street Address**
 City, State, ZIP+4: **City, AR 72205-0000**

Group/Individual NPI: **1477523348**
 Phone: **5011234567**
 County: **Pulaski**

Authorization for Automatic Electronic Funds Deposit

Type of Authorization: New Change What is Shown is Correct *

Routing Transit #: **081000032** *

Name of Depository (Bank): **Any Bank** *

Depository Address: **123 Bank Street** *

City: **Little Rock** *

ZIP+4 Code: **72205-0000** *

Bank Account #: **1234568** *

State: **Arkansas** *

Validate and Save Funds Deposit Authorization Data

Continue Enrollment ← **Click here**

Provider W-9

Click "Open, Print, Complete and Sign W-9 to Continue Enrollment."

[Begin New Enrollment Process](#)

First select the 'Open, Print, Complete and Sign W-9 to Continue Enrollment' link, then you can check the confirmation checkbox...

Select 'Open, Print, Complete and Sign W-9 to Continue Enrollment'. After saving the W-9 form, check the box 'I have read, printed and agreed to the terms on the W-9'... Please do not click your browser's Back button, you can use one of the buttons below instead.)

[Initial](#) [General](#)

Provider Information

Provider Legal Business Name: **Legal Name**
 Doing Business As (DBA) Name: **Legal Name, MD**
 Provider Address: **1234 Street Address**
 City, State, ZIP+4: **City, AR 72205-0000**
 Group/Individual NPI: **1477523348**
 Phone: **5011234567**
 County: **Pulaski**

Authorization for Automatic Electronic Funds Deposit

Type of Authorization: New Change What is Shown is Correct *
 Routing Transit #: 081000032 * Bank Account #: 1234568 *
 Name of Depository (Bank): Any Bank *
 Depository Address: 123 Bank Street *
 City: Little Rock * State: Arkansas *
 ZIP+4 Code: 72205-0000 *

[Validate and Save Funds Deposit Authorization Data](#)

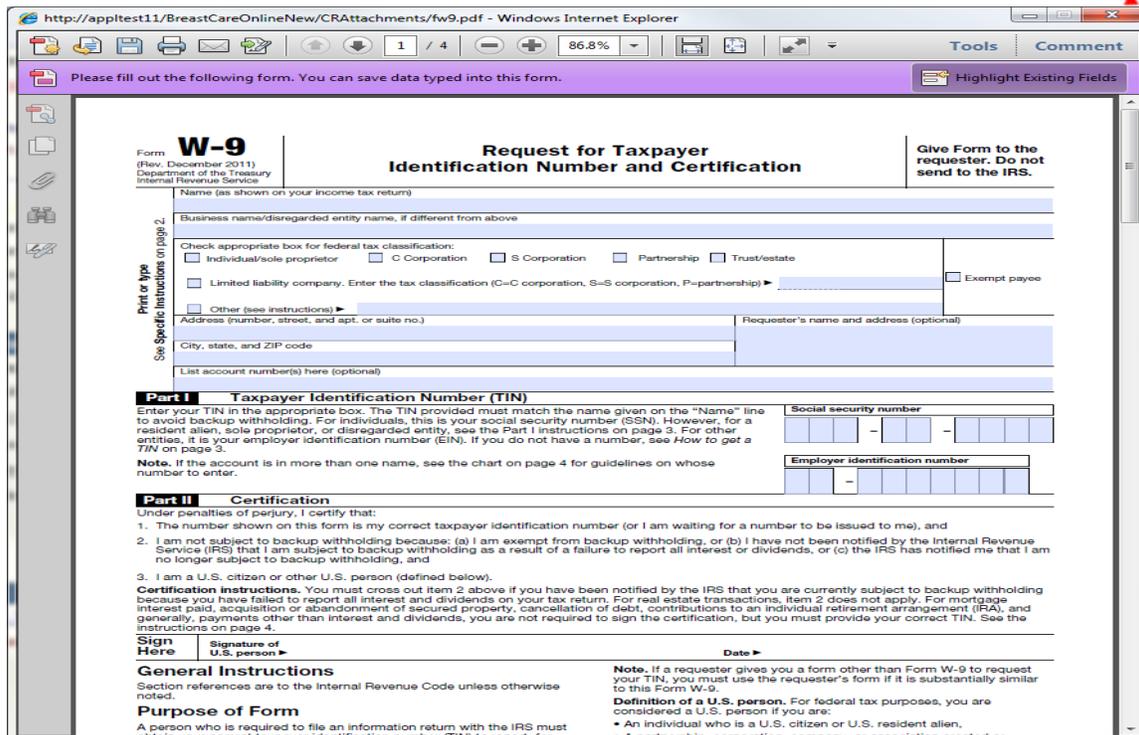
W-9

[Open, Print, Complete and Sign W-9 to Continue Enrollment](#) I have read, printed and agreed to the terms on the W-9

*** NOTE: Please include a filled-out W-9 in your complete mailed packet. If a W-9 is not received, the application will be denied. ***

Click here

The W-9 will open in a new window for you to read, complete, print and sign. Information entered on the form cannot be saved. Click on the red X to close the window.



http://apptest11/BreastCareOnlineNew/CRAttachments/fw9.pdf - Windows Internet Explorer

Please fill out the following form. You can save data typed into this form. [Highlight Existing Fields](#)

Form W-9
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
 Individual/sole proprietor C Corporation S Corporation Partnership Trust/estate
 Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) Exempt payee
 Other (see instructions)

Address (number, street, and apt. or suite no.) Requester's name and address (optional)
 City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)
 Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.
 Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification
 Under penalties of perjury, I certify that:
 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
 3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person **Date**

General Instructions
 Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form
 A person who is required to file an information return with the IRS must

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.
Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:
 • An individual who is a U.S. citizen or U.S. resident alien.

Check the box "I have read and agreed to the terms on the W-9."

Say Yes to a Mammogram! **Begin New Enrollment Process**

Please check the W-9 confirmation checkbox...

Select 'Open, Print, Complete and Sign W-9 to Continue Enrollment'. After saving the W-9 form, check the box 'I have read, printed and agreed to the terms on the W-9'...
(Please do not click your browser's Back button, you can use one of the buttons below instead.)

Initial **General**

Provider Information

Provider Legal Business Name: **Legal Name**
 Doing Business As (DBA) Name: **Legal Name, MD**
 Provider Address: **1234 Street Address**
 City, State, ZIP+4: **City, AR 72205-0000**

Group/Individual NPI: **1477523348**
 Phone: **5011234567**
 County: **Pulaski**

Authorization for Automatic Electronic Funds Deposit

Type of Authorization: New Change What is Shown is Correct *

Routing Transit #: 081000032 * Bank Account #: 1234568 *

Name of Depository (Bank): Any Bank *

Depository Address: 123 Bank Street *

City: Little Rock * State: Arkansas *

ZIP+4 Code: 72205-0000 *

Validate and Save Funds Deposit Authorization Data

W-9

[Open, Print, Complete and Sign W-9 to Continue Enrollment](#) I have read, printed and agreed to the terms on the W-9 **Check box**

*** NOTE: Please include a filled-out W-9 in your complete mailed packet. If a W-9 is not received, the application will be denied. ***

Click "Continue Enrollment."

Say Yes to a Mammogram! **Begin New Enrollment Process**

Please select 'Continue Enrollment'...
(Please do not click your browser's Back button, you can use one of the buttons below instead.)

Initial **General**

Provider Information

Provider Legal Business Name: **Legal Name**
 Doing Business As (DBA) Name: **Legal Name, MD**
 Provider Address: **1234 Street Address**
 City, State, ZIP+4: **City, AR 72205-0000**

Group/Individual NPI: **1477523348**
 Phone: **5011234567**
 County: **Pulaski**

Authorization for Automatic Electronic Funds Deposit

Type of Authorization: New Change What is Shown is Correct *

Routing Transit #: 081000032 * Bank Account #: 1234568 *

Name of Depository (Bank): Any Bank *

Depository Address: 123 Bank Street *

City: Little Rock * State: Arkansas *

ZIP+4 Code: 72205-0000 *

Validate and Save Funds Deposit Authorization Data

W-9

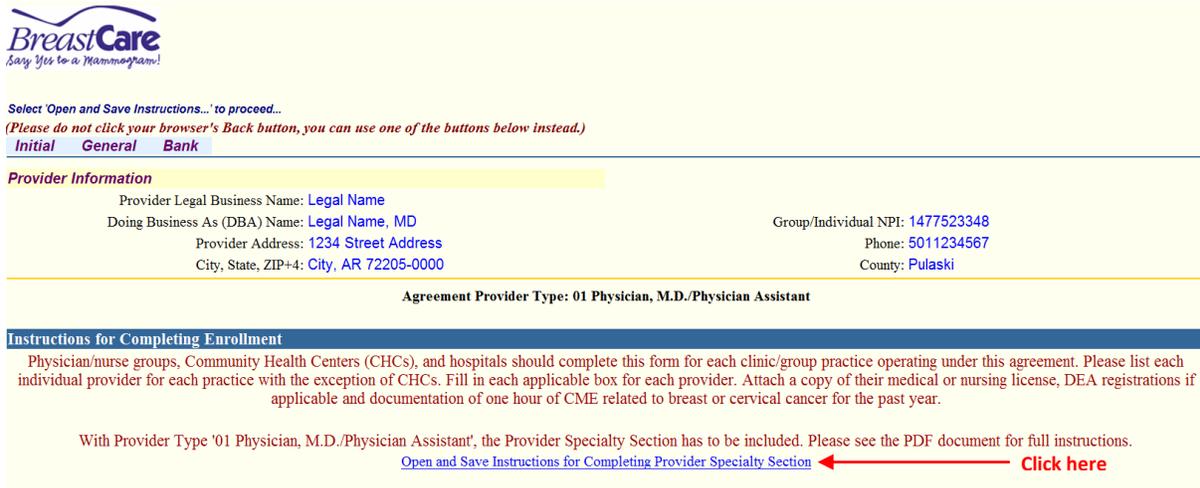
[Open, Print, Complete and Sign W-9 to Continue Enrollment](#) I have read, printed and agreed to the terms on the W-9

*** NOTE: Please include a filled-out W-9 in your complete mailed packet. If a W-9 is not received, the application will be denied. ***

[Continue Enrollment](#) **Click here**

Provider Specialty Section

Click "Open and Save Instructions for Completing Provider Specialty Section."



BreastCare
Say Yes to a Mammogram!

Select 'Open and Save Instructions...' to proceed...
(Please do not click your browser's Back button, you can use one of the buttons below instead.)

[Initial](#) [General](#) [Bank](#)

Provider Information

Provider Legal Business Name: Legal Name	Group/Individual NPI: 1477523348
Doing Business As (DBA) Name: Legal Name, MD	Phone: 5011234567
Provider Address: 1234 Street Address	County: Pulaski
City, State, ZIP+4: City, AR 72205-0000	

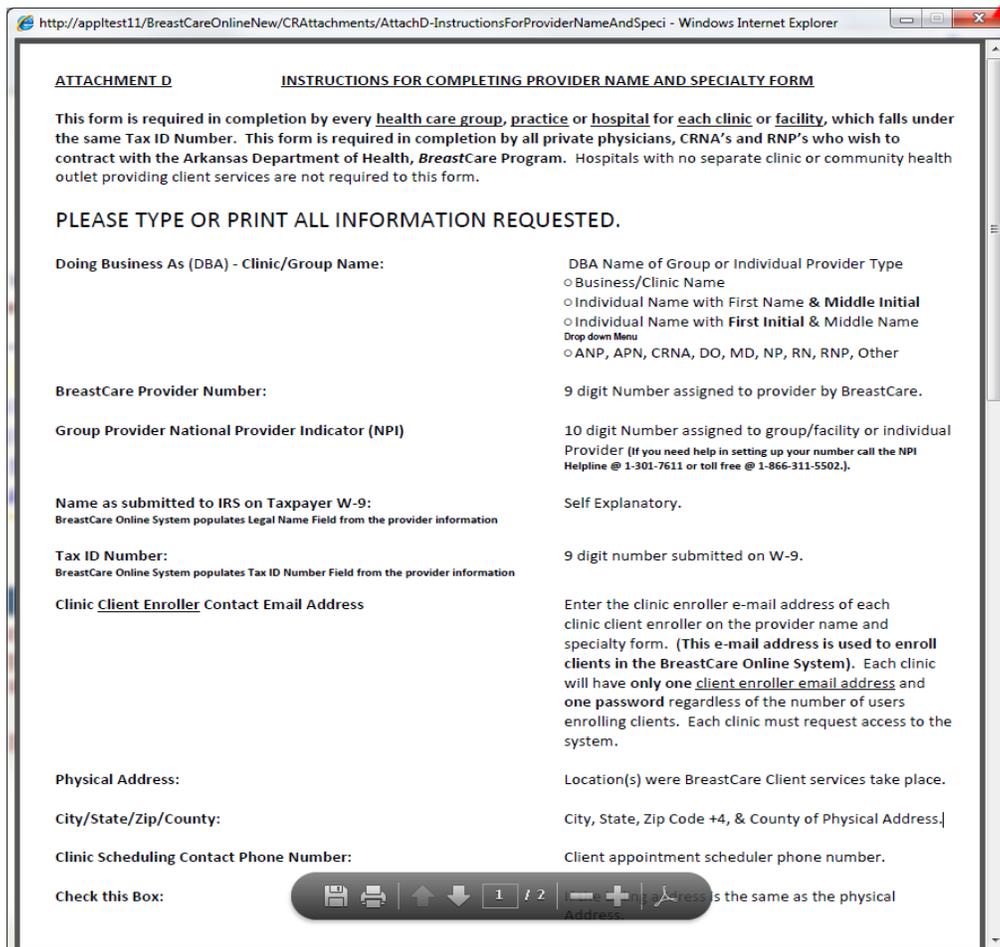
Agreement Provider Type: 01 Physician, M.D./Physician Assistant

Instructions for Completing Enrollment

Physician/nurse groups, Community Health Centers (CHCs), and hospitals should complete this form for each clinic/group practice operating under this agreement. Please list each individual provider for each practice with the exception of CHCs. Fill in each applicable box for each provider. Attach a copy of their medical or nursing license, DEA registrations if applicable and documentation of one hour of CME related to breast or cervical cancer for the past year.

With Provider Type '01 Physician, M.D./Physician Assistant', the Provider Specialty Section has to be included. Please see the PDF document for full instructions.
[Open and Save Instructions for Completing Provider Specialty Section](#) ← **Click here**

The Instructions for Completing Provider Name and Specialty Form will open in a new window for you to read and print. Click on the red X to close the window.



http://apptest11/BreastCareOnlineNew/CRAttachments/AttachD-InstructionsForProviderNameAndSpeci - Windows Internet Explorer

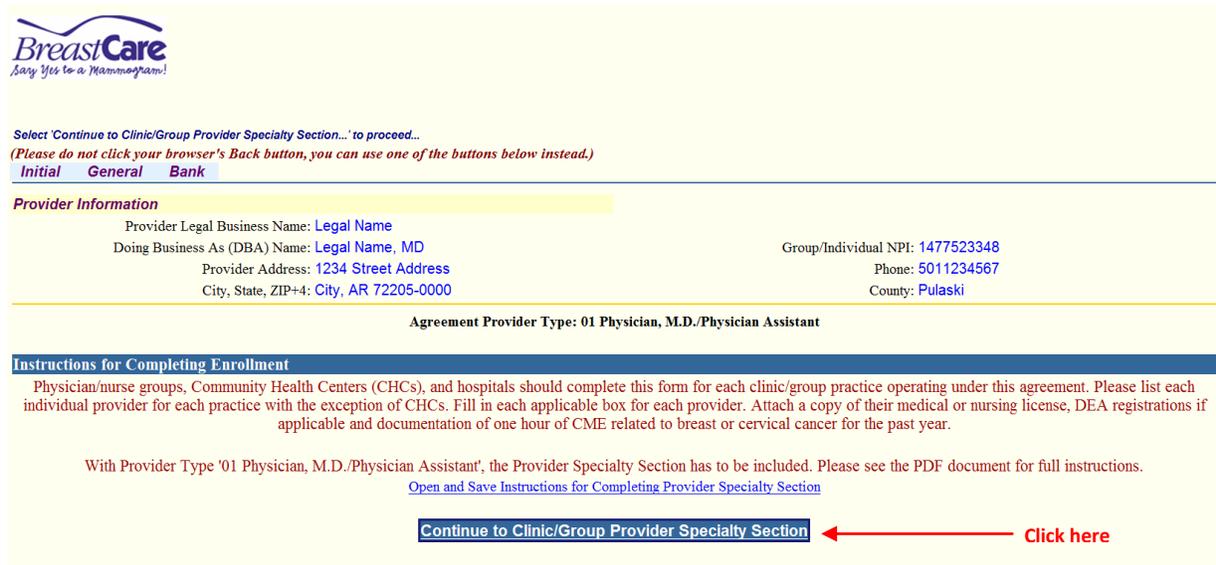
ATTACHMENT D **INSTRUCTIONS FOR COMPLETING PROVIDER NAME AND SPECIALTY FORM**

This form is required in completion by every health care group, practice or hospital for each clinic or facility, which falls under the same Tax ID Number. This form is required in completion by all private physicians, CRNA's and RNP's who wish to contract with the Arkansas Department of Health, **BreastCare Program**. Hospitals with no separate clinic or community health outlet providing client services are not required to this form.

PLEASE TYPE OR PRINT ALL INFORMATION REQUESTED.

Doing Business As (DBA) - Clinic/Group Name:	DBA Name of Group or Individual Provider Type <input type="radio"/> Business/Clinic Name <input type="radio"/> Individual Name with First Name & Middle Initial <input type="radio"/> Individual Name with First Initial & Middle Name <small>Drop down Menu</small> <input type="radio"/> ANP, APN, CRNA, DO, MD, NP, RN, RNP, Other
BreastCare Provider Number:	9 digit Number assigned to provider by BreastCare.
Group Provider National Provider Indicator (NPI)	10 digit Number assigned to group/facility or individual Provider (If you need help in setting up your number call the NPI Helpline @ 1-301-7611 or toll free @ 1-866-311-5502).
Name as submitted to IRS on Taxpayer W-9: <small>BreastCare Online System populates Legal Name Field from the provider information</small>	Self Explanatory.
Tax ID Number: <small>BreastCare Online System populates Tax ID Number Field from the provider information</small>	9 digit number submitted on W-9.
Clinic Client Enroller Contact Email Address	Enter the clinic enroller e-mail address of each clinic client enroller on the provider name and specialty form. (This e-mail address is used to enroll clients in the BreastCare Online System). Each clinic will have only one client enroller email address and one password regardless of the number of users enrolling clients. Each clinic must request access to the system.
Physical Address:	Location(s) were BreastCare Client services take place.
City/State/Zip/County:	City, State, Zip Code +4, & County of Physical Address
Clinic Scheduling Contact Phone Number:	Client appointment scheduler phone number.
Check this Box:	<input type="checkbox"/> <small>is the same as the physical</small>

Click “Continue to Clinic/Group Provider Specialty Section.”



BreastCare
Say Yes to a Mammogram!

Select 'Continue to Clinic/Group Provider Specialty Section...' to proceed...
(Please do not click your browser's Back button, you can use one of the buttons below instead.)

[Initial](#) [General](#) [Bank](#)

Provider Information

Provider Legal Business Name: Legal Name	Group/Individual NPI: 1477523348
Doing Business As (DBA) Name: Legal Name, MD	Phone: 5011234567
Provider Address: 1234 Street Address	County: Pulaski
City, State, ZIP+4: City, AR 72205-0000	

Agreement Provider Type: 01 Physician, M.D./Physician Assistant

Instructions for Completing Enrollment

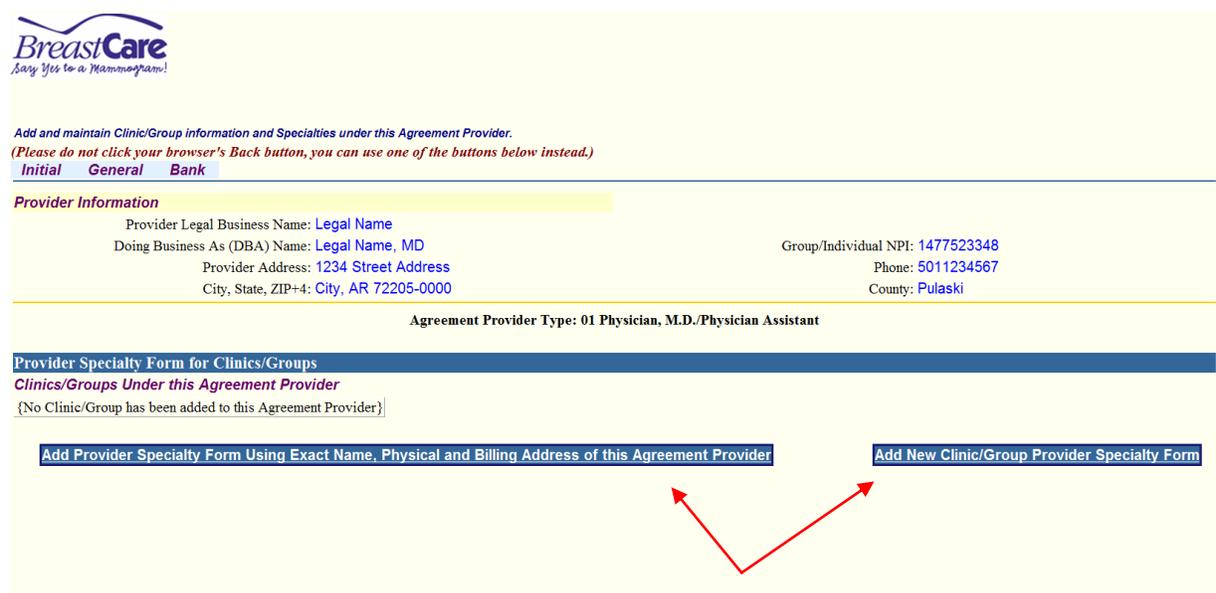
Physician/nurse groups, Community Health Centers (CHCs), and hospitals should complete this form for each clinic/group practice operating under this agreement. Please list each individual provider for each practice with the exception of CHCs. Fill in each applicable box for each provider. Attach a copy of their medical or nursing license, DEA registrations if applicable and documentation of one hour of CME related to breast or cervical cancer for the past year.

With Provider Type '01 Physician, M.D./Physician Assistant', the Provider Specialty Section has to be included. Please see the PDF document for full instructions.
[Open and Save Instructions for Completing Provider Specialty Section](#)

[Continue to Clinic/Group Provider Specialty Section](#) ← **Click here**

Add Provider Specialty Form by clicking on either “Add Provider Specialty Form Using Exact Name, Physical and Billing Address of this Agreement Provider” or “Add New Clinic/Group Provider Specialty Form.”

- To add a new clinic/group specialty form that has the same information as this agreement, select “Add Provider Specialty Form Using Exact Name, Physical and Billing Address of this Agreement Provider.”
- If there are other clinic/groups that need to be added under this agreement, select “Add New Clinic/Group Provider Specialty Form.”



BreastCare
Say Yes to a Mammogram!

Add and maintain Clinic/Group information and Specialties under this Agreement Provider.
(Please do not click your browser's Back button, you can use one of the buttons below instead.)

[Initial](#) [General](#) [Bank](#)

Provider Information

Provider Legal Business Name: Legal Name	Group/Individual NPI: 1477523348
Doing Business As (DBA) Name: Legal Name, MD	Phone: 5011234567
Provider Address: 1234 Street Address	County: Pulaski
City, State, ZIP+4: City, AR 72205-0000	

Agreement Provider Type: 01 Physician, M.D./Physician Assistant

Provider Specialty Form for Clinics/Groups

Clinics/Groups Under this Agreement Provider
{No Clinic/Group has been added to this Agreement Provider}

[Add Provider Specialty Form Using Exact Name, Physical and Billing Address of this Agreement Provider](#)
[Add New Clinic/Group Provider Specialty Form](#)

Add Provider Specialty Form Using Exact Name, Physical and Billing Address of this Agreement Provider

- Select the specialties for this clinic/group
- Click “Save.”

The DBA Name, Physical Address, Billing Address, Email, and Provider Type of the Agreement Provider have been copied into the Clinic/Group Specialty Form on this page. Make corrections if needed, choose one or more Specialties, and Save...
(Please do not click your browser's Back button, you can use one of the buttons below instead.)

[Initial](#) [General](#) [Bank](#) [Clinics/Groups](#)

Clinic/Group Information and Provider Specialty Form

Add a New Clinic/Group Specialty Form that has the same information as this Agreement Provider: **Legal Name, MD**

Select Clinic/Group Name Type: Business Clinic Name Individual Name with First Name Individual Name with First Initial & Middle Name *

Legal
Name
MD

Clinic/Group BreastCare Provider Number: Name as submitted to IRS on taxpayer W-9: **Legal Name**
Clinic/Group NPI: 1477523348 Tax ID #: 123-45-6789
Clinic/Group Email Address: email@yahoo.com

Physical Address of Clinic: 1234 Street Address
City: State: Arkansas ZIP+4 Code: 72205-0000
County: Pulaski
Clinic Phone Number: (501) 123-4567

Clinic/Group Billing Address is Same as Physical Address

Billing Address of Clinic: 1234 Street Address
City: State: Arkansas ZIP+4 Code: 72205-0000
Billing Phone Number: (501) 123-4567

Select Specialties for this Clinic/Group

Provider Type: 01 Physician, M.D./Physician Assistant

Specialties:

- 02 Surgery: General/Oncology
- 05 Anesthesia
- 08 Family General Practice
- 11 Internal Medicine
- 16 OB/GYN
- 22 Pathology
- 30 Radiology
- 31 Radiation Oncology
- C3 CRNA
- H2 hematology
- X1 Medical Oncology

Select specialty

[Return to List of Clinics/Groups](#) **Click here**

Click “View/Add Individual Providers for this Clinic/Group” to add a new individual provider.

[Initial](#) [General](#) [Bank](#) [Clinics/Groups](#)

Clinic/Group Information and Provider Specialty Form

Add a New Clinic/Group Specialty Form that has the same information as this Agreement Provider: **Legal Name, MD**

Select Clinic/Group Name Type: Business Clinic Name Individual Name with First Name Individual Name with First Initial & Middle Name *

Legal
Name
MD

Clinic/Group BreastCare Provider Number: Name as submitted to IRS on taxpayer W-9: **Legal Name**
Clinic/Group NPI: 1477523348 Tax ID #: 123-45-6789
Clinic/Group Email Address: email@yahoo.com

Physical Address of Clinic: 1234 Street Address
City: State: Arkansas ZIP+4 Code: 72205-0000
County: Pulaski
Clinic Phone Number: (501) 123-4567

Clinic/Group Billing Address is Same as Physical Address

Billing Address of Clinic: 1234 Street Address
City: State: Arkansas ZIP+4 Code: 72205-0000
Billing Phone Number: (501) 123-4567

Select Specialties for this Clinic/Group

Provider Type: 01 Physician, M.D./Physician Assistant

Specialties:

- 02 Surgery: General/Oncology
- 05 Anesthesia
- 08 Family General Practice
- 11 Internal Medicine
- 16 OB/GYN
- 22 Pathology
- 30 Radiology
- 31 Radiation Oncology
- C3 CRNA
- H2 hematology
- X1 Medical Oncology

Click here

[Return to List of Clinics/Groups](#) [View/Add Individual Providers for This Clinic/Group](#)

Click "Add New Individual Provider."



BreastCare
Say Yes to a Mammogram!

Individual Providers in the Clinic/Group LegalName, MD

Select "Add New Individual Provider" to add, or modify or delete Individual Providers from the list...
(Please do not click your browser's Back Button, information entered may not be saved. Please use tabs below to navigate.)

Initial General Bank Clinics/Groups Clinic/Group

Clinic/Group and Agreement Provider that these Individual Providers are Under
Clinic/Group Name: LegalName, MD Agreement Provider DBA Name: Legal Name, MD

Individual Providers List

[No Individual Providers have been added to this Clinic/Group]

[Add New Individual Provider](#) ← Click here

[Return to List of Clinics/Groups](#)

Enter individual provider information. Click "Save."



BreastCare
Say Yes to a Mammogram!

Individual Providers in the Clinic/Group LegalName, MD

Select "Add New Individual Provider" to add, or modify or delete Individual Providers from the list...
(Please do not click your browser's Back Button, information entered may not be saved. Please use tabs below to navigate.)

Initial General Bank Clinics/Groups Clinic/Group

Clinic/Group and Agreement Provider that these Individual Providers are Under
Clinic/Group Name: LegalName, MD Agreement Provider DBA Name: Legal Name, MD

Individual Provider and Specialties

Add Individual Provider Information

Select Individual Provider Name Display Type: Individual Name with First Name & Middle Initial or Blank Individual Name with First Initial & Middle Name Business/Clinic Name

Individual BreastCare Provider Number:
Individual NPI: *
Individual SSN:
Provider Type: (select) *
Provider Specialties:
Individual Provider Email Address:
Medicare Number: *
AR License Number: *
DEA Number:

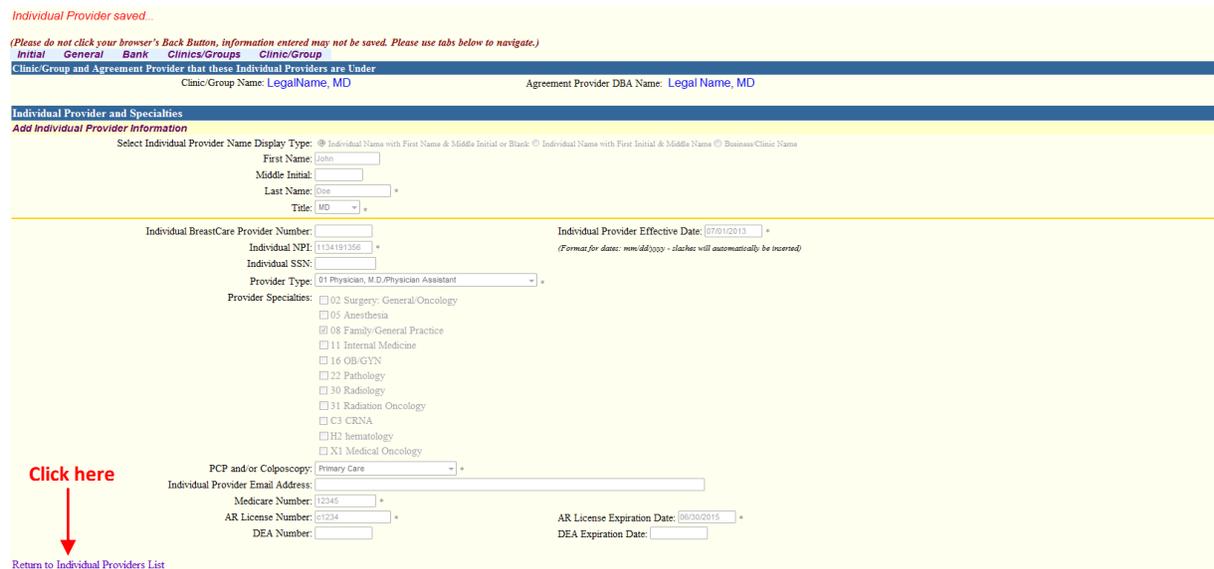
Individual Provider Effective Date: *
(Format for date: mm/dd/yyyy - slashes will automatically be inserted)

AR License Expiration Date: *
DEA Expiration Date:

[Return to Individual Providers List](#)

[Save](#) ← Click here

Click "Return to Individual Providers List."



Individual Provider saved.

(Please do not click your browser's Back Button, information entered may not be saved. Please use tabs below to navigate.)

Initial General Bank Clinics/Groups Clinic/Group

Clinic/Group and Agreement Provider that these Individual Providers are Under
Clinic/Group Name: LegalName, MD Agreement Provider DBA Name: Legal Name, MD

Individual Provider and Specialties

Add Individual Provider Information

Select Individual Provider Name Display Type: Individual Name with First Name & Middle Initial or Blank Individual Name with First Initial & Middle Name Business/Clinic Name

First Name: John
Middle Initial:
Last Name: Doe *
Title: MD *
Individual Provider Effective Date: 07/01/2013 *
(Format for date: mm/dd/yyyy - slashes will automatically be inserted)

Individual BreastCare Provider Number:
Individual NPI: 1134191358 *
Individual SSN:
Provider Type: 01 Physician, M.D./Physician Assistant *
Provider Specialties: 02 Surgery - General/Oncology
 05 Anesthesia
 08 Family/General Practice
 11 Internal Medicine
 16 OB-GYN
 22 Pathology
 30 Radiology
 31 Radiation Oncology
 C3 CRNA
 H21 Hematology
 X1 Medical Oncology

PCP and/or Colposcopy: Primary Care *
Individual Provider Email Address:
Medicare Number: 12345 *
AR License Number: 61234 *
DEA Number:

AR License Expiration Date: 06/30/2015 *
DEA Expiration Date:

[Return to Individual Providers List](#)

← Click here

- Click Add New Individual Provider to add another provider
- If you have no other individual providers to add, click “Return to List of Clinics/Groups.”



BreastCare
Say Yes to a Mammogram!

Individual Providers in the Clinic/Group LegalName, MD

(Please do not click your browser's Back Button, information entered may not be saved. Please use tabs below to navigate.)

Initial General Bank Clinics/Groups Clinic/Group

Clinic/Group and Agreement Provider that these Individual Providers are Under

Clinic/Group Name: LegalName, MD Agreement Provider DBA Name: Legal Name, MD

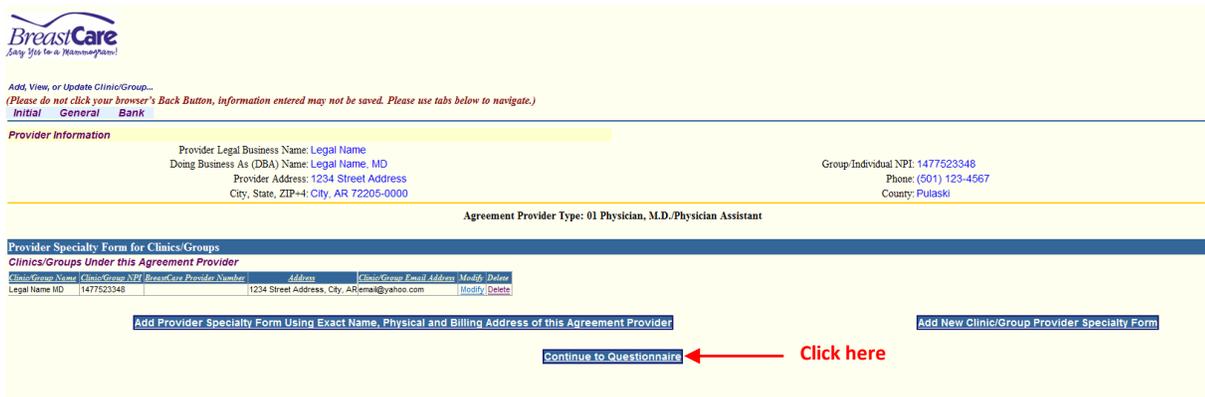
Individual Providers List

[Add New Individual Provider](#) ← Click here to add more individual providers

Individual Provider Name	Provider Type	BreastCare Provider Number	Individual Provider NPI	Address	Modify	Delete
John Doe MD	Physician, M.D./Physician Assistant		1134191356	1234 Street Address, City, AR	Modify	Delete

[Return to List of Clinics/Groups](#) ← Click here to return to list of clinics/groups

Click “Continue to Questionnaire.”



BreastCare
Say Yes to a Mammogram!

Add, View, or Update Clinic/Group...

(Please do not click your browser's Back Button, information entered may not be saved. Please use tabs below to navigate.)

Initial General Bank

Provider Information

Provider Legal Business Name: Legal Name
Doing Business As (DBA) Name: Legal Name, MD
Provider Address: 1234 Street Address
City, State, ZIP+4, City, AR 72205-0000

Group/Individual NPI: 1477523348
Phone: (501) 123-4567
County: Pulaski

Agreement Provider Type: 01 Physician, M.D./Physician Assistant

Provider Specialty Form for Clinics/Groups

Clinics/Groups Under this Agreement Provider

Clinic/Group Name	Clinic/Group NPI	BreastCare Provider Number	Address	Clinic/Group Email Address	Modify	Delete
Legal Name MD	1477523348		1234 Street Address, City, AR	email@yahoo.com	Modify	Delete

[Add Provider Specialty Form Using Exact Name, Physical and Billing Address of this Agreement Provider](#)
[Add New Clinic/Group Provider Specialty Form](#)

[Continue to Questionnaire](#) ← Click here

Provider Questionnaire

Complete the questionnaire and click “Save and Continue to Checklist.” Answers are required to all questions.

(Please do not click your browser's Back Button, information entered may not be saved. Please use tabs below to navigate.)

ADH Internet Apps (Quit) Initial General Bank Clinics/Groups

Network Provider Questionnaire

Please complete the following questions, **if applicable**, to your practice. This information will help BreastCare create a comprehensive network of providers to ensure patients have coverage for all needed services/procedures without being billed. Your cooperation in completing this questionnaire is appreciated.

Do you provide mammograms at your facility?: Yes No *

What radiology group/individual reads mammograms at your facility?:

Do you have a pathology lab/service provider that you use?: Yes No *

What pathology lab/service provider do you use?:

Are anesthesia services provided for your facility?: Yes No *

Who provides anesthesia services for your facility?:

Do you refer patients to any providers/facilities for surgical care?: Yes No *

What providers/facilities do you refer patients to for surgical care?:

Do you refer patients to any providers/facilities for gynecological/colposcopy care?: Yes No *

What providers/facilities do you refer patients to for gynecological/colposcopy care?:

What percentage of your patients are

Uninsured?: % *

Medicaid?: % *

Private Insurance?: % *

In what kind of setting do you primarily work?: (select)

Do you currently utilize an electronic medical health record (EMR/EHR) at your primary work location?: Yes No *

Do you currently utilize patient reminders?: Yes No *

How do you prefer to receive information from BreastCare?: Mail
 Email
 Social Media (e.g. Facebook or Twitter)
 Website
 Other

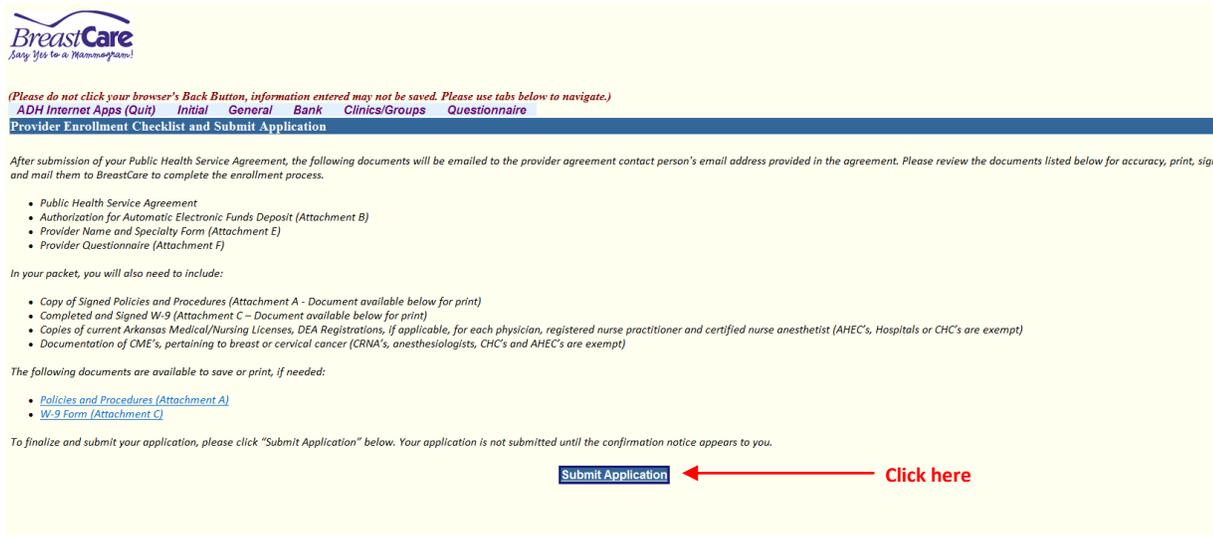
Complete questionnaire

[Save and Continue to Checklist](#) ← **Click here**

Done Trusted sites | Protected Mode: Off 100%

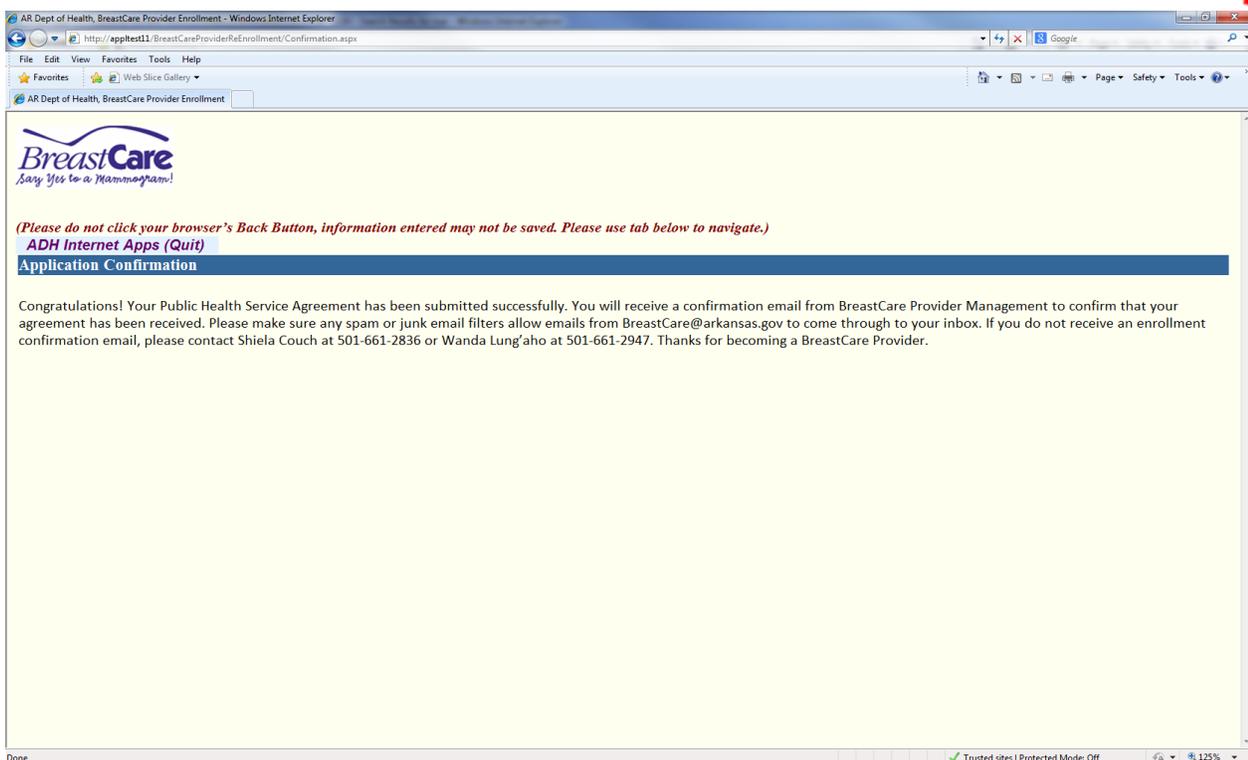
Provider Checklist and Application Submission

Review checklist and documents available for saving or printing (Policies and Procedures and W-9). Click "Submit Application."



The screenshot shows the 'Provider Enrollment Checklist and Submit Application' page. It includes a navigation menu with 'ADH Internet Apps (Quit)', 'Initial', 'General', 'Bank', 'Clinics/Groups', and 'Questionnaire'. A blue bar highlights 'Provider Enrollment Checklist and Submit Application'. Below this, there is a list of documents to be submitted, including Public Health Service Agreement, Authorization for Automatic Electronic Funds Deposit, Provider Name and Specialty Form, and Provider Questionnaire. A 'Submit Application' button is visible at the bottom, with a red arrow pointing to it and the text 'Click here'.

Application confirmation is displayed. Click red X to close browser and end your session.



The screenshot shows the 'Application Confirmation' page in a browser window. The page displays the BreastCare logo and a message: 'Congratulations! Your Public Health Service Agreement has been submitted successfully. You will receive a confirmation email from BreastCare Provider Management to confirm that your agreement has been received. Please make sure any spam or junk email filters allow emails from BreastCare@arkansas.gov to come through to your inbox. If you do not receive an enrollment confirmation email, please contact Shiela Couch at 501-661-2836 or Wanda Lung'aho at 501-661-2947. Thanks for becoming a BreastCare Provider.' A red arrow points to the 'X' button in the browser window's title bar.

Field Definitions

PROVIDER LEGAL NAME: Name as shown on your income tax return

BREASTCARE PROVIDER #: Number assigned to provider by BreastCare.

CLINIC/GROUPNAME (Dong Business As (DBA)): Name under which the group is known or individual provider's name

GROUP/PROVIDER NPI #: National Provider Indicator # assigned to the group/facility or individual provider. (Call NPI Helpline at 501-301-7611 or toll free at 1-866-311-5502, if you need help in setting up your number.)

TAXPAYER ID NAME: Name under which the Group, Entity or Individual receives a 1099 and reports taxes.
Official name on W-9.

PHYSICAL ADDRESS: Location(s) where *BreastCare* clients are referred for services.

CLINIC PHONE #: Best phone number to use for scheduling appointments

BILLING ADDRESS: Where correspondence about claims should be sent

BILLING PHONE #: Best phone number to reach appropriate person to discuss claims, billing or this agreement.

BREASTCARE #: Unless this is an application for a new provider, you already have an assigned *BreastCare* number

PROVIDER NAME: Name of individual physician, APN, CRNA, surgeon, etc.

ADD OR DELETE: Indicate if a participating provider has left (**Delete**) your group (retired, died or moved) or is being added (**Add**) to your group.

EFFECTIVE DATE: Date when individual was added or deleted from your practice.

INDIVIDUAL SS #: Social Security number for each individual provider (physician, APN, etc.)

INDIVIDUAL NPI #: National Provider Indicator number assigned to individual provider

SPECIALTY: Whether PCP, radiologist, RNP, APN, anesthesiologist, pathologist, surgeon, etc.

PCP and/or COLPOSCOPY: Indicate if individual provides **Primary care**, **Colposcopy only** or **Both primary care and colposcopy**.

MEDICARE #: Number assigned by Medicare to the individual provider

Basic Tips/FAQs

FORMS NOT OPENING

Disable pop-up blocker in your internet browser for the duration of the enrollment process. Tip: Save forms to your computer hard drive for printing later.

CAN I SAVE AND CONTINUE LATER?

Yes. If the session times out or you need to complete later, you can log back in and resume the application process using the session number and password created when you started the application.

SERVER ERROR

This is most likely to be caused by internet connectivity issues. Check your internet connection. You may need to restart the process if the application has timed-out while fixing your connectivity issues. If error persists, then contact the ADH Help Desk for technical support. (In the Little Rock calling area, the ADH Help Desk's phone number is 280-HELP (280-4357). Outside of the Little Rock calling area, the ADH Help Desk's phone number is 1-800-441-9232. The ADH Help Desk email address is ADH.HELPDESK@arkansas.gov.)

BROWSER BACK AND REFRESH BUTTONS

Please do not use your browser's back button or refresh button. Information entered may not be saved. Please use the "Enrollment Menu Tabs" at the top of the screen to navigate.

HOW MANY CONTRACT APPLICATIONS DO I COMPLETE?

One contract is to be completed and is good for a two-year period, e.g. July 1, 2013 – June 30, 2015. If a clinic under a group has a different tax ID and banking information from the group, then you need to complete a separate contract application for that clinic. Also, if the clinic has the same tax ID but different banking information, you must complete a separate contract application for this clinic.

HOW LONG WILL IT TAKE TO PROCESS MY APPLICATION AFTER I ENROLL ONLINE?

The application process can take up to 30 days. After review, your application will be emailed to you for original signatures. You should return the signed application, with other required documentations, immediately to the ADH BreastCare. Delays and/or denials can occur if all documents are not received within a reasonable time period.

WHO SHOULD I CONTACT IF I HAVE QUESTIONS ABOUT ENROLLMENT?

Arkansas Department of Health - BreastCare Provider Management at 1-800-462-0599 ext. 661-2836 or ext. 661-2947 or email Shiela.Couch@arkansas.gov or Wanda.Lungaho@arkansas.gov.

CAN I ENROLL AS A PROVIDER AFTER JULY 1? Providers wishing to provide services to BreastCare patients are expected to enroll by July 1 of the enrollment year. However, providers can still enroll after this date but the agreement end date (June 30, 2015) would remain unchanged.

HOW CAN I MAKE CHANGES TO MY CONTRACT?

All changes to provider contracts will be made using a change form. All forms including the Provider Manual reimbursement rates and change forms are available on the web at www.arbreastcare.com, under Just for Providers.

WHEN CAN I RE-ENROLL? The enrollment period ends June 30, 2015. However, you are required to re-submit your credentials every year. Please provide your provider ID on all documentation, to facilitate processing. You will need to fax updated copies of each individual provider's Arkansas Medical or Nursing Licenses, and DEA Registrations (if applicable) prior to expiration to 501-661-2189, Attention BreastCare Provider Management.