



Arkansas Department of Health

# *BreastCare*

## **PROVIDER RE-ENROLLMENT SYSTEM USER MANUAL**

## Revisions

<b>Release No.</b>	<b>Date</b>	<b>Revision Description</b>
Rev. 0	05/08/2013	First edition in MS Word format

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## **Overview**

The BreastCare Provider Re-enrollment System is a new system designed by the BreastCare program for providers to update an existing Public Health Service Agreement (PHSA).

BreastCare has developed this document to guide you through the process of accessing the internet-based re-enrollment system.

There are four basic steps to completing this re-enrollment process:

1. Have all applicable information ready including current routing and bank account numbers, medical license, DEA registration and e-mail addresses of individual providers.
2. Update and submit your PHSA
3. ADH BreastCare reviews your application and emails the PHSA to you for your review and signature
4. Print, sign, date, and mail all pages of the PHSA to

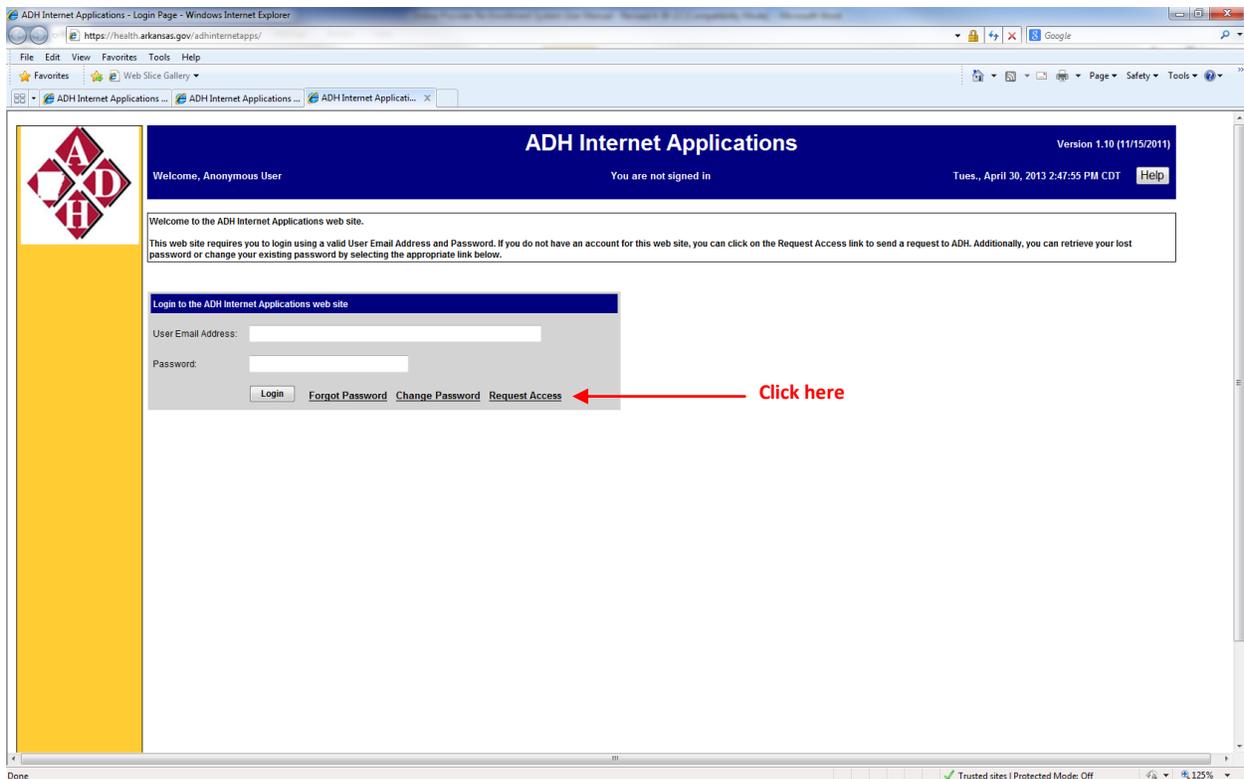
BreastCare Provider Management  
Arkansas Department of Health  
Attn: Shiela Couch  
4815 West Markham, Slot 11  
Little Rock, AR 72205

## Update a Provider Enrollment Application

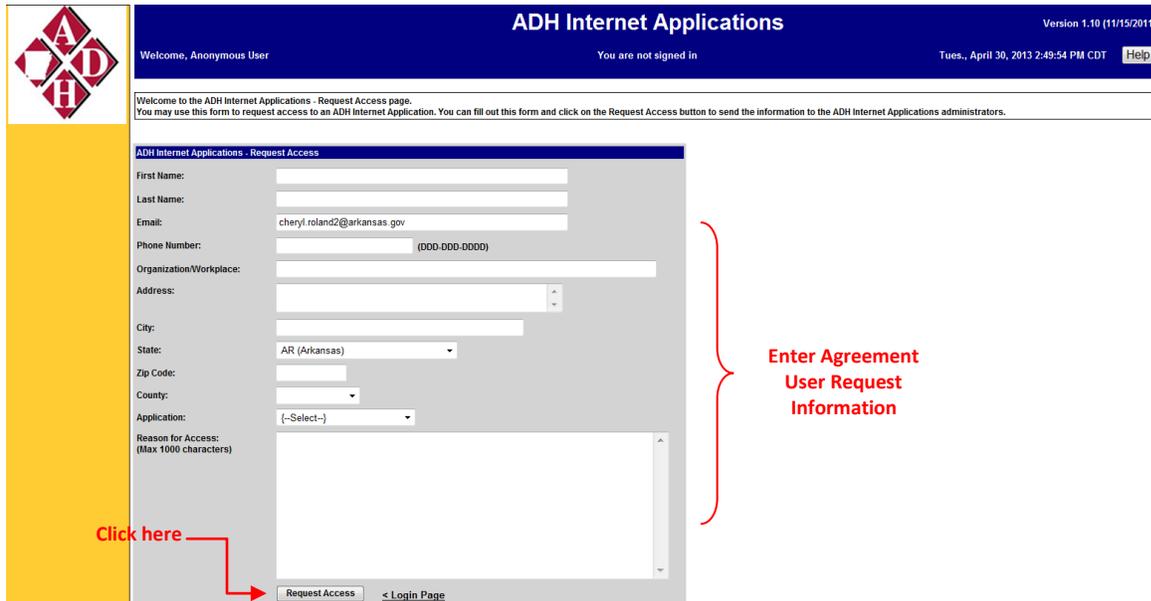
An existing enrollment application may be reviewed and updated by typing, copying and pasting the following internet address in the address bar of your browser and pressing enter or by simply clicking on the following link.

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

Once the link is opened, enter email address of the person responsible for updating BreastCare PHSA. You do not need to enter a password at this time. Click “Request Access.”



Complete the ADH Internet Applications – Request Access information. Select “BreastCare Prov. Re-enroll” in the application dropdown box. Type BreastCare Provider Re-enrollment in the Reason for Access box. Click “Request Access.”



**ADH Internet Applications** Version 1.10 (11/15/2011)

Welcome, Anonymous User You are not signed in Tues., April 30, 2013 2:49:54 PM CDT [Help](#)

Welcome to the ADH Internet Applications - Request Access page.  
You may use this form to request access to an ADH Internet Application. You can fill out this form and click on the Request Access button to send the information to the ADH Internet Applications administrators.

**ADH Internet Applications - Request Access**

First Name:

Last Name:

Email:

Phone Number:  (DDD-DDD-0000)

Organization/Workplace:

Address:

City:

State:

Zip Code:

County:

Application:

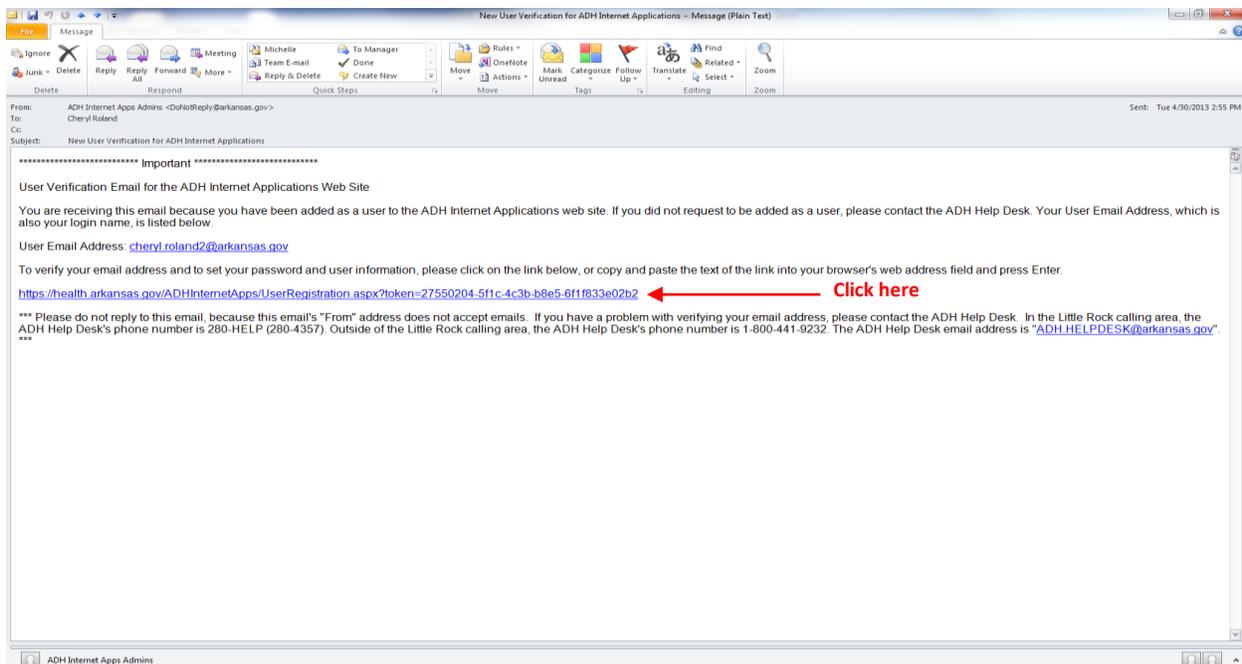
Reason for Access:  
(Max 1000 characters)

[< Login Page](#)

**Click here** →

**Enter Agreement User Request Information**

The person responsible for updating the BreastCare PHSA will receive an email from BreastCare, which will include provider verification link. Click on verification link to setup your password.



Enter a password of your choice. You will be required to re-enter the password a second time for verification. Click “save.”

Welcome, Anonymous User You are not signed in Tues., April 30, 2013 2:56:39 PM CDT Help

Welcome to the ADH Internet Applications - User Registration and Password creation page. You may use this page to enter your user information and to create a new password to log in to ADH Internet Applications.

ADH Internet Applications - User Registration - cheryl roland (cheryl.roland2@arkansas.gov)

Create Password —

New Password:

Confirm Password:

Personal Information —

First Name:

Last Name:

Phone Number:  (DDD.DDD.DDDD)

Click here

Your password has been created successfully. Now, enter user e-mail address, password and click “Login.”

Welcome, Anonymous User You are not signed in Tues., April 30, 2013 2:59:16 PM CDT Help

Welcome to the ADH Internet Applications web site.

This web site requires you to login using a valid User Email Address and Password. If you do not have an account for this web site, you can click on the Request Access link to send a request to ADH. Additionally, you can retrieve your lost password or change your existing password by selecting the appropriate link below.

Login to the ADH Internet Applications web site

Password created successfully. Please use your User Email Address and Password to log in.

User Email Address:

Password:

[Forgot Password](#) [Change Password](#) [Request Access](#)

Click here

Click provider “re-enrollment” button, located in the gold menu to the left.

Welcome, Cheryl Roland You are signed in as a User Tues., April 30, 2013 3:07:55 PM CDT Help

You are logged in to "ADH Internet Applications".

Look to your left and you will see a menu of the applications you can access. If you have any questions please contact the ADH Help Desk.  
(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.HELP@DE.SG@arkansas.gov".)

[Request Access Message After Login](#)

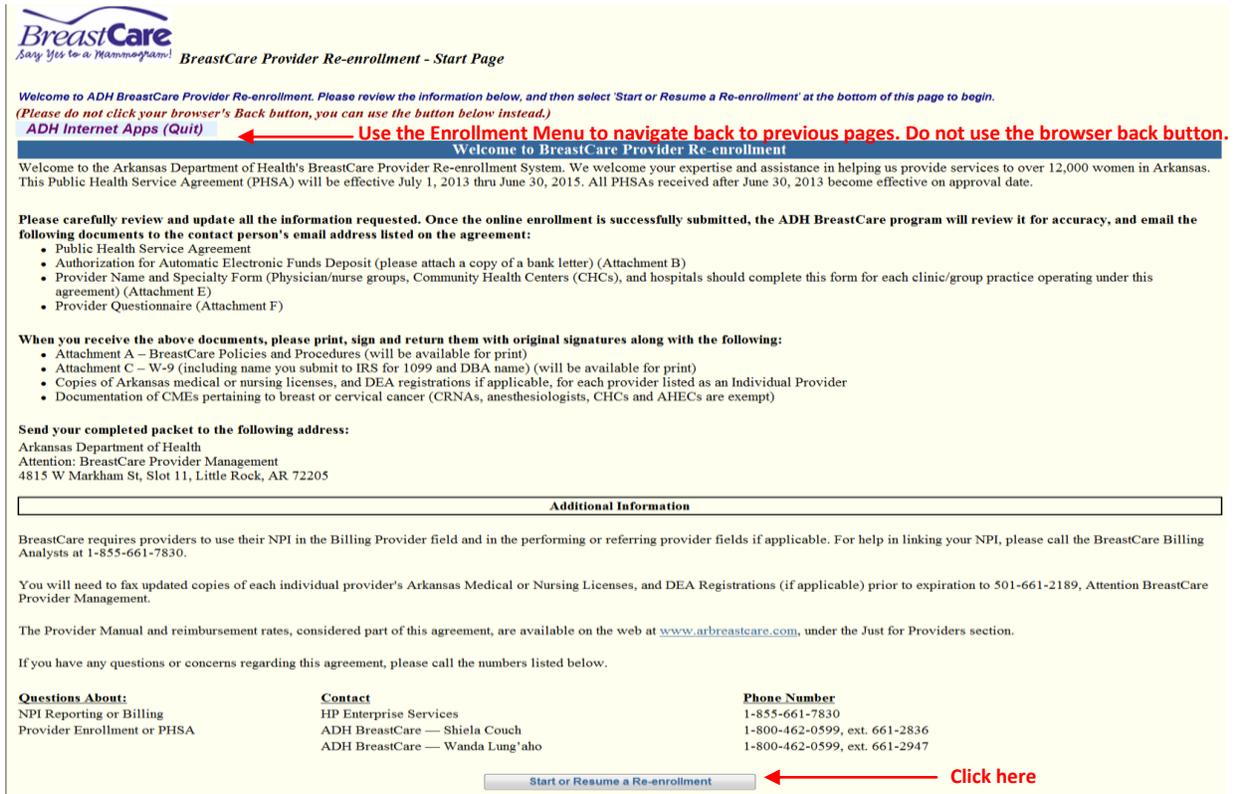
[Provider Re-enrollment](#) Click here

[Sign Out](#)

## Start Page

Review BreastCare Provider Re-enrollment start page. Once a page is reviewed, 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 changes made may not be saved.**

Click "Start or Resume a Re-enrollment" button at the bottom of the page to begin.



**BreastCare**  
Sary Yes to a Mammogram! **BreastCare Provider Re-enrollment - Start Page**

Welcome to ADH BreastCare Provider Re-enrollment. Please review the information below, and then select 'Start or Resume a Re-enrollment' at the bottom of this page to begin.  
(Please do not click your browser's Back button, you can use the button below instead.)  
**ADH Internet Apps (Quit)** ← **Use the Enrollment Menu to navigate back to previous pages. Do not use the browser back button.**

**Welcome to BreastCare Provider Re-enrollment**

Welcome to the Arkansas Department of Health's BreastCare Provider Re-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.

**Please carefully review and update 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 DBA 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

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**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.

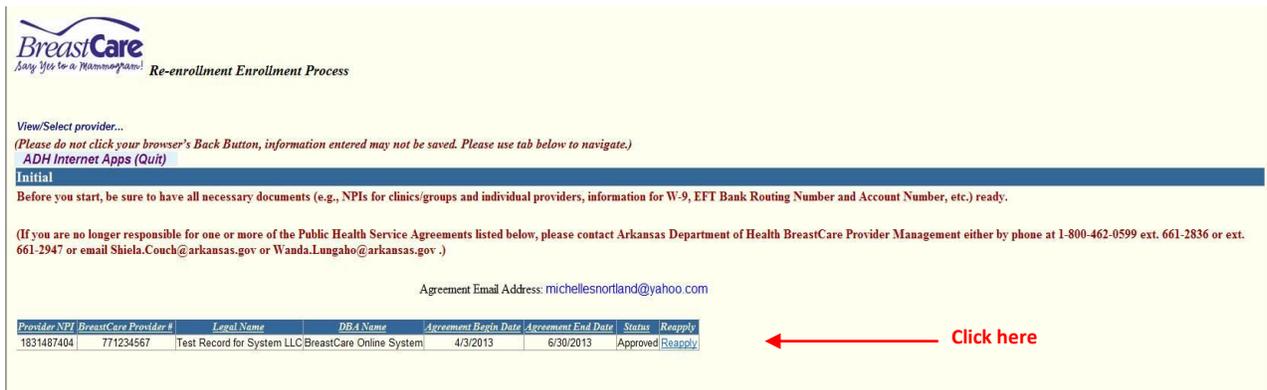
The Provider Manual and reimbursement rates, considered part of this agreement, are available on the web at [www.arbreastcare.com](http://www.arbreastcare.com), under the Just for Providers section.

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

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

Start or Resume a Re-enrollment ← **Click here**

Agreement(s) will appear for all groups associated with provider agreement contact person email. If you are no longer responsible for one or more of the PHSA listed on the page, please contact 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](mailto:Shiela.Couch@arkansas.gov) or [Wanda.Lungaho@arkansas.gov](mailto:Wanda.Lungaho@arkansas.gov). Click "Reapply" or "Resume" to review or update your PHSA.



**BreastCare**  
Sary Yes to a Mammogram! **Re-enrollment Enrollment Process**

View/Select provider...  
(Please do not click your browser's Back Button, information entered may not be saved. Please use tab below to navigate.)  
**ADH Internet Apps (Quit)**

**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.

(If you are no longer responsible for one or more of the Public Health Service Agreements listed below, please contact Arkansas Department of Health BreastCare Provider Management either by phone at 1-800-462-0599 ext. 661-2836 or ext. 661-2947 or email [Shiela.Couch@arkansas.gov](mailto:Shiela.Couch@arkansas.gov) or [Wanda.Lungaho@arkansas.gov](mailto:Wanda.Lungaho@arkansas.gov).)

Agreement Email Address: [michellesnortland@yahoo.com](mailto:michellesnortland@yahoo.com)

Provider NPI	BreastCare Provider #	Legal Name	DBA Name	Agreement Begin Date	Agreement End Date	Status	Reapply
1831487404	771234567	Test Record for System LLC	BreastCare Online System	4/3/2013	6/30/2013	Approved	Reapply

← **Click here**

## Provider General Information

Review and update provider information as needed. If your provider legal business name has changed, please contact 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](mailto:Shiela.Couch@arkansas.gov) or [Wanda.Lungaho@arkansas.gov](mailto:Wanda.Lungaho@arkansas.gov). After review and changes are complete, click "Validate and Save Data Entered So Far."

BreastCare Online Enrollment...

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

[ADH Internet Apps \(Quit\)](#)   [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.): 02 Physician, M.D., Group/CRNA Group

Provider Legal Business Name: ADH - Test System LLC

Physical Address: 4815 West Markham    Addr Line 2:

City: Little Rock    State: Arkansas    ZIP+4 Code: 72205-0000

County: Pulaski

Provider Agreement Contact Name: Shiela Couch

Clinic/Facility Location Phone Number: (501) 661-2836

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

Employer Identification Number: 71-1234567

BreastCare Provider Number: 770304302

Group/Individual NPI Number: 1790756328

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

Business (DBA) Name: ADH - Test System LLC

Billing Address is Same as Physical Address Above

Agreement Billing Address: 4815 West Markham    Addr Line 2:

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

Billing County: Pulaski

Billing Contact Name: Shiela Couch

Agreement Email Address: Shiela.Couch@arkansas.gov    Billing Phone: (501) 661-2836

[Validate and Save Data Entered So Far](#) ← **Click here**

## Policies and Procedures

Click “Open, Print and Sign Policies and Procedures to Continue Enrollment.”

Enrollment Agreement data was saved. Select 'Open and Save Policies and Procedures to Continue Enrollment' to proceed...

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

[ADH Internet Apps \(Quit\)](#) [Initial](#)

### General

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### Provider Information

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Provider Legal Business Name: ADH - Test System LLC

Physical Address: 4815 West Markham Addr Line 2:

City: Little Rock State: Arkansas ZIP+4 Code: 72205-0000

County: Pulaski

Provider Agreement Contact Name: Shiela Couch

Clinic/Facility Location Phone Number: (501) 661-2836

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

Employer Identification Number: 71-1234567

BreastCare Provider Number: 770304302

Group/Individual NPI Number: 1790756328

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

Business (DBA) Name: ADH - Test System LLC

Billing Address is Same as Physical Address Above

Agreement Billing Address: 4815 West Markham Addr Line 2:

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

Billing County: Pulaski

Billing Contact Name: Shiela Couch

Billing Phone: (501) 661-2836

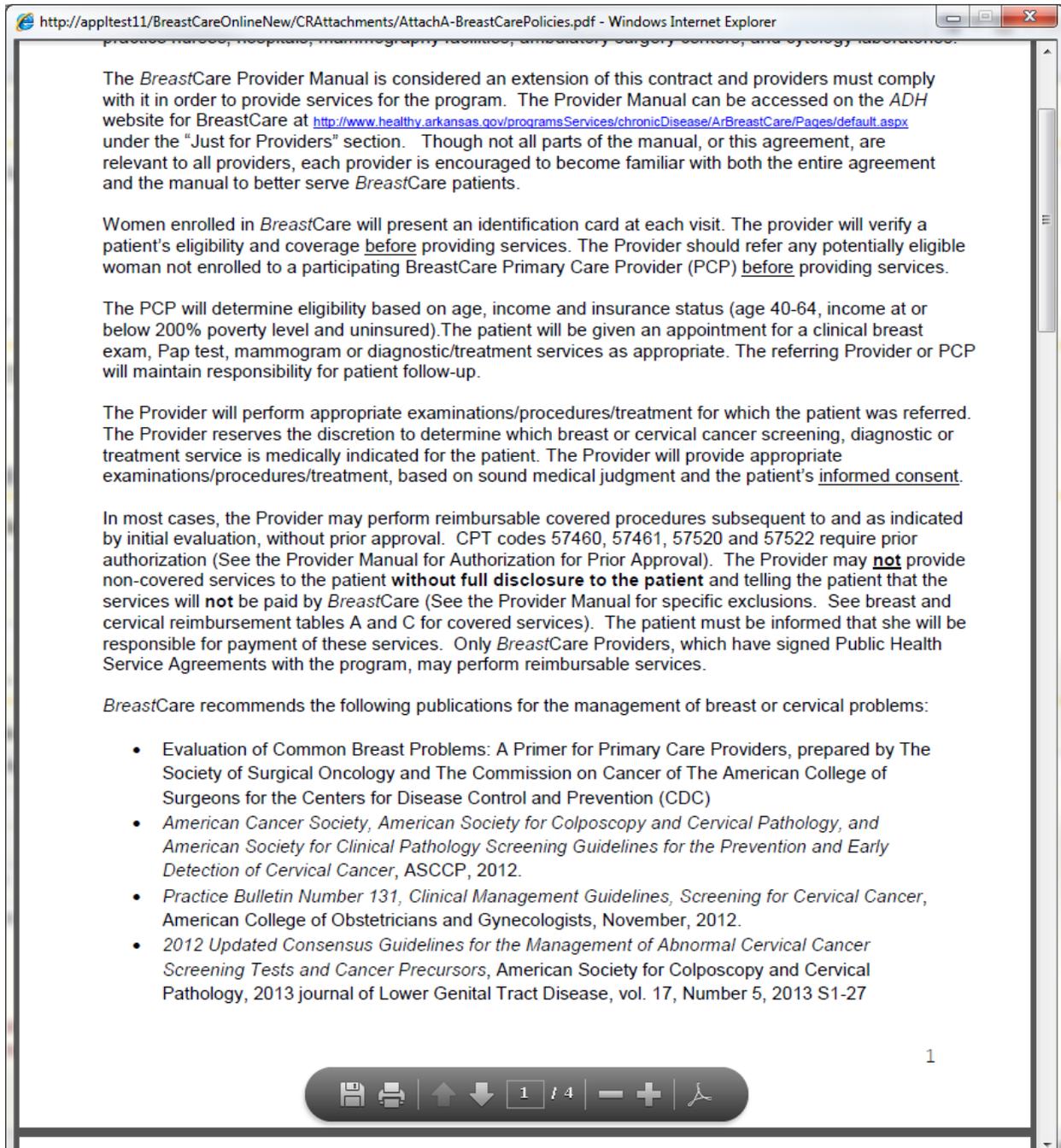
Agreement Email Address: Shiela.Couch@arkansas.gov

[Validate and Save Data Entered So Far](#)

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

Click here

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



http://apptest11/BreastCareOnlineNew/CRAAttachments/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/programs/Services/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

Save | Print | Up | Down | 1 / 4 | - | + | PDF

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

**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**

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Provider Legal Business Name: ADH - Test System LLC

Physical Address: 4815 West Markham  
City: Little Rock State: Arkansas ZIP+4 Code: 72205-0000  
County: Pulaski

Provider Agreement Contact Name: Shiela Couch  
Clinic/Facility Location Phone Number: (501) 661-2836

Type of Taxpayer Identification Number (TIN):  SSN or ITIN  EIN (aka FEIN or Federal Tax Identification Number)  
Employer Identification Number: 71-1234567  
BreastCare Provider Number: 770304302  
Group/Individual NPI Number: 1790756328

DBA (Doing Business As) Name Type:  Business Clinic Name  Individual Name, First Name & Middle Initial or Blank  Individual Name, First Initial & Middle Name  
Business (DBA) Name: ADH - Test System LLC

Billing Address is Same as Physical Address Above  
Agreement Billing Address: 4815 West Markham  
Billing City: Little Rock State: Arkansas ZIP+4 Code: 72205-0000  
Billing County: Pulaski  
Billing Contact Name: Shiela Couch  
Billing Phone: (501) 661-2836  
Agreement Email Address: Shiela.Couch@arkansas.gov

[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.”

**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.): 02 Physician, M.D., Group/CRNA Group

Provider Legal Business Name: ADH - Test System LLC

Physical Address: 4815 West Markham  
City: Little Rock State: Arkansas ZIP+4 Code: 72205-0000  
County: Pulaski

Provider Agreement Contact Name: Shiela Couch  
Clinic/Facility Location Phone Number: (501) 661-2836

Type of Taxpayer Identification Number (TIN):  SSN or ITIN  EIN (aka FEIN or Federal Tax Identification Number)  
Employer Identification Number: 71-1234567  
BreastCare Provider Number: 770304302  
Group/Individual NPI Number: 1790756328

DBA (Doing Business As) Name Type:  Business Clinic Name  Individual Name, First Name & Middle Initial or Blank  Individual Name, First Initial & Middle Name  
Business (DBA) Name: ADH - Test System LLC

Billing Address is Same as Physical Address Above  
Agreement Billing Address: 4815 West Markham  
Billing City: Little Rock State: Arkansas ZIP+4 Code: 72205-0000  
Billing County: Pulaski  
Billing Contact Name: Shiela Couch  
Billing Phone: (501) 661-2836  
Agreement Email Address: Shiela.Couch@arkansas.gov

[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 **Click here**

[Continue](#)

## Provider Banking Information

Review and update bank information as needed. After review and changes are complete, click "Validate and Save Funds Deposit Authorization Data."



**BreastCare**  
Say Yes to a Mammogram! Re-enrollment 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.)  
[ADH Internet Apps \(Quit\)](#) [Initial](#) [General](#)

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**Provider Information**

Provider Legal Business Name: ADH - Test System LLC	BreastCare Provider Number: 770304302
Doing Business As (DBA) Name: ADH - Test System LLC	Group/Individual NPI: 1790756328
Provider Address: 4815 West Markham	Phone: (501) 661-2836
City, State, ZIP+4: Little Rock, AR 72205-0000	County: Pulaski

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**Authorization for Automatic Electronic Funds Deposit**

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

Routing Transit #: 042000013

Bank Account #: 123456789

Name of Depository (Bank): J.S. Bank

Depository Address: 1111 Walnut Street

City: Little Rock

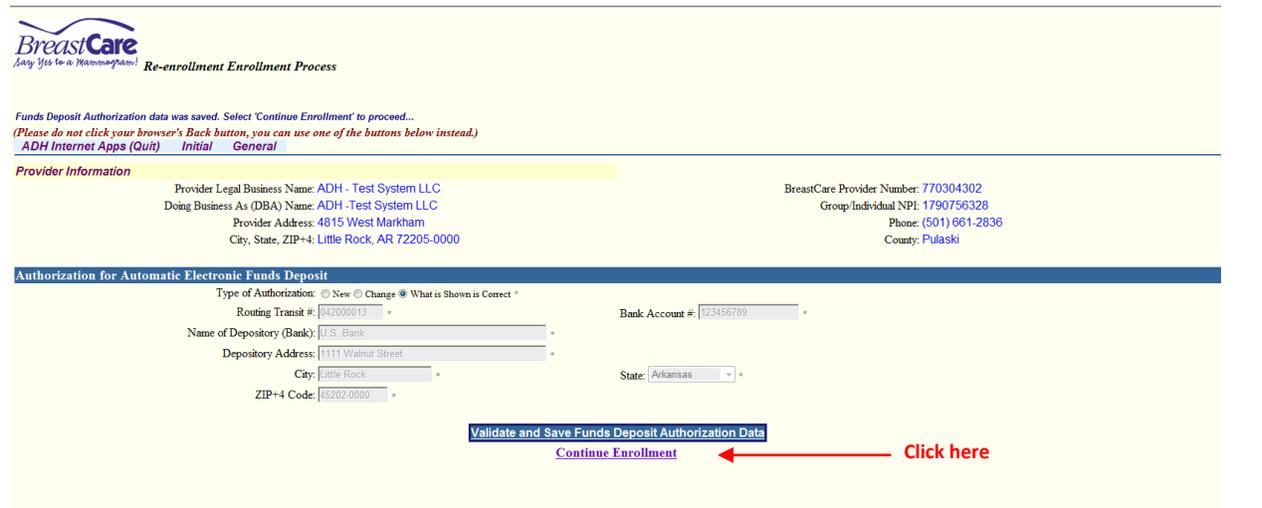
State: Arkansas

ZIP+4 Code: 45202-0000

**Review banking information and select the type of authorization. If information needs to be corrected, select "Change" and make the changes. If everything is correct, select "What is Shown is Correct."**

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

Then, click "Continue Enrollment."



**BreastCare**  
Say Yes to a Mammogram! Re-enrollment 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.)  
[ADH Internet Apps \(Quit\)](#) [Initial](#) [General](#)

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**Provider Information**

Provider Legal Business Name: ADH - Test System LLC	BreastCare Provider Number: 770304302
Doing Business As (DBA) Name: ADH - Test System LLC	Group/Individual NPI: 1790756328
Provider Address: 4815 West Markham	Phone: (501) 661-2836
City, State, ZIP+4: Little Rock, AR 72205-0000	County: Pulaski

---

**Authorization for Automatic Electronic Funds Deposit**

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

Routing Transit #: 042000013

Bank Account #: 123456789

Name of Depository (Bank): J.S. Bank

Depository Address: 1111 Walnut Street

City: Little Rock

State: Arkansas

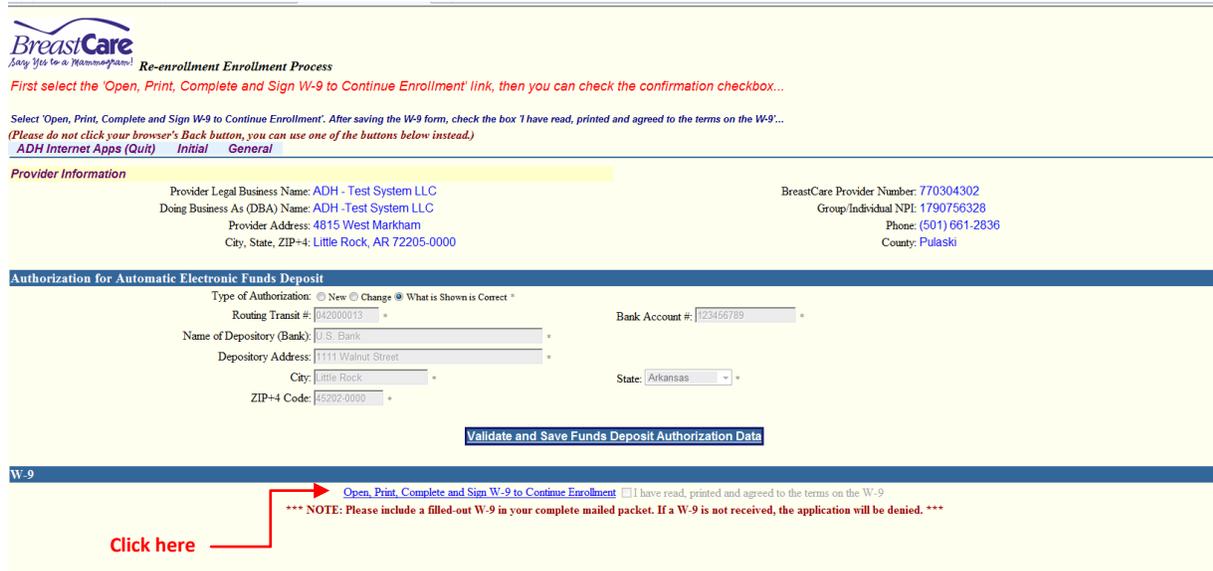
ZIP+4 Code: 45202-0000

[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."



**BreastCare**  
Sary Yes to a Mammogram! Re-enrollment 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.)

ADH Internet Apps (Quit) Initial General

**Provider Information**

Provider Legal Business Name: ADH - Test System LLC	BreastCare Provider Number: 770304302
Doing Business As (DBA) Name: ADH - Test System LLC	Group/Individual NPI: 1790756328
Provider Address: 4815 West Markham	Phone: (501) 661-2836
City, State, ZIP+4: Little Rock, AR 72205-0000	County: Pulaski

**Authorization for Automatic Electronic Funds Deposit**

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

Routing Transit #: 042000013 \* Bank Account #: 123456789 \*

Name of Depository (Bank): U.S. Bank \*

Depository Address: 1111 Walnut Street \*

City: Little Rock \* State: Arkansas \*

ZIP+4 Code: 72202-0000 \*

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

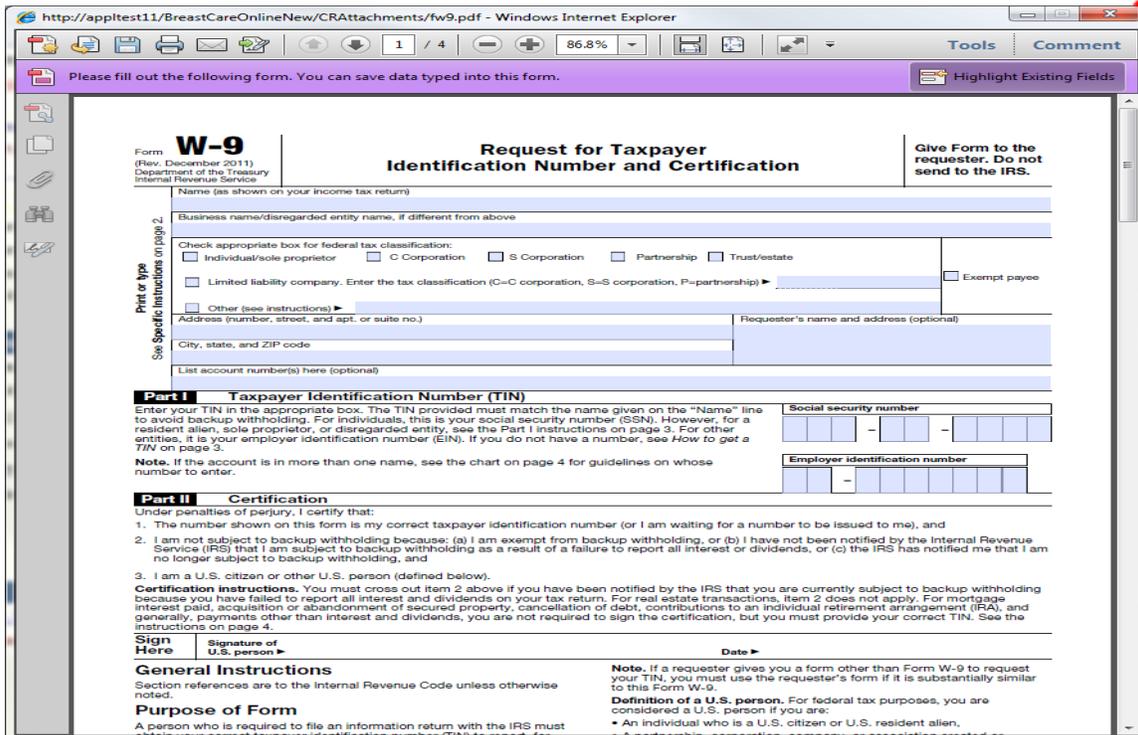
**W-9**

[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. Please note that data entered on this 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.

**W-9**  
Request for Taxpayer Identification Number and Certification

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

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.

**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 and 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 ▶

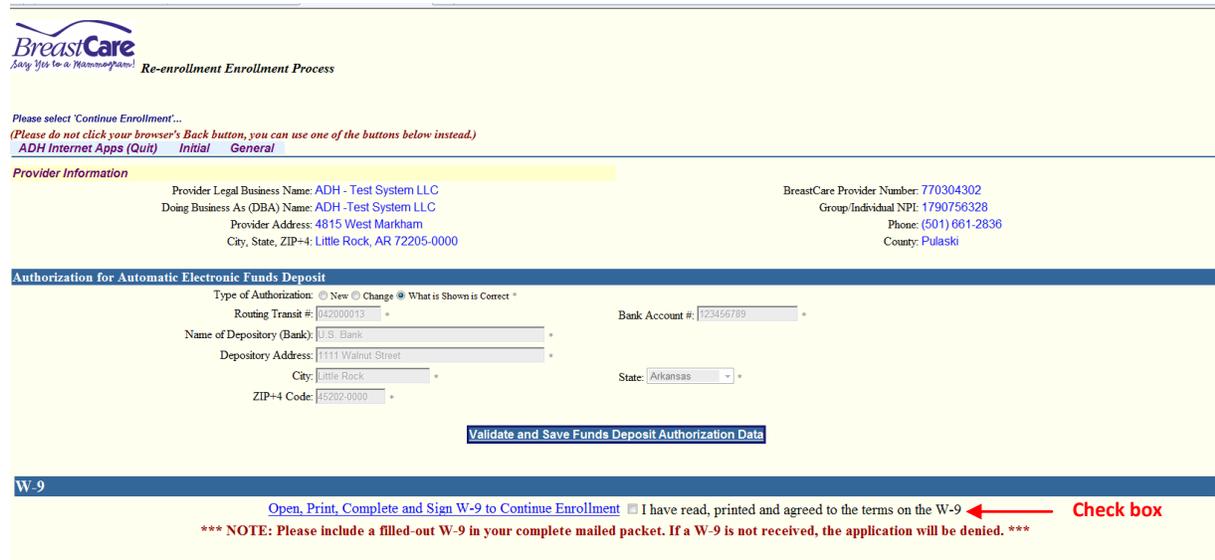
**General Instructions**  
Section references are to the Internal Revenue Code unless otherwise noted.

**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, printed and agreed to the terms on the W-9.”



**BreastCare**  
Say Yes to a Mammogram! **Re-enrollment Enrollment Process**

Please select 'Continue Enrollment'...  
(Please do not click your browser's Back button, you can use one of the buttons below instead.)  
[ADH Internet Apps \(Quit\)](#) [Initial](#) [General](#)

**Provider Information**

Provider Legal Business Name: ADH - Test System LLC	BreastCare Provider Number: 770304302
Doing Business As (DBA) Name: ADH -Test System LLC	Group/Individual NPI: 1790756328
Provider Address: 4815 West Markham	Phone: (501) 661-2836
City, State, ZIP+4: Little Rock, AR 72205-0000	County: Pulaski

**Authorization for Automatic Electronic Funds Deposit**

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

Routing Transit #: 042000013 Bank Account #: 123456789

Name of Depository (Bank): J.S. Bank

Depository Address: 1111 Walnut Street

City: Little Rock State: Arkansas

ZIP+4 Code: 72202-0000

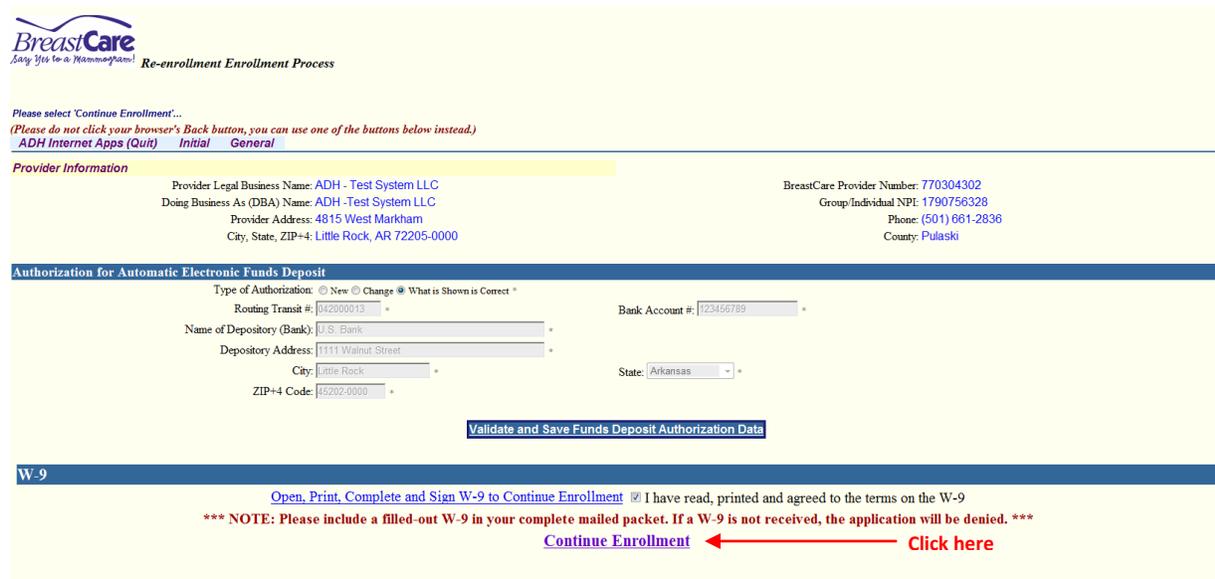
[Validate and Save Funds Deposit Authorization Data](#)

**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.”



**BreastCare**  
Say Yes to a Mammogram! **Re-enrollment Enrollment Process**

Please select 'Continue Enrollment'...  
(Please do not click your browser's Back button, you can use one of the buttons below instead.)  
[ADH Internet Apps \(Quit\)](#) [Initial](#) [General](#)

**Provider Information**

Provider Legal Business Name: ADH - Test System LLC	BreastCare Provider Number: 770304302
Doing Business As (DBA) Name: ADH -Test System LLC	Group/Individual NPI: 1790756328
Provider Address: 4815 West Markham	Phone: (501) 661-2836
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**Authorization for Automatic Electronic Funds Deposit**

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Depository Address: 1111 Walnut Street

City: Little Rock State: Arkansas

ZIP+4 Code: 72202-0000

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

**W-9**

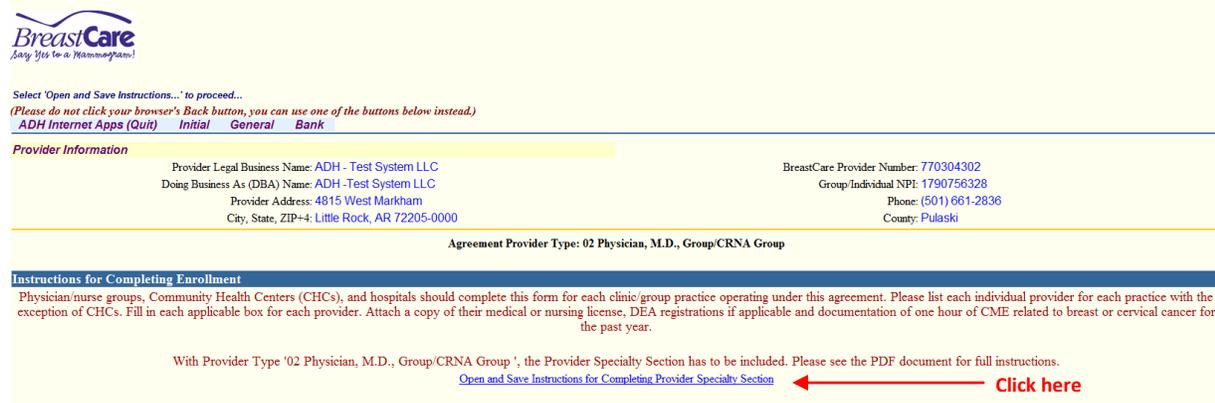
[Open, Print, Complete and Sign W-9 to Continue Enrollment](#)  I have read, printed and agreed to the terms on the W-9

\*\*\* 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**

## Clinic/Group Provider Specialty Section

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



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.)

ADH Internet Apps (Quit) Initial General Bank

**Provider Information**

Provider Legal Business Name: ADH - Test System LLC	BreastCare Provider Number: 770304302
Doing Business As (DBA) Name: ADH - Test System LLC	Group/Individual NPI: 1790756328
Provider Address: 4815 West Markham	Phone: (501) 661-2836
City, State, ZIP+4: Little Rock, AR 72205-0000	County: Pulaski

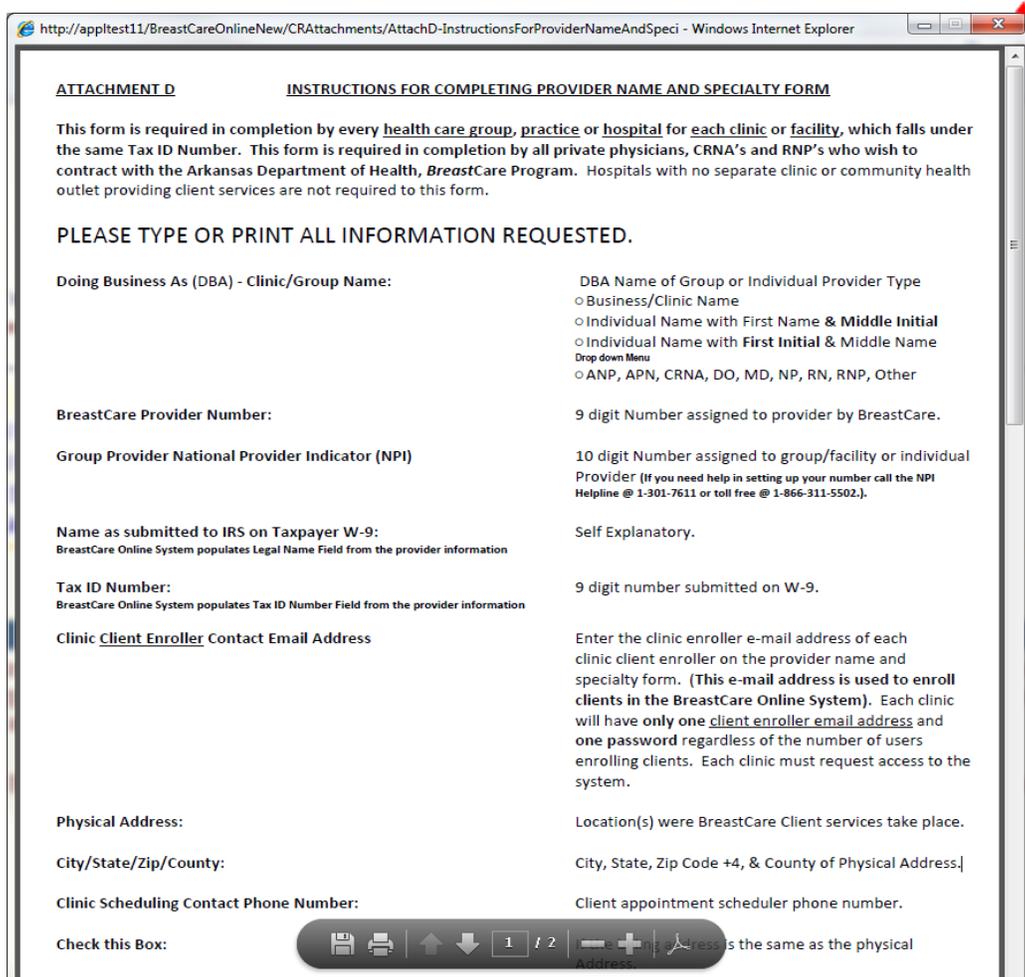
Agreement Provider Type: 02 Physician, M.D., Group/CRNA Group

**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 '02 Physician, M.D., Group/CRNA Group', 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/CRAAttachments/AttachD-InstructionsForProviderNameAndSpeci - Windows Internet Explorer

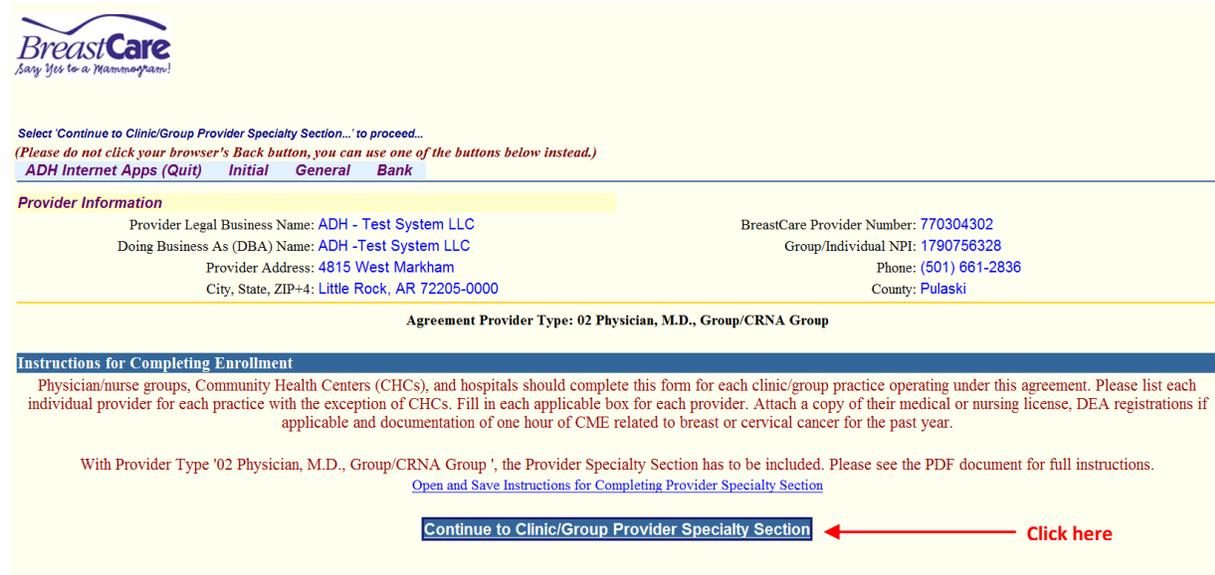
**ATTACHMENT D INSTRUCTIONS FOR COMPLETING PROVIDER NAME AND SPECIALTY FORM**

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.**

<b>Doing Business As (DBA) - Clinic/Group Name:</b>	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 Drop down Menu <input type="radio"/> ANP, APN, CRNA, DO, MD, NP, RN, RNP, Other
<b>BreastCare Provider Number:</b>	9 digit Number assigned to provider by BreastCare.
<b>Group Provider National Provider Indicator (NPI)</b>	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.).
<b>Name as submitted to IRS on Taxpayer W-9:</b> BreastCare Online System populates Legal Name Field from the provider information	Self Explanatory.
<b>Tax ID Number:</b> BreastCare Online System populates Tax ID Number Field from the provider information	9 digit number submitted on W-9.
<b>Clinic Client Enroller Contact Email Address</b>	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 <b>only one client enroller email address</b> and <b>one password</b> regardless of the number of users enrolling clients. Each clinic must request access to the system.
<b>Physical Address:</b>	Location(s) were BreastCare Client services take place.
<b>City/State/Zip/County:</b>	City, State, Zip Code +4, & County of Physical Address.}
<b>Clinic Scheduling Contact Phone Number:</b>	Client appointment scheduler phone number.
<b>Check this Box:</b>	<input type="checkbox"/> Results is the same as the physical Address

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



**BreastCare**  
*Easy 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.)

[ADH Internet Apps \(Quit\)](#) [Initial](#) [General](#) [Bank](#)

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**Provider Information**

Provider Legal Business Name: <b>ADH - Test System LLC</b>	BreastCare Provider Number: <b>770304302</b>
Doing Business As (DBA) Name: <b>ADH -Test System LLC</b>	Group/Individual NPI: <b>1790756328</b>
Provider Address: <b>4815 West Markham</b>	Phone: <b>(501) 661-2836</b>
City, State, ZIP+4: <b>Little Rock, AR 72205-0000</b>	County: <b>Pulaski</b>

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**Agreement Provider Type: 02 Physician, M.D., Group/CRNA Group**

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**Instructions for Completing Enrollment**

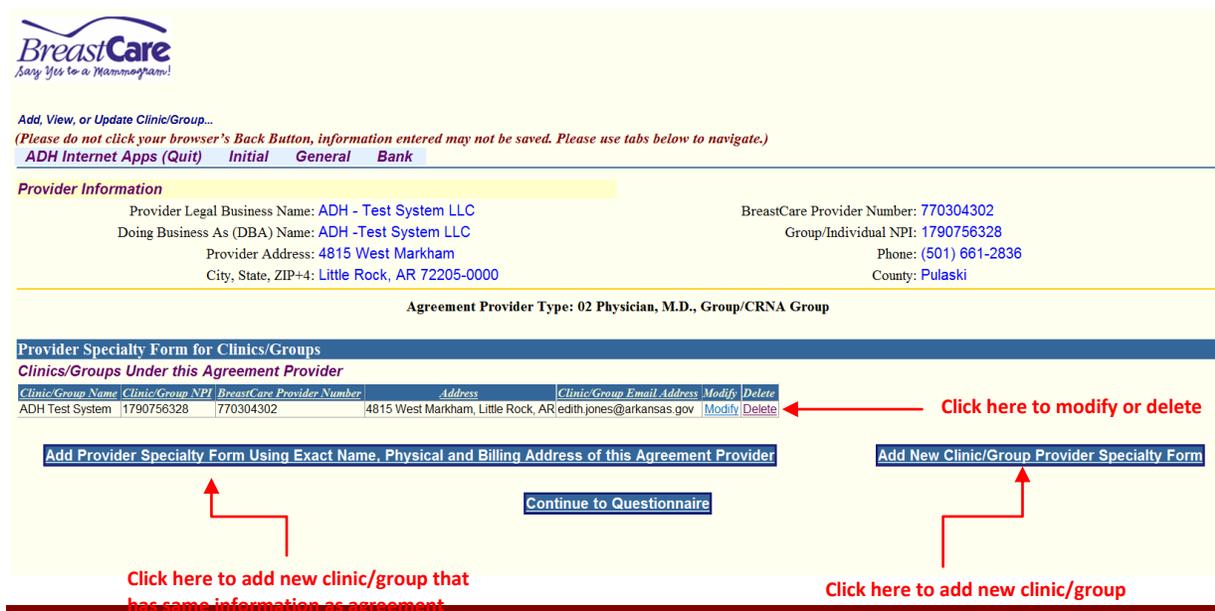
Physician/nurse groups, Community Health Centers (CHCs), and hospitals should complete this form for each clinic/group practice operating under this agreement. Please list each individual provider for each practice with the exception of CHCs. Fill in each applicable box for each provider. Attach a copy 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 '02 Physician, M.D., Group/CRNA Group ', 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**

Review and update clinics/groups (including individual providers) under this agreement by clicking “modify.” Only select “delete” if clinic/group is no longer associated with this agreement.

- 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**  
*Easy 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.)

[ADH Internet Apps \(Quit\)](#) [Initial](#) [General](#) [Bank](#)

---

**Provider Information**

Provider Legal Business Name: <b>ADH - Test System LLC</b>	BreastCare Provider Number: <b>770304302</b>
Doing Business As (DBA) Name: <b>ADH -Test System LLC</b>	Group/Individual NPI: <b>1790756328</b>
Provider Address: <b>4815 West Markham</b>	Phone: <b>(501) 661-2836</b>
City, State, ZIP+4: <b>Little Rock, AR 72205-0000</b>	County: <b>Pulaski</b>

---

**Agreement Provider Type: 02 Physician, M.D., Group/CRNA Group**

---

**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
ADH Test System	1790756328	770304302	4815 West Markham, Little Rock, AR	edith.jones@arkansas.gov	<a href="#">Modify</a>	<a href="#">Delete</a>

← **Click here to modify or 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 to add new clinic/group that has same information as agreement**
**Click here to add new clinic/group**

## Modify Clinic/Group

Review and update clinic/group information as needed.

- To review, add or delete individual providers for the clinic/group location, click “View/Add Individual Providers for this Clinic/Group.”

[ADH Internet Apps \(Quit\)](#) [Initial](#) [General](#) [Bank](#) [Clinics/Groups](#)

**Clinic/Group Information and Provider Specialty Form**  
*Modify a Clinic/Group that is Under Agreement with Surgical Associates*

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

Clinic/Group DBA Name:

---

Clinic/Group BreastCare Provider Number:  Name as submitted to IRS on taxpayer W-9: [Surgical Associates](#)

Clinic/Group NPI:  Tax ID #:

Clinic/Group Email Address:

---

Physical Address of Clinic:

City:  State:  ZIP+4 Code:

County:

Clinic Phone Number:

Clinic/Group Billing Address is Same as Physical Address

Billing Address of Clinic:

City:  State:  ZIP+4 Code:

Billing Phone Number:

---

**Select Specialties for this Clinic/Group**

Provider Type:

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

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



- To add new individual provider, click “Add New Individual Provider.” Then, complete requested information and click “Save.”
- To delete individual provider, click “delete.”
- To modify individual provider, click “modify.”

 **Individual Providers in the Clinic/Group ADH Test System**

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.)

[ADH Internet Apps \(Quit\)](#) [Initial](#) [General](#) [Bank](#) [Clinics/Groups](#) [Clinic/Group](#)

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

Clinic/Group Name: [ADH Test System](#) Agreement Provider DBA Name: [Surgical Associates](#)

**Individual Providers List**

[Click here](#)

Individual Provider Name	Provider Type	BreastCare Provider Number	Individual Provider NPI	Address	Modify	Delete
Dale V Smith MD	Physician, M.D./Physician Assistant	770012345	1134191356	3401 Springhill, Ste 400, North Little Rock, AR	<a href="#">Modify</a>	<a href="#">Delete</a>

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



If you clicked “modify,” review and update information including e-mail address and license expiration. Click “Save.”

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

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

Clinic/Group Name: ADH Test System Agreement Provider DBA Name: Surgical Associates

**Individual Provider and Specialties**

**Modify 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: Dale  
Middle Initial: V  
Last Name: Smith \*  
Title: MD \*

---

Individual BreastCare Provider Number: 770012345 Individual Provider Effective Date: 04/01/2011 \*  
Individual NPI: 1134191356 \* (Format for dates: mm/dd/yyyy - slashes will automatically be inserted)  
Individual SSN: 111-11-1111  
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  
 H2 hematology  
 X1 Medical Oncology  
PCP and/or Colposcopy: Primary Care \*

Individual Provider Email Address: \_\_\_\_\_  
Medicare Number: 12345 \*  
AR License Number: C1234 \* AR License Expiration Date: 01/02/2013 \*  
DEA Number: AS1234564 \* DEA Expiration Date: 01/02/2013 \*

[Return to Individual Providers List](#)   **Click here**

Next, click “Return to Individual Providers List.”

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

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

Clinic/Group Name: ADH Test System Agreement Provider DBA Name: Surgical Associates

**Individual Provider and Specialties**

**Modify 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: Dale  
Middle Initial: V  
Last Name: Smith \*  
Title: MD \*

---

Individual BreastCare Provider Number: 770012345 Individual Provider Effective Date: 04/01/2011 \*  
Individual NPI: 1134191356 \* (Format for dates: mm/dd/yyyy - slashes will automatically be inserted)  
Individual SSN: 111-11-1111  
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  
 H2 hematology  
 X1 Medical Oncology  
PCP and/or Colposcopy: Primary Care \*

Individual Provider Email Address: \_\_\_\_\_  
Medicare Number: 12345 \*  
AR License Number: C1234 \* AR License Expiration Date: 01/02/2013 \*  
DEA Number: AS1234564 \* DEA Expiration Date: 01/02/2013 \*

[Return to Individual Providers List](#)  **Click here**

Repeat steps as needed to add additional individual providers. Then, click “Return to List of Clinic/Groups.”



**BreastCare**  
Sary Yes to a Mammogram!

*Individual Providers in the Clinic/Group ADH Test System*

(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](#)   [Clinic/Group](#)

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

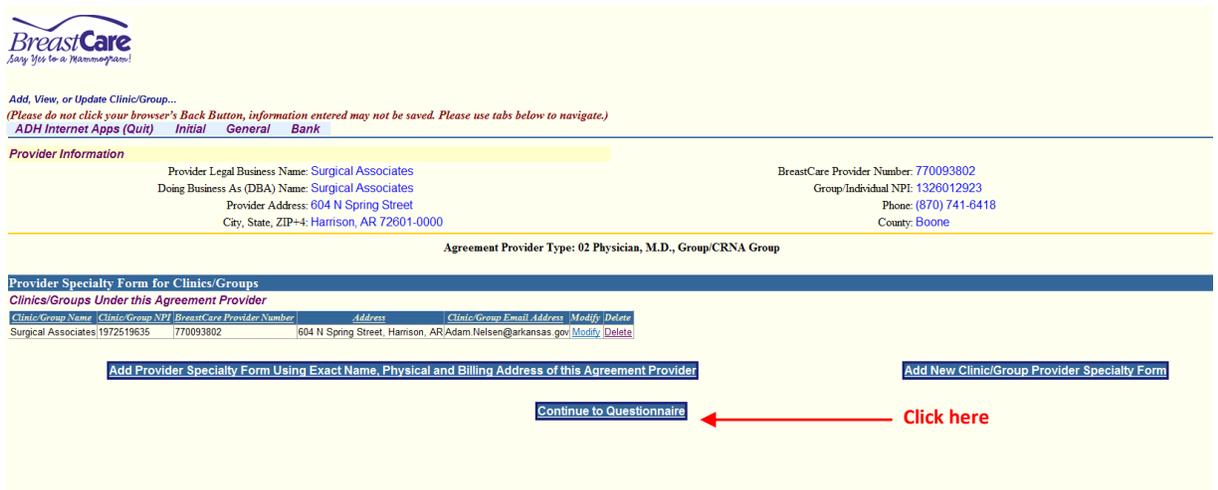
Clinic/Group Name: **ADH Test System**      Agreement Provider DBA Name: **Surgical Associates**

**Individual Providers List**      [Add New Individual Provider](#)

Individual Provider Name	Provider Type	BreastCare Provider Number	Individual Provider NPI	Address	Modify	Delete
Dale V Smith MD	Physician, M.D./Physician Assistant	770012345	1134191356	4815 West Markham, Little Rock, AR	<a href="#">Modify</a>	<a href="#">Delete</a>

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

Click “Continue to Questionnaire.”



**BreastCare**  
Sary 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.)

[ADH Internet Apps \(Quit\)](#)   [Initial](#)   [General](#)   [Bank](#)

**Provider Information**

Provider Legal Business Name: <b>Surgical Associates</b> Doing Business As (DBA) Name: <b>Surgical Associates</b> Provider Address: <b>604 N Spring Street</b> City, State, ZIP+4: <b>Harrison, AR 72601-0000</b>	BreastCare Provider Number: <b>770093802</b> Group/Individual NPI: <b>1326012923</b> Phone: <b>(870) 741-6418</b> County: <b>Boone</b>
--	---

Agreement Provider Type: **02 Physician, M.D., Group/CRNA Group**

**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
Surgical Associates	1972519635	770093802	604 N Spring Street, Harrison, AR	Adam.Nelsen@arkansas.gov	<a href="#">Modify</a>	<a href="#">Delete</a>

[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

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

**Complete questionnaire**

## Provider Checklist and Application Submission

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



*(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](#)   [Questionnaire](#)

**Provider Enrollment Checklist and Submit Application**

After submission of your Public Health Service Agreement, the following documents will be emailed to the provider agreement contact person's email address provided in the agreement. Please review the documents listed below for accuracy, print, sign and mail them to BreastCare to complete the enrollment process.

- Public Health Service Agreement
- Authorization for Automatic Electronic Funds Deposit (Attachment B)
- Provider Name and Specialty Form (Attachment E)
- Provider Questionnaire (Attachment F)

In your packet, you will also need to include:

- Copy of Signed Policies and Procedures (Attachment A - Document available below for print)
- Completed and Signed W-9 (Attachment C - Document available below for print)
- Copies of current Arkansas Medical/Nursing Licenses, DEA Registrations, if applicable, for each physician, registered nurse practitioner and certified nurse anesthetist (AHEC's, Hospitals or CHC's are exempt)
- Documentation of CME's, pertaining to breast or cervical cancer (CRNA's, anesthesiologists, CHC's and AHEC's are exempt)

The following documents are available to save or print, if needed:

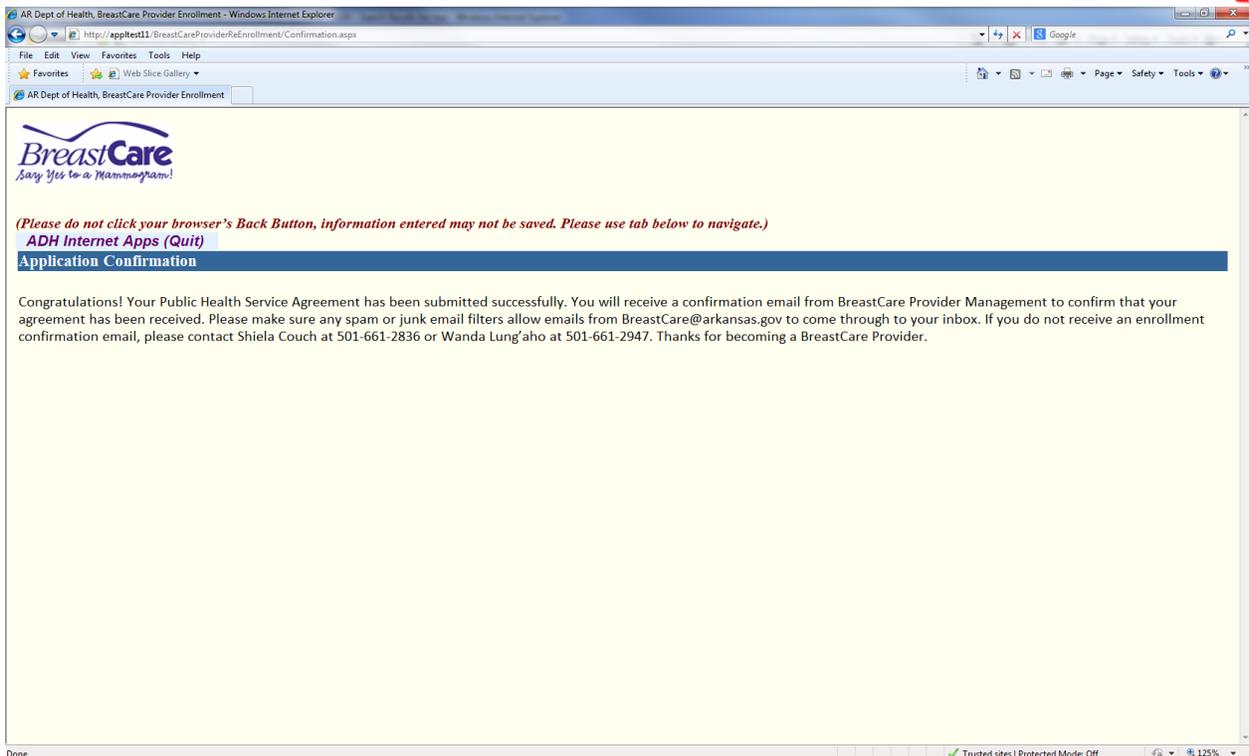
- [Policies and Procedures \(Attachment A\)](#)
- [W-9 Form \(Attachment C\)](#)

To finalize and submit your application, please click “Submit Application” below. Your application is not submitted until the confirmation notice appears to you.

[Submit Application](#)

← Click here

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



## **Field Definitions**

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

**BREASTCARE PROVIDER #:** Number assigned to provider by BreastCare.

**CLINIC/GROUPNAME (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?**

No. In this version of the application, that feature is not available. The application should normally time-out after about 60 minutes. When this happens, you should see an error like **“The Session has timed out”** on the screen. You will need to close your web browser, log back in and resume the application process.

### **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](mailto: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](mailto:Shiela.Couch@arkansas.gov) or [Wanda.Lungaho@arkansas.gov](mailto: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](http://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.