

ARKANSAS DEPARTMENT OF HEALTH PUBLIC HEALTH SERVICE AGREEMENT

This agreement 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.

I. PROVIDER INFORMATION:

Name:					
Physical Address:					
City:		State:		Zip Code:	
Taxpayer/Employer Identification #:				NPI#	
Phone Number:					
Provider Contact Name:					
Name:					
Agreement Billing Address:					
City:		State:		Zip Code:	
Agreement Contact Name:					
Agreement Phone Number:					
Agreement Contact Email Address:					

Provider Contact Name, Title, & Telephone:

Center/Office Contact Name, Title, & Telephone:

Becky Kossover, Contracts & Grants Coordinator
800-462-0599, ext 280-4097 or 501-280-4097

II. AGREEMENT PERIOD:

This agreement will begin July 1, 2009 and will end on June 30, 2011
on _____

In no event shall the initial term of the agreement extend beyond the end of the current biennial period unless the General Assembly, prior to the expiration of the biennial period, makes an appropriation for such purpose.

III. FINANCIAL TERMS:

BreastCare agrees to provide fee-for-service, or fixed reimbursement, as set forth in Breast and Cervical Reimbursement Rate Tables (see website www.arbreastcare.com). These reimbursement rates are based on current 100% Medicare allowable rates and are subject to change annually. Any provider of service must be enrolled in the program prior to reimbursement being made for any services provided. A program provider will be eligible for retroactive reimbursement for services rendered three (3) months prior to the date the contract is signed by the program signing party, as long as the service has been rendered within the same fiscal year. The Provider agrees to accept the amount reimbursed by the patient's insurance and/or *BreastCare* as payment in full and will not bill the patient. The Provider will waive insurance co-payments. Insurance must be billed first. *BreastCare* is the payer of last resort. All claims for patient services must be submitted within 60 days after the date of service. Claims for services provided during the current fiscal year (July 1 – June 30) must be received for payment by August 15th of the following fiscal year. (See Attachment A for reporting & billing requirements)

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IV. OBJECTIVE AND SCOPE:

Purpose of Agreement:

This agreement is to assure that enrolled program clients receive screening, diagnostic and/or treatment services according to guidelines that have been approved by the Breast Cancer Control Advisory Board, the Arkansas Medical Advisory Committee and/or the Center for Disease Control and Prevention (CDC). Providers agree to accept the *BreastCare* reimbursement rates for covered services and to provide NO non-covered services without full disclosure to the patient. Providers also agree to follow all *BreastCare* Program Policies and Procedures as outlined in Attachment A. The Provider agrees to submit a copy of a valid, unencumbered Arkansas license, DEA, Medicare number and CME, as required in Attachment A. Agreements submitted without all required documentation will not be executed.

All parties agree that following attachments contain material provisions of this agreement in regard to program deliverables and are hereby made a part of this agreement. These attachments may not be altered or modified without a written amendment signed by all parties.

Attachment No.	Description
A.	<i>BreastCare</i> program Policies and Procedures
B.	Authorization for Automatic Deposit (returned with a voided check)
C.	W-9 (first page only)
D.	Provider Name & Specialty Form (complete for each clinic, private practice physicians, CRNAs,
E.	Instructions for completing Provider Name & Specialty Form (Attach. D)
F.	Network Provider Questionnaire
G.	<i>BreastCare</i> Screening Form (only to be used as needed by appropriate providers)

V. CANCELLATION:

- A. The Department and the Provider agree that either party may cancel this agreement unilaterally at any time by giving the other party thirty (30) calendar days written notice, and delivering notice of cancellation either in person or by certified mail, return receipt requested, restricted delivery. Cancellation notices to the Arkansas Department of Health must be sent to the ADH Director or the authorized representative designated herein.

VI. ADMINISTRATIVE COMPLIANCE:

- A. **STATE AND FEDERAL LAWS:** Performance of this agreement by the Provider and the Department must comply with state and federal laws and regulations. If any statute or regulation is enacted which requires a change in this contract or any attachment, then both parties will deem this contract and any attachment to be automatically amended to comply with the newly enacted statute or regulation as of its effective date.
- B. **COMPLIANCE WITH NONDISCRIMINATION LAWS:** The Provider will comply with all applicable provisions of the following federal regulations related to nondiscrimination, both in service delivery to clients and in employment, including, but not limited to, the following:
- Title 45 Code of Federal Regulations:

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Part 80 (Nondiscrimination on the Basis of Race or Sex)

Part 84 (Nondiscrimination on the Basis of Handicap)

Part 90 (Nondiscrimination on the Basis of Age)

- Americans with Disabilities Act of 1990, U.S.C. Section 12101 et. seq.
- Title 28 Code of Federal Regulations:
 - Part 35 (Nondiscrimination on the Basis of Disability in State and Local Government Services)
- Title 41 Code of Federal Regulations:
 - Part 60-741 (OFCCP: Affirmative Action Regulations on Handicapped Workers)

The Department will furnish a copy of these regulations to the Provider upon request.

- C. CERTIFICATION REGARDING LOBBYING:** The Provider will comply with Public Law 101-121, Section 319 (Section 1352 of Title 31 U.S.C.) by certifying that appropriated federal funds have not been or will not be used to pay any person to influence or attempt to influence a federal official/employee in connection with the awarding of any federal contract, sub-grant, loan or cooperative agreement for an award in excess of \$100,000.00.

If the Provider has paid or will pay for lobbying using funds other than appropriated federal funds, Standard Form-LLL (Disclosure of Lobbying Activities) shall be completed.

- D. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION:** The Provider, as a lower tier recipient of federal funds, will comply with Executive Order 12549 (Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion - Lower Tier Covered Transactions). By signing and submitting this lower tier proposal, the prospective lower tier participant, as defined in 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

1. are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any federal department or agency.
2. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal.

- E. STATISTICAL AND FINANCIAL INFORMATION:** Financial information shall be maintained in accordance with generally accepted accounting principles.

- F. ACCESS TO RECORDS:** The Provider will grant access to its records upon request by duly authorized representatives of state or federal government entities. Access will be given to any books, documents, papers or records of the Provider which are related to any services performed under the agreement. The Provider additionally consents that all subcontracts will contain adequate language to allow the same guaranteed access to the records of subcontractors.

- G. CONFIDENTIALITY OF CLIENT RECORDS:** The Provider will maintain the confidentiality and security of all client records in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and ADH policies.

The Provider shall safeguard the use and disclosure of information concerning applicants for or recipients of Title XIX services in accordance with 42 CFR Part 431, Subpart F, and shall comply with 45 CFR Parts 160 and 164 and shall restrict access to and disclosure of such information in compliance with federal and state laws and regulations.

- H. LIABILITY**

In the event of non-performance of a contractual obligation by the Provider or his agents which results in the determination by Federal authorities of noncompliance with Federal regulations and standards, the Provider will be liable to the Department in full for all penalties, sanctions and disallowances assessed against the Department.

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I. RECORDS RETENTION

The Provider agrees to retain all records for five (5) years after final payment is made under this contract or any related subcontract. In the event any audit, litigation or other action involving these records is initiated before the end of the five (5) year period, the Provider agrees to retain these records until all issues arising out of the action are resolved or until the end of the five (5) year period, whichever is later. The Provider agrees to retain all protected health information as defined by the Privacy Rule promulgated pursuant to HIPAA for six (6) years or as otherwise required by HIPAA.

VII. FISCAL PRACTICES

- A. CLAIMS:** Only those claims for costs and services specifically authorized under this agreement will be allowed by the Department. Any work performed, material furnished or costs incurred and NOT covered by this agreement shall be the sole responsibility of the Provider.
- B. NON-DUPLICATION OF PAYMENT:** Services provided or costs incurred under this agreement shall not be allocated to or included as a cost of any other State or Federally financed program.
- C. LIMITATION OF THE DEPARTMENT'S OBLIGATION TO PAY:** The Department is not obligated to make payment under this agreement if the Department does not receive sufficient monies from the funding source(s) designated in this agreement to fund said obligations and other obligations of the Department, or is not given legal authority from the Arkansas Legislature to expend these funds. The Department is not obligated to make payment if sufficient state or local matching money is not available at the time the bill is presented for payment.
- D. PAYMENT FROM DEPARTMENT CONSIDERED PAYMENT IN FULL:** Payment received from the Department under this agreement shall be payment in full for all services and/or costs covered by the payment. No fee or other charge shall be made against a client or a third party for these services and/or costs. This paragraph does not preclude allocation of costs among two or more funding sources, or payment of portions of a service and/or cost under different funding sources, so long as there is no duplication of payment.
- E. DEPARTMENTAL RECOVERY OF FUNDS:** The Department shall seek to recover funds not utilized in accordance with the terms and conditions of this agreement.

VIII. AMENDMENT:

Any amendment to this agreement shall require completion of form FIN-9700-A ("Public Health Service Agreement AMENDMENT") and must be signed by the authorized representative(s) of the Provider and the

Arkansas Department of Health. Provider and Department acknowledge that no verbal or written representations, other than those contained herein, have been made as an inducement to enter into this agreement and that this writing constitutes the entire agreement.

IX. CERTIFICATIONS AND SIGNATURE:

- A. PROVIDER CERTIFICATION OF DOCUMENTATION:** The Provider certifies that all documentation presented to obtain this agreement is true and complete. The Provider agrees to notify the Department of any changes in this documentation except when the Department has given specific written permission to waive such notification.
- B. PROVIDER CERTIFICATION REGARDING CONTEMPORANEOUS EMPLOYMENT:** The Provider certifies that she/he is not a full-time, part-time or extra help employee of an Arkansas state agency.

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C. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): The Provider agrees to execute a Business Associate Agreement (BAA) as required by HIPAA and agrees that said BAA is incorporated herein by reference as if set out word for word.

D. SIGNATURES:

<u>DEPARTMENT</u>	
Signature of ADH Authorized Representative	Date
Bob Bennett	CFO, Arkansas Department of Health
Printed Name of ADH Authorized Representative	Title
In signing this document, I attest I am exercising appropriate fiduciary authority in the commitment of available resources to achieve program agency objectives.	

<u>PROVIDER</u>	
Signature of Authorized Representative	Date
Printed Name of Authorized Representative	Title
In signing this document, I attest that I am authorized by the Provider's Board of Directors or other governing authority to sign this agreement on behalf of the provider. This agreement is effective on date specified on Page 1, but no earlier than the date signed by the last signing party.	

ATTACHMENT A

BREASTCARE PROGRAM POLICIES AND PROCEDURES (Revised 2-1-09)

I. Requirements for all Providers:

For the purpose of this agreement, Providers include physicians, registered nurse practitioners, advanced practice nurses, hospitals, mammography facilities, ambulatory surgery centers, cytology laboratories and radiation therapy facilities.

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 *BreastCare* website at www.arBreastCare.com 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 before providing services by calling toll free 1-877-670-2273.

The telephone center will determine eligibility based on age, income and insurance status (age 40 or older, income at or below 200% poverty level and uninsured or underinsured). The telephone center will schedule an appointment for a clinical breast exam, Pap test, mammogram or diagnostic/treatment services as appropriate. The referring Provider or Primary Care Physician (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 19301, 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, B, C and D 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)
- ◆ 2006 Consensus guidelines for the Management of Women with Abnormal Cervical Cancer Screening Tests (Oct. 2007, *American Journal of Obstetrics and Gynecology*, www.asccp.org).
- ◆ 2006 Consensus Guidelines for the Management of Women with Cervical Intraepithelial Neoplasia or Adenocarcinoma in situ (Oct. 2007, *American Journal of Obstetrics and Gynecology*, www.asccp.org).

Breast biopsies are considered reimbursable procedures only when performed by participating providers after preliminary image evaluation on an outpatient basis and in accordance with approved guidelines. The least invasive and least costly approach should be used when appropriate.

Breast and cervical cancer and certain cervical tissue diagnosis of CIN II/III and carcinoma in situ are now covered by the Breast and Cervical Cancer Medicaid Category 07 regardless of age. Medicaid coverage begins at date of diagnosis and can be retroactive up to three (3) months. For patients who are diagnosed with breast or cervical cancer and are Medicaid recipients, treatment must be rendered and billed according to Medicaid's guidelines. Claims for treatment services for Medicaid recipients must be submitted to Medicaid. State funds will continue to cover treatment services for *BreastCare* enrollees who are not eligible for Breast and Cervical Cancer Medicaid (i.e., age 65 or older or male).

Mammography facilities must have proof of Food and Drug Administration Mammography Quality Standards Act certification or provisional certification. Laboratories must have proof of CLIA certification.

HIPAA requires all medical providers to **have a National Provider Identifier (NPI)**. The provider must enter their assigned group or facility number on the first page of the *BreastCare* agreement and the individual providers' NPI numbers must be entered on the Provider Name and Specialty Form.

II. Requirements for Physicians, Registered Nurse Practitioners, Advance Practice Nurses and Certified Registered Nurse Anesthetists Participants:

The Provider must have a valid, unencumbered Arkansas license and a Medicare number. A copy of their license and DEA number, if relevant, and their Medicare number must be submitted with the initial contract. A copy of the current Arkansas license and current DEA license is submitted annually. CRNAs must submit their RN and CRNA license annually. Each Provider in a group practice must submit this documentation before a *BreastCare* agreement can be executed.

The Provider agrees to obtain one (1) CME/CEU annually, as appropriate, related to breast cancer diagnosis/treatment and/or cervical cancer diagnosis/management. Documentation of CME must be submitted with each initial and renewal contract. The Provider agrees and understands that a performance evaluation/chart review will occur annually on a randomly selected number of participating providers or as needed, if problems are identified. Review of biopsy utilization and surgical procedures will be provided to appropriate providers. Documentation of CME/CEU may also be reviewed during this evaluation. **CRNAs and anesthesiologists are exempt from the CME requirement.**

III. Requirements for Primary Care Provider (PCP) Participation:

For the purpose of this program, the following specialties enrolled as *BreastCare* providers will be considered Primary Care Providers (PCP): family practice, general practice (including osteopath), gynecologist, internal medicine, registered nurse practitioner, advance practice nurse and radiologist.

The PCP agrees to:

- ◆ Authorize his/her name to be listed and consents to the release of his/her name to women in Plan A, who do not have a participating PCP.
- ◆ Perform a clinical breast exam (CBE) and Pap test, if needed (reimbursable visit). (See the Provider Manual for cervical cancer screening guidelines).
- ◆ Receive the mammogram and Pap test reports.
- ◆ Follow up on abnormal mammograms and Pap tests according to accepted standard of care.
- ◆ Refer patients or lab work only to participating providers (for listing, see www.arBreastCare.com).
- ◆ A performance evaluation/chart review annually on a random basis or as needed.

IV. Requirements for Reporting and Billing:

Providers must use a unique *BreastCare* claim form. Paper claims are accepted; however, electronic billing is preferred. Special software, installation and training are provided free to Providers (See Billing Instructions and printable version of the claim form at www.arBreastCare.com).

After the appropriate procedures have been performed, the provider will notify the patient and/or the ordering physician of the test results/diagnosis and submit the test result codes on the Claim Form to Electronic Data Systems (EDS), an HP Company. Contact EDS at 1-877-670-2273 for reporting/billing questions.

- 1 Within ten (10) working days**, the patient will be notified of her mammogram results in easily understandable “layman’s” terms.
- 2 Within ten (10) working days**, the mammography facility, cytology laboratory or specialist will send the mammogram/Pap test results/diagnosis to the referring Provider. Mammography results will be reported using the MQSA assessment categories. Pap test/cervical cytology results will be reported in the Bethesda System.
- 3 Within 24 hours**, the mammography facility and cytology laboratory will notify the *BreastCare* Nurse Coordinator by phone (501) 661-2636, fax (501) 280-4049) or e-mail Dianne.Crippen@arkansas.gov giving her information about any test which needs immediate follow-up.
- 4 Within sixty (60) days**, the Provider must submit the claim to EDS. The Provider understands that providing specified test results is a condition of payment. All providers are not required to submit test result codes for all CPT codes. See the *BreastCare* billing instructions at www.arBreastCare.com for a detailed explanation of the provider’s responsibilities for submitting test result codes to EDS. Anesthesia providers are not required to submit any test result codes. Electronic billing is preferred and will be given first priority; however, paper claims may be submitted, only if necessary. Payments are disbursed electronically into the provider’s bank account. **The Provider must complete an Authorization for Automatic Funds Deposit form in order to receive the electronic funds transfers for claims. No paper checks are issued.**
- 5 By August 15th of the following fiscal year (July 1 – June 30)**, the Provider must have submitted all claims for services rendered to *BreastCare* patients during that fiscal year. If the Provider fails to submit the claim within this time frame and *BreastCare* cannot pay, the Provider is prohibited from billing the patient. Because of untimely filing, the claim then becomes the responsibility of the provider. There will be no exceptions to this policy!

V. Requirements for Reimbursement:

BreastCare will provide a Provider Manual, reporting and billing forms and technical assistance, as needed. EDS will provide special, user friendly, computer software, at no charge, for electronic reporting and billing. Fee-for-service reimbursement is provided for screening and diagnostic procedures in Table A (reimbursement tables). The professional and technical fees may be invoiced separately for screening and diagnostic procedures in Table A. A fixed reimbursement is provided for breast biopsies when performed in an outpatient facility (Table A) and for treatment services in Table B. The Provider will refer to the appropriate table for billing purposes and submit claims to EDS as instructed in the billing instructions. Procedure codes submitted to Medicaid for treatment will be reimbursed according to Medicaid’s guidelines. Reimbursement tables are found and updated as needed at www.arBreastCare.com.

Pap tests and CBEs are reimbursable services according to program guidelines for eligible women in Plans A, B and C. Specimens must be submitted to *BreastCare* participating laboratories. After the patient’s exam, the PCP schedules a mammogram/ultrasound appointment based on the CBE result. The PCP completes the enclosed *BreastCare* Screening Form and faxes it to the *BreastCare* Data Team at 501-661-2264.

Any claim that is submitted for an office visit will be suspended if *BreastCare* has not received the Screening Form with CBE result, Pap information and mammogram appointment. The

Provider will be contacted for the results. When the results are obtained, payment will be activated.

The Provider agrees to accept the amount reimbursed by the patient's insurance and/or *BreastCare* as payment in full and **will not** bill the patient. The Provider will waive co-payments. Exception: If a patient diagnosed with breast or cervical cancer or a cervical precancerous condition that is eligible for Medicaid refuses to apply for Medicaid within 30 days from the date of their diagnosis, the patient may be billed. **Insurance must be billed first.** *BreastCare* is the payer of last resort. All claims for patient services must be submitted within 60 days of the date of service.



Attachment B

Arkansas Department of Health (ADH) – *BreastCare* Program
Authorization for Automatic Electronic Funds *Deposit*

Provider Legal Business Name: _____ Provider #: _____

Doing Business As Name (DBA): _____

Provider Address: _____ Telephone: (____) _____

City, State: _____ Zip: _____

Type of Authorization: Same Change New *Please check appropriate box.*

For verification purposes, please complete the following:

Routing Transit #: _____ Bank Account #: _____

PLEASE ATTACH A COPY OF A VOIDED CHECK TO VERIFY THESE NUMBERS. The name on the voided check/deposit slip should match the name on the provider business name or DBA stated above

Name of Depository (Bank): _____

Depository Address: _____

City, State: _____ Zip Code: _____

I hereby authorize the ADH, *BreastCare* to initiate credit entries to the account indicated above and the depository named above to *credit* the same to such account. I understand that I am responsible for the validity of information on this form.

I understand in endorsing this funds transfer that payment will be from Federal and State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

ADH *BreastCare* will send the direct deposit to the Depository indicated above until notified by me that I wish to change the Depository receiving the direct deposit. If my Depository information changes, I agree to submit to *BreastCare* an updated Automatic Authorization Agreement.

Authorized Official Name (Print): _____

Authorized Official Title: _____

Authorized Official Signature: _____ **Date:** _____

Please return this form to:
BreastCare
ADH
4815 WEST MARKHAM SLOT 11
LITTLE ROCK AR 72205

Request for Taxpayer Identification Number and Certification

**Give form to the
 requester. Do not
 send to the IRS.**

Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> 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 Line 1 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.

Social security number
or
Employer identification number

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 ▶
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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 obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

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,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,



Attachment D

**Arkansas Department of Health – BreastCare Program
Provider Name and Specialty Form**

Please list each individual provider in your clinic/group or practice in space in lower half of this form. Fill in each applicable box on each provider. Please attach a copy of their medical or nursing license, DEA license if applicable and documentation of one hour of CME related to breast or cervical cancer for the past year. List their specialty, their Social Security, Medicare and NPI numbers. *If you are adding or deleting a provider to your contract, enter "A" for add "D" for delete and enter the effective date for each.* This form is not required for non-physician/nurse facilities. Hospitals and groups should complete a form for each clinic or facility site.

Clinic/Group Name: _____ Group NPI # _____

Name as submitted to IRS on taxpayer W-9 (if different than group name): _____

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

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

Billing Phone # : _____

<u>BreastCare #</u>	<u>Provider Name</u>	<u>Add Delete</u>	<u>Effective Date</u>	<u>Indiv. SS #</u>	<u>Indiv. NPI #</u>	<u>Specialty</u>	<u>*PCP and/or Colposcopy P/C/B</u>	<u>Medicare #</u>	<u>AR License #</u>	<u>DEA #</u>
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										

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

Make additional copies of this form, if needed.

Attachment E

INSTRUCTIONS FOR COMPLETING PROVIDER SPECIALTY FORM

One form is to be completed by every health care group, practice or hospital for each clinic or facility which falls under their Tax ID. It should also be completed by all private practice physicians, CRNAs and RNPs who wish to contract with the Arkansas Department of Health, *BreastCare* Program. **Not required of hospitals which have no separate clinic or community health outlet providing client services.**

Please type or print all information requested.

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.

COMPLETE LOWER SECTION

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 (**D**) your group (retired, died or moved) or been added (**A**) 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)

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 **P** (primary care), **C** (colposcopy only) or **B** (both primary care and colposcopy)).

MEDICARE #: Number assigned by Medicare to the individual provider

AR LICENSE #: Individual's current state medical license number

DEA #: Individual's number for dispensing drugs (if applicable) or indicate N/A



ATTACHMENT F

Name Of Clinic/Facility/Group: _____ Date: _____

Provider Number (not applicable for new applicants) _____

NETWORK PROVIDER QUESTIONNAIRE

Please complete the following questions, when applicable, giving us names of providers in your community network which will be providing services to *BreastCare* clients. This will help ensure that our clients have coverage for all specialties when needed and without being billed. Thank you for your cooperation.

1. Who is the radiology group/individual who reads mammograms at your facility, if applicable?

2. Who is the pathology group/individual who interprets your Pap test specimens?

3. Who is the pathology group/individual who provides pathology services for your hospital or group?

4. Who provides anesthesia services at your hospital or surgical facility?

5. To whom do you refer for surgical care?

6. To whom do you refer for gynecological/colposcopy care?

ARKANSAS DEPARTMENT OF HEALTH
BREASTCARE SCREENING FORM

Attachment G

MM/DD/YYYY – Date of Exam		Patient's BreastCare ID Number 7777	
Last Name of Patient		First Name of Patient	MI
Date of Birth		Social Security Number: <input type="checkbox"/> N/A	
Name of Clinic		County of Clinic	
<p>Does the client report any of the following breast symptoms?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes: (Check all that apply) <input type="checkbox"/> Palpable mass <input type="checkbox"/> Skin ulceration/inflammation <input type="checkbox"/> Skin dimpling <input type="checkbox"/> Spontaneous nipple discharge <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Focal pain <input type="checkbox"/> Other _____ <p><i>(If yes, refer for diagnostic mammogram)</i></p>		<p>Does the client report any of the following cervical symptoms?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes: (Check all that apply) <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Post menopausal bleeding <input type="checkbox"/> Irregular bleeding <p><i>(If yes, refer for GYN consult regardless of Pap test results)</i></p>	
<p>Clinical Breast Exam (Objective Findings):</p> <input type="checkbox"/> Normal/benign (includes scarring And implants) <input type="checkbox"/> Abnormal (Check abnormality) <input type="checkbox"/> Palpable mass/thickening <i>(refer for US & diagnostic mammogram)</i> <input type="checkbox"/> Skin dimpling/retraction/ inflammation <input type="checkbox"/> Spontaneous nipple discharge observed <input type="checkbox"/> Nipple or areolar scaliness <input type="checkbox"/> Needed, but not performed (includes refused) <input type="checkbox"/> Not done <p><i>For abnormal CBE, refer for diagnostic mammogram, follow-up required</i></p>		<p>Pap Test: (Check type of Pap Performed) <input type="checkbox"/> Liquid-based with ASC-US Reflex Testing <input type="checkbox"/> Conventional smear</p> <p>Pap not needed because: <input type="checkbox"/> Benign hyst, no cervix <input type="checkbox"/> Pap test in past 12 months <input type="checkbox"/> Negative LBT last year <input type="checkbox"/> 3 Negative/benign consecutive Pap tests in last 5 years <input type="checkbox"/> Pap needed, but not performed (includes refused)</p>	
<p>Pelvic Exam:</p> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal, not suspicious for cancer <input type="checkbox"/> Abnormal, suspicious for cancer <input type="checkbox"/> Not done		<p>Note: ASC-US reflex testing for HPV High Risk DNA must be ordered for all liquid-based tests (LBT). HPV High Risk DNA Testing is reimbursable for laboratories.</p>	
Print Name and Title of Person Performing Pap and/or CBE		Name of Cytology Laboratory for Paps	
Mammogram Appointment Date	Appointment Time	Check scheduled procedure(s): <input type="checkbox"/> Screening Mammogram <input type="checkbox"/> Diagnostic Mammogram <input type="checkbox"/> Ultrasound	
Name of Mammogram Facility	Town of Facility		