



Attachment E

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

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

Clinic/Group Name: _____ Provider Number: _____ Group NPI #: _____

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

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

Billing Address (if different from physical add): _____ City/State/Zip: _____, _____

Billing Phone #: _____

<u>BreastCare #</u>	<u>Provider Name</u>	<u>Add Delete</u>	<u>Effective Date</u>	<u>Indiv. NPI Number</u>	<u>Specialty</u>	<u>*PCP and/or Colposcopy P/C/B</u>	<u>AR License Number</u>	<u>Expiration Date</u>	<u>DEA Number</u>	<u>Expiration Date</u>
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										

*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.