Please note as you are completing the document, list your program after the **Place of Residency** at the bottom of the page.
PRACTITIONER IDENTIFICATION NUMBER REQUEST FORM

Please select one of the following:

☐ Physician Assistant NV (Include a W9 for the Individual)
☐ Non-Independent Licensed Clinician (Include license) NW
☐ Certified Behavioral Analyst Paraprofessional BP
☐ Certified Peer Recovery Support Specialist BH/SU RS
☐ Resident NU
☐ QBHP NT
☐ Community Support Staff CS
☐ Personal Care Aide NT

Practitioner Name ________________________________________________________________

(Please print)

NPI/Taxonomy Code______________________________________________________________

Social Security Number ______________________ Date of Birth________________________

Physical Work __________________________ Address

City __________________________ State ______ ZIP+4

County __________________________ Phone Number (Include area code)

Mail to Address ______________________________________________________________

City __________________________ State ______ ZIP+4

Phone Number (Include area code)

Individual Email Address _______________________________________________________

Residents Only __________________________ Place of Residency ______________________

Effective Date of Residency __________________________

By signing, the applicant authorizes the Arkansas Department of Human Services to conduct a State and Federal background check. Results from the background check will determine the provider enrollment status with the Arkansas Medicaid program.

Practitioner’s Signature __________________________ Date ________________________

Mail or Fax this completed form to:
Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 8105
Little Rock, AR 72203-8105
Fax Number: 501-374-0746

DMS-7708 (Rev. 4/21)