Attachment D

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 number 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 (CHCs) and hospitals should complete this form for each clinic/group operating under this agreement. List each performing individual provider per each practice location with the exception of CHCs.

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

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

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

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

Billing Phone #: _____

BreastCare #	Provider Name	Add Delete	Effective Date	Indiv. NPI Number	Specialty	*PCP and/or Colposcopy P/C/B	AR License Number	Expiration Date	DEA Number	Expiration Date
	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.

Revised 11/2018