How to submit a PT 95 RX Pharmacist application.

gainwell

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Starting the application

- Click the link to - Start your application
- Select "**Enrollment Application**"

- Select the options below
- **NPI**: List registered to the enrolling pharmacist listed on the application.
- **TAX ID**: List the SSN of the enrolling pharmacist.

Home

Home > Provider Enrollment

Provider Enrollment

Enrollment Application
Initiate a New Enrollment application.

Re-Enrollment
Initiate a Re-enrollment application.

Resume Enrollment
Resume an existing application that you previously started.

Enrollment Status
Check the current status of an enrollment application.

Completing an Online Application
Watch this video to see step by step instructions on how to complete an online Enrollment Application.

Provider Enrollment: Start Enrollment Back t

Select Enrollment Type, Provider Type, and Specialty then enter your assigned NPI and Tax ID (Employee Identification Number or Social Security Number)

The * indicates a required field.

*Enrollment Type: Atypical
*Provider Type: 95 - REGISTERED, NONCREDENTIALED PROVIDEF
*Specialty: RX - PHARMACIST
NPI:
*Tax ID:

Continue | Cancel

Entering the application data: Welcome tab

- The welcome tab will detail key information that will be asked during the application process. At the bottom the online application will show if any documentation is needed to be attached towards the end of the application.
- Hit continue to proceed with the application.

Provider Enrollment: Welcome

- Welcome
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Welcome to the Online Provider Enrollment Process

Please complete each step in the enrollment process. When you have completed all steps of the application, "Submit" and "Confirm" the application for further processing.

As a condition for entering into or renewing a provider agreement all applicants must complete an application. A true, accurate and complete disclosure of all requested information is required by the Federal and State regulations that govern the Medical Assistance Program. Failure of an applicant to submit the requested information or the submission of inaccurate or incomplete information may result in refusal by the Medical Assistance program to enter into, renew or continue a provider agreement with the applicant. Furthermore, the applicant is required by Federal and State regulations to update the information submitted on the application.

You will need the following information to complete your enrollment request:

- National Provider Identifier
- Address Information including Zip Code + 4
- Taxonomy Codes
- Tax ID - either Employee Identification Number or Social Security Number
- License Number

Also, please look for required attachments for your application below and click the **"Continue"** button to start the enrollment application.

Enrollment Type Atypical
Provider Type 95 - REGISTERED, NONCREDENTIALED PROVIDEI
Specialty RX - PHARMACIST

Document(s) required to be attached

License: General required

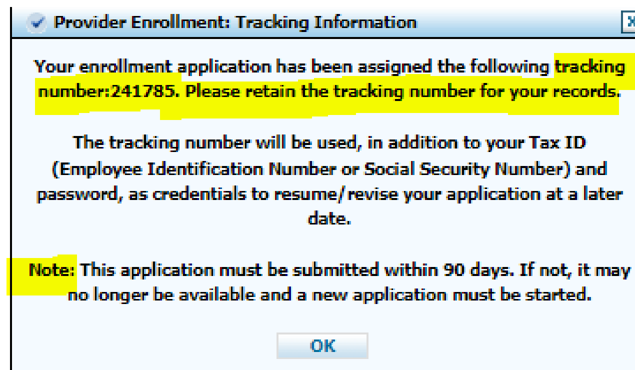
Make sure you have all document(s) ready to attach before submitting application.

Continue Cancel

Entering the application data: Requested Information

- **NPI**: List registered to the enrolling pharmacist listed on the application.
- **Primary Taxonomy**: You can search or enter any valid taxonomy. Must list a taxonomy.
- **TAX ID**: List the SSN of the enrolling pharmacist.
- **Are you a Personal Care Aide?** – This question should always be marked as no for RX – Pharmacist.
- **Effective date** – List a requested effective date or place todays date.
- **Fiscal Year End**: Enter December unless fiscal year end falls on another date.
- **Complete Contact Information**: This sections will receive email notifications if the ATN is RTP'd. RTP= Returned to Provider for review/corrections.
- **Provider Enrollment Credentials**: Keep note of the password and security questions you completed for your application. If you need to check the status online or re-access the application after RTP to resubmit for processing; this information will be asked and cant be reset.

Once all sections have been completed, hit continue and a message will pop up with your application tracking ID. An email notification will also be sent.



Provider Enrollment: Request Information

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You are initiating a new Enrollment application. Below is the initial enrollment screen. Complete the fields on each screen and select the Continue button to move forward to each page. All mandatory data is required to "Finish Later".
The contact person will potentially be contacted to answer any questions regarding the information provided in this enrollment application.
You are enrolling as a new provider and you will get a new number.
The * indicates a required field.

Initial Enrollment Information

*Enrollment Type: Atypical
*Provider Type: 95 - REGISTERED, NONCREDENTIALED PRO

Provider Information

The provider identification numbers listed below are additional identifiers for the enrolling providers. Not all fields are required.

NPI: 0000001111
NPI Zip + 4: 721200001
Primary Taxonomy: pharmacist
*Tax ID (Employee Identification Number or Social Security Number): 123456789
*Tax ID Type: EIN / SSN
*Are you a personal care aide? Yes / No
*Effective Date: 03/01/2023
*Fiscal End Date: December

Contact Information

*Last Name: Brickey
*First Name: John
Title:
*Phone: 5015902000
Ext:
Fax Number:
*Contact Email: John.brickey@gainwelltechnologies.com
*Confirm Email: john.brickey@gainwelltechnologies.com
Preferred Method of Communication: Email

Provider Enrollment: Credentials

Please provide the following information, which will be required to resume your application at a later date. Your password must be between 8 to 20 alphanumeric characters. Your tax id (Employee Identification Number or Social Security Number) is provided, if already contained within your provider enrollment application.

Once this information is entered and the Submit button is selected, a tracking number will be provided. The tracking number along with the following information, will be used as your credentials to resume your suspended enrollment application.

*Password
*Confirm Password
*What was the name of your elementary / primary school?
*What was the last name of your third grade teacher?
*What is the name of the last high school you attended?

Continue | Finish Later | Cancel

Entering the application data: Specialties tab

- Hit continue to proceed with the application.

Home

Home > Provider Enrollment > Start Enrollment > Enrollment Application > Enrollment Request Information > Enrollment Specialties   Tuesday 09/05/2023 10:51 PM CST

Provider Enrollment: Specialties

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Specialties

The provider type is established on the Request Information screen. All subsequent specialties available for the selected provider type can be added on this screen. Only one specialty can be designated as the primary specialty.
Taxonomies are available to be added for the selected provider.

The * (in red) indicates required fields.

Indicates a primary record.

Click "+" to view or update the details in a row. Click "-" to collapse the row. Click **"Remove"** link to remove the entire row.

	Specialty	Action
-	PHARMACIST	
+	Click to add specialty.	

Additional Taxonomies

Click the **"Remove"** link to remove the entire row.

	Taxonomy Code	Action
+	Click to add Taxonomy	

Continue | Finish Later | Cancel

Entering the application data: Addresses

- Service location is required. Once entered you must hit “Verify Address” before the application will allow you to save the information.
- Complete address info for Home Office, Mail to, and Pay to. If these sections are not completed the information listed on the service location will be copied for all addresses.

Home

Home > Provider Enrollment > Enrollment Addresses

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Provider Enrollment: Addresses

- Welcome
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The * (in red) indicates required fields.

Indicates a primary record.

Provider Addresses

The Service Location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

- The Service Location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The Service Location name must match the business name on the W-9.
- The Service Location address must be a physical location. A post office box is not a valid Service Location address.
- Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their Service Location address.

Click the **"Remove"** link to remove the entire row.

	Type	Address	City	State	Action

Click to collapse.

*Address Type: Service Location

Primary Address

Contact Name

Location Code

*Address

*City

County _

*State

*Zip Code

Verify Address

County Code _

Latitude _

Longitude _

*Primary Email

Confirm Email

*Phone

Ext

Phone

Ext

Add

Reset

Continue

Finish Later

Cancel

Entering the application data: Addresses

	Type	Address	City	State	Action

⊟ Click to collapse.

*Address Type: Service Location (options: Home Office, Mail To, Service Location, Pay To)
Primary Address

Contact Name
Location Code

*Address

*City
County _

*State
*Zip Code

Verify Address

County Code _

Latitude _
Longitude _

*Primary Email
Confirm Email

*Phone Ext
Phone Ext

Add Reset

Continue Finish Later Cancel

Address Verification: Results

Original Address

**Original address may be undeliverable.

Line 1 526 South Fairway Ave
Line 2
City Sherwood
State ARKANSAS Zip Code 72120
County
Latitude _ Longitude _

Exact Address Match Found

Click on **SELECT** to choose the address.

Address	City, State	County	ZipCode	Action
526 S FAIRWAY AVE	SHERWOOD, ARKANSAS	PULASKI	72120-5807	Select

Cancel

Entering the application data: Requested Information

Click "Remove" link to remove the entire row.		City	State	Action

Click to collapse.

*Address Type: Service Location
Primary Address

Contact Name: John Brickey
Location Code: In State

*Address: 526 S FAIRWAY AVE

*City: SHERWOOD
County: _

*State: ARKANSAS
*Zip Code: 721205807

Verify Address

County Code _

Latitude _
Longitude _

*Primary Email: John.brickey@gainwelltechnologie
Confirm Email: John.brickey@gainwelltechnologie

*Phone: Office 5015906005 Ext
Phone Ext

Add Reset

Continue Finish Later Cancel

Entering the application data: Requested Information

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Home > Provider Enrollment > Enrollment Addresses

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Provider Enrollment: Addresses

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The * (in red) indicates required fields.

Indicates a primary record.

Provider Addresses

The Service Location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

- The Service Location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The Service Location name must match the business name on the W-9.
- The Service Location address must be a physical location. A post office box is not a valid Service Location address.
- Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their Service Location address.

Click the **"Remove"** link to remove the entire row.

	Type	Address	City	State	Action
⊞	Service Location	526 S FAIRWAY AVE	SHERWOOD	ARKANSAS	Copy Remove
⊞	Click to add address.				

Continue | Finish Later | Cancel

Entering the application data: Requested Information

Home

Home > Provider Enrollment > Enrollment Addresses

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Provider Enrollment: Addresses

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The * (in red) indicates required fields.

Indicates a primary record.

Provider Addresses

The Service Location name and address generally is the site where members obtain services and is either owned or rented by the provider. This location should be where supporting documentation related to claims is maintained.

- The Service Location name must be the Doing Business As (DBA) name registered with the Secretary of State if registered. This does not apply to informal associations such as Sole Proprietorships and General Partnerships that are not registered.
- The Service Location name must match the business name on the W-9.
- The Service Location address must be a physical location. A post office box is not a valid Service Location address.
- Providers that provide services at a "place of service site," such as at a hospital or nursing facility, should enter their home/business office as their Service Location address.

Click the **"Remove"** link to remove the entire row.

	Type	Address	City	State	Action
⊞	Service Location	526 S FAIRWAY AVE	SHERWOOD	ARKANSAS	Copy Remove
⊞	Click to add address.				

Continue | Finish Later | Cancel

Entering the application data: Provider Identification

- **Provider Legal Name**: List the providers legal name.
- **Tax Name**: This section should match the same name listed above.
- **Gender/DOB**: Enter gender & DOB of Pharmacist.
- **License**: List the provider license information.

Issuing State*	AR - ARKANSAS
Issuing Board*	PHA - ARKANSAS STATE BOARD OF PHARMACY

- **Medicare & CLIA** is optional if applicable
- You can proceed without the Medicare and CLIA by hitting the continue button at the bottom.

Provider Enrollment: Provider Identification

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The * (in red) indicates required fields.

Provider Legal Name

The provider legal name and information is provided once for each enrollment.

*Last Name
*First Name
Middle Title
*Tax Name

Individual Providers

*Gender *Birth Date

License

Click the "**Remove**" link to remove the entire row.

License #	Effective Date	End Date	Issuing Board	Issuing State	Action

Click to collapse.

*License # *Effective Date *End Date
*Issuing State *Issuing Board
Classification

Add Reset

Medicare Participation

Medicare # Effective Date Medicare Type

CLIA Certification

Click the "**Remove**" link to remove the entire row.

CLIA #	Effective Date	End Date	Action

Click to collapse.

*CLIA # *Effective Date *End Date

Add Reset

Continue Finish Later Cancel

Entering the application data: Provider Identification

Provider Enrollment: Provider Identification

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The * (in red) indicates required fields.

Provider Legal Name

The provider legal name and information is provided once for each enrollment.

*Last Name: Brickey
*First Name: John
Middle
Title
*Tax Name: John Brickey

Individual Providers

*Gender: Male
*Birth Date: 06/23/1987

License

Click the "**Remove**" link to remove the entire row.

License #	Effective Date	End Date	Issuing Board	Issuing State	Action

Click to collapse.

*License #: PD99911
*Effective Date: 06/01/2022
*End Date: 06/30/2025
*Issuing State: ARKANSAS
*Issuing Board: ARKANSAS STA
Classification: PHARMACY

Add Reset

ARKANSAS STATE BOARD OF CHIROPRACTIC EXAMINERS
ARKANSAS STATE BOARD OF EXAMINERS IN COUNSELING
ARKANSAS BOARD OF NURSING
ARKANSAS BOARD OF PODIATRIC MEDICINE
ARKANSAS DEPT OF HEALTH
ARKANSAS STATE BOARD OF OPTOMETRY
ARKANSAS STATE BOARD OF PHYSICAL THERAPY
ARKANSAS PSYCHOLOGY BOARD
BOARD OF HEARING INSTRUMENT DISPENSERS
DIVISION OF DEVELOPMENTAL DISABILITIES
PHARMACY AND DEA LICENSE
DIV OF HEALTH FACILITY SVCS, AR DEPT OF HEALTH
DEPT OF HEALTH AND ARKANSAS DEPT OF LABOR
ADHS - AR DEPARTMENT OF HUMAN SERVICES
DPSQA - DIV OF PROVIDER SVCS AND QUALITY ASSURANCE
INPATIENT PSYCHIATRIC LICENSE
ARKANSAS DEPT OF HEALTH OR LEA#
OFFICE OF LONG TERM CARE
ARKANSAS STATE BOARD OF PHARMACY

Medicare Participation

Medicare #
Effective Date

CLIA Certification

Click the "**Remove**" link to remove the entire row.

CLIA #	Effe

Click to collapse.

*CLIA #
*Effective Date
*End Date

Add Reset

Continue Finish Later Cancel

Entering the application data: Provider Identification

Provider Enrollment: Provider Identification

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The * (in red) indicates required fields.

Provider Legal Name

The provider legal name and information is provided once for each enrollment.

*Last Name: Brickey
*First Name: John
Middle: Title:
*Tax Name: John Brickey

Individual Providers

*Gender: Male *Birth Date: 06/23/1987

License

Click the "**Remove**" link to remove the entire row.

	License #	Effective Date	End Date	Issuing Board	Issuing State	Action
⊞	PD99911	06/01/2022	06/30/2025	PHA	ARKANSAS	Remove
⊞	Click to add license					

Medicare Participation

Medicare #: Effective Date: Medicare Type:

CLIA Certification

Click the "**Remove**" link to remove the entire row.

	CLIA #	Effective Date	End Date	Action
⊟	Click to collapse.			

*CLIA #: *Effective Date: *End Date:

Add Reset

Continue Finish Later Cancel

Entering the application data: Attachments and Fees

- Required to upload a copy of the Pharmacy board License. Is best to submit the license verification page from the board website.
- This link can be used to obtain a copy of the providers license from Arkansas Pharmacy Board. https://arbopharmprod.glsuite.us/glsuiteweb/clients/arbopharm/public/verification/search.aspx
- All providers boarding or out of state will need to provide a copy of their license from their state Pharmacy Board.
- All optional listings are only needed if applicable or requested.

Provider Enrollment: Attachments And Fees

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Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit electronic attachments, please follow the instructions in the Attachments panel below.

Verify that all required documentation, including copies of applicable professional and operating licenses, is included as an attachment.

If you are submitting **Fingerprint Background information**, include a copy of the proof of fingerprint collection as an attachment.

Note if you choose to "Upload" attachments by "File Transfer", a maximum of 700 MBs of information can be uploaded."

The * (in red) indicates required fields.

Attachments

To add an attachment, complete the required fields and click the **Add** button.
Use the 'Other' selection to upload attachments not in the list.

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action

Click to collapse.

*Transmission Method: EL-Electronic Only
Upload File: Select
*Attachment Type
*Description

(OPTIONAL) OTHER - Miscellaneous
(OPTIONAL) Providers from NON-BORDERING states must attach an Arkansas claim
License: General required

Attachments

Application Fee

No Application Fee Required

Continue | Finish Later | Cancel

Entering the application data: Attachments and Fees

Provider Enrollment: Attachments And Fees

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Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit electronic attachments, please follow the instructions in the Attachments panel below.

Verify that all required documentation, including copies of applicable professional and operating licenses, is included as an attachment.

If you are submitting **Fingerprint Background information**, include a copy of the proof of fingerprint collection as an attachment.

Note if you choose to "Upload" attachments by "File Transfer", a maximum of 700 MBs of information can be uploaded."

The * (in red) indicates required fields.

Attachments

To add an attachment, complete the required fields and click the **Add** button.
Use the 'Other' selection to upload attachments not in the list.

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action

Click to collapse.

*Transmission Method: EL-Electronic Only

Upload File: John Brickey Pharmacist License.pdf

*Attachment Type: License: General required

*Description: License

Add | Cancel

Home

Home > Provider Enrollment > Attachments and Fees — Tuesday 09/05/2023 11:17 PM CST

Provider Enrollment: Attachments And Fees

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Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit electronic attachments, please follow the instructions in the Attachments panel below.

Verify that all required documentation, including copies of applicable professional and operating licenses, is included as an attachment.

If you are submitting **Fingerprint Background information**, include a copy of the proof of fingerprint collection as an attachment.

Note if you choose to "Upload" attachments by "File Transfer", a maximum of 700 MBs of information can be uploaded."

The * (in red) indicates required fields.

Attachments

Click the **Remove** link to remove the entire row.

#	Transmission Method	File	Attachment Type	Action
1	EL-Electronic Only	JOHN BRICKEY PHARMACIST LICENSE.PDF (147K)	License: General required	Remove

Click to add attachment.

Application Fee

No Application Fee Required

Continue | Finish Later | Cancel

Entering the application data: Agreement

- Click “I Accept” to terms of agreement
- Enter the providers legal name and title to finalize the signature page for the application.

Provider Enrollment: Agreement

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Instructions

The terms of enrollment are stated below. You must accept these terms in order to submit the enrollment application. Failure to accept these terms means that no enrollment application is retained or submitted.

Access the summary of enrollment link to review all data that has been entered into the enrollment application. Changes can be made to the existing application by navigating back to the appropriate screen using the links in the table of contents. Once changes are made, the enrollment application can be reviewed again.

The enrollment application terms must be accepted in order to submit the application for approval.

Once the application is submitted, a tracking number will be assigned and a cover sheet can be printed for submission with all hard copy materials to the enrollment office.

Terms of Agreement

Provider Name John Brickey
Address 526 S FAIRWAY AVE
SHERWOOD
ARKANSAS, 72120-5807
Tax ID (Employee Identification Number or Social Security Number) 123456789
NPI 0000001111
Contact Name John Brickey
Contact Email John.brickey@gainwelltechnologies.com

The above atypical provider agrees to participate in the Medicaid and/or SeniorCare Program, hereinafter referred to as the Title XIX Program.

I agree that my fees or charges for services or items delivered to Title XIX beneficiaries will not exceed my fees or charges for similar services or items delivered to non-Title XIX individuals. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to Title XIX beneficiaries are not greater then charges for service to non-Title XIX individuals, the Department of Health and Family Services, hereinafter referred to as the Department or its authorized representatives will be used to make such determinations.

I. Provider, in consideration of the covenants therein, agrees:

A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services.

B. To make available and, upon request, furnish all records described above to the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or a

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By entering your name in the space provided below and submitting this application electronically, you state that, you are the person whom you represent yourself to be herein. If you are an authorized representative for a group you may sign as well.

*I accept ☑ I understand that my electronic signature is equivalent to my written signature.

*Your Signature (Entering your name in the box to the right will constitute your electronic signature.) John Brickey
Title Pharmacist
Submission Date 09/05/2023

Continue | Finish Later | Cancel

Entering the application data: Summary

- This is a preview of your application before you complete your submission.
- Hit “Print Preview”
- Save a copy of the application summary for your records.
- Must go to the bottom of the page in order to complete the submission of the application.

Print Preview

Provider Enrollment: Summary

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Request Information

Requesting Enrollment Effective Date 09/05/2023
Enrollment Type Atypical
Provider Type REGISTERED, NONCREDENTIALED PROVIDERS
Provider Federal Tax Identification Number (TIN) 123456789
Effective Date 03/01/2023
End Date _
Fiscal End Date December
NPI 0000001111
NPI Zip + 4 72120-0001
Taxonomy 183500000X-PHARMACIST
Are you a personal care aide? No

Contact Name John Brickey
Contact Phone 1-501-590-2000
Ext _
Contact Email John.brickey@gainwelltechnologies.com
Preferred Method of Communication Email
Email For Provider Publications _

Addresses Expand All | Collapse All

	Address Type	Address	City	State
⊞	Service Location	526 S FAIRWAY AVE	SHERWOOD	ARKANSAS

Specialties

Specialty PHARMACIST

Provider Identification

Last Name Brickey
First Name John
Middle _
Title _
Gender Male
Birth Date 06/23/1987
Tax Name John Brickey

License #	Effective Date	End Date	Issuing Board	Issuing State	Classification
PD99911	06/01/2022	06/30/2025	PHA	ARKANSAS	PHARMACY

Medicare # _
Effective Date _
Medicare Type _

Other Information

Board Certification

No Board Certification exist for this application

Entering the application data: Summary

Ownership/Controlling Interest

Enter the name, address and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or controlling interest or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. (This applies to all Medicaid providers.) By completing and signing this form, I give consent for the Arkansas Department of Human Services to request, copy, access, and use State and Federal criminal records and other information about the Owner in order for the Department to determine the status with the Arkansas Medicaid program.

If you are correcting an already submitted application or this is a revalidation application, please use form Ownership and Conviction Disclosure (DMS-675) for ownership changes needed for any listed entities in the owner section only.

No owner relationships exist for this enrollment.

Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit electronic attachments, please follow the instructions in the Attachments panel below.

Verify that all required documentation, including copies of applicable professional and operating licenses, is included as an attachment.

If you are submitting **Fingerprint Background information**, include a copy of the proof of fingerprint collection as an attachment.

Note if you choose to "Upload" attachments by "File Transfer", a maximum of 700 MBs of information can be uploaded."

Attachments

#	Transmission Method	File	Control #	Attachment Type
1	EL-Electronic Only	JOHN BRICKEY PHARMACIST LICENSE.PDF (147K)	20230905224175	License: General required

Terms of Agreement

I. Provider, in consideration of the covenants therein, agrees:

A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services.

B. To make available and, upon request, furnish all records described above to the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to records. For all Medicaid beneficiaries these records include, but are not limited to those records which are defined in Section "A" of this contract. For clients who are not Medicaid beneficiaries, the records that must be furnished are financial records of charges billed to non-Medicaid insurance to ensure that charges billed to Medicaid do not exceed charges billed to non-Medicaid insurance.

1. In connection with this contract each party hereto will receive certain confidential information relating to the other party. For purposes of this contract, any information furnished or made available to one party relating to the financial condition, results of operation, business, customers, properties, assets, liabilities or information relating to the financial condition relating to beneficiaries and providers, including but not limited to protected health information as defined by the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, is collectively referred to as "Confidential Information."

2. The contract shall safeguard the use and disclosure of information concerning applicants for or beneficiaries 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.

Entering the application data: Finalizing Submission

- Must go to the bottom of the page in order to complete the submission of the application.
- Hit "Submit" to complete the application. Save the tracking ID for your records.

III. This contract may be terminated or renewed in accordance with the following provisions:

A. This contract may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party without cause and/or convenience of either party;

B. This contract will be automatically renewed for one year on July 1 of each year if neither party gives notice requesting termination;

C. This contract may be terminated immediately by the Department for the following reasons:

1. Returned mail
2. Death of provider
3. Change of ownership
4. Or other reason for which a sanction may be issued as set forth under the applicable Medicaid Provider Manual.

The above atypical provider agrees to participate in the Medicaid and/or SeniorCare Program, hereinafter referred to as the Title XIX Program.

I agree that my fees or charges for services or items delivered to Title XIX beneficiaries will not exceed my fees or charges for similar services or items delivered to non-Title XIX individuals. In any case or cases where it becomes necessary for State or Federal representatives to ascertain that charges for services to Title XIX beneficiaries are not greater then charges for service to non-Title XIX individuals, the Department of Health and Family Services, hereinafter referred to as the Department or its authorized representatives will be used to make such determinations.

You will be submitting the Provider Enrollment application electronically. Therefore, your signature on this application will be electronic. By entering your name in the space provided below and submitting this application electronically, you state that, you are the person whom you represent yourself to be herein. If you are an authorized representative for a group you may sign as well.

I accept I understand that my electronic signature is equivalent to my written signature.

Your Signature John Brickey
(Entering your name in the box to the right will constitute your electronic signature.)
Title Pharmacist
Agreement Date 09/05/2023

Instructions for Summary Page

If changes are required when viewing the Summary page, please select the appropriate link in the Table of Contents panel, navigate back to that page, and make changes. Note that if the Enrollment Type or Provider Type fields are modified on the Request Information page, that you will be required to navigate through the enrollment application wizard again and update all fields that are contingent upon these two fields.
Once you have reviewed the contents of this application, select 'Submit' to complete the enrollment application for processing.
Please print a copy of this summary for your records.

Print Preview | Submit | Finish Later | Cancel

Privacy Notice

Ownership/Controlling Interest

Enter the name, address and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or controlling interest or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. (This applies to all Medicaid providers.) By completing and signing this form, I give consent for the Arkansas Department of Human Services to request, copy, access, and use State and Federal criminal records and other information about the Owner in order for the Department to determine the status with the Arkansas Medicaid program.

If you are correcting an already submitted application or this is a revalidation application, please use form Ownership and Conviction Disclosure (DMS-675) for ownership changes needed for any listed entities in the owner section only.

No owner relationships exist for this enrollment.

Supporting Documentation

The following actions need to be taken to complete the individual enrollment process. If you need to submit electronic attachments, please follow the instructions in the Attachments panel below.

Verify that all required documentation, including copies of applicable professional and operating licenses, is included as an attachment.

If you are submitting **Fingerprint Background information**, include a copy of the proof of fingerprint collection as an attachment.

Note if you choose to "Upload" attachments by "File Transfer", a maximum of 700 MBs of information can be uploaded."

Attachments

#	Transmission Method	File	Control #	Attachment Type
1	EL-Electronic Only	JOHN BRICKEY PHARMACIST LICENSE.PDF (147K)	20230905224175	License: General required

Terms of Agreement

I. Provider, in consideration of the covenants therein, agrees:

A. To keep records in accordance with generally accepted standards for the type of business and the healthcare services provided, related to services provided to individuals receiving assistance under the State Plan and billing for such services.

B. To make available and, upon request, furnish all records described above to the Department, the Medicaid Fraud Control Unit of the Arkansas Office of the Attorney General, the U.S. Secretary of the Department of Health and Human Services or a designated agent or representative of any entity entitled to records. For all Medicaid beneficiaries these records include, but are not limited to those records which are defined in Section "A" of this contract. For clients who are not Medicaid beneficiaries, the records that must be furnished are financial records of charges billed to non-Medicaid insurance to ensure that charges billed to Medicaid do not exceed charges billed to non-Medicaid insurance.

1. In connection with this contract each party hereto will receive certain confidential information relating to the other party. For purposes of this contract, any information furnished or made available to one party relating to the financial condition, results of operation, business, customers, properties, assets, liabilities or information relating to the financial condition relating to beneficiaries and providers, including but not limited to protected health information as defined by the Privacy Rule promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, is collectively referred to as "Confidential Information."

2. The contract shall safeguard the use and disclosure of information concerning applicants for or beneficiaries 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.

ARMedicaid

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Home

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Applications submitted on portal

You can **check the status** of any application submitted and see any notes for corrections or documents needed to complete your application.

If corrections are needed, you can click the "Resume Enrollment" to access the previously submitted application and upload any document or make changes need for your application and resubmit.

Provider Enrollment

Enrollment Application
Initiate a New Enrollment application.

Re-Enrollment
Initiate a Re-enrollment application.

Resume Enrollment
Resume an existing application that you previously started.

Enrollment Status
Check the current status of an enrollment application.

Completing an Online Application
Watch this video to see step by step instructions on how to complete an online Enrollment Application.

Customer Links

Print an Application for Mailing
Pay Application Fee (new window)
Provider User Manual