Division of Medical Services Medicaid Provider Enrollment Unit
Gainwell Technologies
P.O. Box 8105, Little Rock, AR 72203-8105
P: 501.376.2211 In state WATS: 800.457.4454 F: 501.374.0746

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**

Practitioner's Signature _____ **Date** _____

Mail or Fax this completed form to:
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Gainwell Technologies
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Little Rock, AR 72203-8105
Fax Number: 501-374-0746

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Medicaid Provider Enrollment Unit

DXC Technology
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Caregivers Name

This will likely be blank since they wont have a number

Participants home address

Caregivers home address

Required field

Must be a hard signature, cannot be electronic