Thank you for your interest in becoming an in network provider with Empower Healthcare Solutions. Please complete this form and include all of the requested data and an Empower team member will contact you with instructions on how to become an in network provider.

Legal Name: _____

Tax ID #: _____

NPI Number: _____

Provider Type Code: _____

Arkansas Medicaid Number: _____

Contact Name: _____

Contact Phone: _____

Contact Email: _____

This information will be used in the onboarding and contracting process. Please be advised that by submitting this information, you are not yet in network and Empower makes no guarantees that completing and submitting this form will result in you being an In Network provider. Please send this form to Empower.Network@empowerarkansas.com.

Thank you and we will contact you soon.