empower
HEALTHCARE SOLUTIONS

PROVIDER PORTAL ACCESS REQUEST

Once completed, please email form to: Empower.Network@empowerarkansas.com
You can also fax to: 888-614-5168 ATTN: Empower Network

1. Individual/Provider NPI:
2. Legal Business Name (*Last Name, First Name, MI if Individual)*:
3. Degree *(if Individual)*:
4. Email Address:
5. Tax ID Number:
6. Business/Billing NPI *(If different than above)*:
7. Business/Billing Name *(If different than above)*:
8. Business/Billing Mailing Address:
9. Business/Billing City, State, Zip:
10. Service Location Address:
11. Service Location City, State, Zip:
12. Service Location Contact Name:
13. Service Location Phone Number:
14. Service Location Taxonomy Code:
15. Service Location AR Medicaid ID:

(If you have more than one service location, please complete second page for each separate location)

Service Location Address:

Service Location City, State, Zip:

Service Location Contact Name:

Service Location Phone Number:

Service Location Taxonomy Code:

Service Location AR Medicaid ID:

■Please include a W-9 with this access request form.
Any requests submitted without a W-9 will be denied.

AS A CONDITION OF PAYMENT AND ENROLLMENT WITH EMPOWER HEALTHCARE SOLUTIONS, THE UNDERSIGNED, BEING THE PROVIDER OR HAVING BEEN DESIGNATED THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS REQUEST, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL STIPULATIONS, CONDITIONS, AND TERMS SET FORTH IN FEDERAL REGULATIONS, STATE REGULATIONS, EMPOWER PROVIDER MANUAL, AND TERMS OF EMPOWER PROVIDER PORTAL USAGE AND CONTRACTS. THE UNDERSIGNED ACKNOWLEDGES PORTAL USAGE AND CONTRACTS. THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID PROGRAM RELATED OFFENSE AS SET OUT IN 42 USC 1620a-7b MAY BE PUNISHABLE BY A FINE OF UP TO $100,000 OR IMPRISONMENT OF UP TO TEN YEARS OR BOTH. BY SIGNING THIS REQUEST THE PROVIDER OR THEIR DESIGNEE ACKNOWLEDGES AND ACCEPTS THESE TERMS.

Signature:

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