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.