Provider Roster Form

This form contains PHI and must be transmitted to Empower via secured email or fax in accordance with federal regulations.

Submissions can be directed to empower.network@empowerarkansas.com
Additional questions can be directed to EmpowerHealthcareSolutionsPR@EmpowerArkansas.com

Please Note: Additional site locations will need have an additional tab filled out.

Business NPI # **Practice Name**

Business TIN # **Practice Addess** **Zipcode**

Medicaid ID	Provider NPI	Provider First Name	Provider Last Name	Effective Date	Expiration Date

Business NPI # Practice Name

Please Note: Additional site locations will need have an additional tab filled out.

Business TIN # Practice Addess Zipcode

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