ARMedicaid

ARKANSAS DEPARTMENT OF HUMAN SERVICES

# ARKANSAS PROVIDER MEDICAID UPDATE

Q3 SFY 2026
(January–March 2026)

## What's New for Arkansas Medicaid Providers

- New Official Notices
- New Provider Manual Updates
- New RA Messages

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## Consolidated Appropriations Act (CAA), 2023 Medicaid and CHIP Services

The Consolidated Appropriations Act is a comprehensive piece of legislation that provides funding for various federal departments and agencies consolidating multiple appropriation bills into one. Section 5121 of the CAA creates new coverage for eligible juveniles who are post adjudication.

Please review the recorded webinar presented by the Arkansas Department of Human Services and Gainwell Technologies to learn about the Consolidated Appropriations Act, identifying eligible juveniles, available services, and the requirements for qualified providers.

View Webinar Recording

## Vision Benefit Changes for PASSE Members effective 1/1/26

Effective January 1, 2026, routine vision services, such as eye exams and glasses, are no longer provided through PASSE organizations. These services will be covered under the Arkansas Medicaid Fee-for-Service (FFS) program. PASSE members will access routine vision care directly from FFS providers.

**What stays the same?**

- Ophthalmology services (medical eye care) will remain under PASSE coverage. Examples of ophthalmology services include diagnosing and treating conditions such as glaucoma and cataracts and performing procedures such as cataract surgery.
- PASSE Care Coordinators will continue to assist members with all vision services, including helping them schedule appointments with FFS providers for routine vision care.

PORTIONS OF THIS MATERIAL WERE PREPARED BY THE ARKANSAS FOUNDATION FOR MEDICAL CARE INC. (AFMC) PURSUANT TO A CONTRACT WITH THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES. THE CONTENTS PRESENTED DO NOT NECESSARILY REFLECT ARKANSAS DHS POLICIES. THE ARKANSAS DEPARTMENT OF HUMAN SERVICES IS IN COMPLIANCE WITH TITLES VI AND VII OF THE CIVIL RIGHTS ACT.

**What this means for affected providers:**

- If you are an Arkansas Medicaid Optometrist or Optical Dispenser provider, starting January 1, 2026, all services provided within your scope of practice transition to Medicaid FFS.
- You will bill Medicaid FFS for these services, not the PASSE Health Plans.
- Please ensure your staff understands this change and is ready to assist PASSE members who may have questions.
- If you are an Ophthalmologist, you may continue to provide routine vision services but would bill Medicaid FFS for these services, not the PASSE Health Plans. Ophthalmologist practitioners will continue to provide non-routine vision services, (i.e. medical eye care) and submit claims to the Medicaid Health Plans. Please look for communication from the Medicaid Health Plans regarding their approach to ensure claims are routed to the appropriate party for payment.

**Why is this happening?**

This change is designed to make routine vision care easier to access while keeping medical eye care coordinated through PASSE organizations.

**Operational Steps for Vision Providers:**

1. Confirm Medicaid Enrollment: Ensure your practice is enrolled as an Arkansas Medicaid FFS provider and your information is up to date in the Medicaid provider directory.
2. Update Billing Processes: Prepare to bill routine vision services (eye exams, glasses, contact lenses) through the Arkansas Medicaid FFS system starting January 1, 2026.
3. Train Staff: Inform front desk and billing staff about the change so they can assist PASSE members who present for routine vision care. Train staff to explain that ophthalmology services remain with PASSE, but routine vision is now FFS.
4. Coordinate with PASSE Care Coordinators: Establish communication channels with PASSE Care Coordinators to ensure smooth scheduling and continuity of care for members. Respond promptly to coordination requests from PASSE organizations.
5. Verify Eligibility: Confirm member eligibility for Medicaid FFS coverage before providing services. Use the Medicaid eligibility verification system to avoid claim denials.
6. Monitor Claims and Payments: Track claims submitted under FFS to ensure timely payment. Address any issues with Medicaid billing promptly.

If you have questions about billing or provider enrollment, please contact the Arkansas Medicaid Provider Help Desk at (501) 682-8501 or visit:

https://portal.mmis.arkansas.gov/armedicaid/provider/Home/ContactUs/tabid/219/Default.aspx.

# Changes to the Non-Emergency Transportation (NET) Program effective 1/1/26

As of January 2, 2026, Modivcare is the Medicaid Non-Emergency Transportation (NET) provider for medical appointments in Faulkner, Pulaski, and Lonoke counties.

Modivcare began taking calls on January 2, 2026, for appointments taking place on and after January 2, 2026. The toll-free number is: 888-833-4135. Facilities for Early Intervention Day Treatment (EIDT) and Adult Developmental Day Treatment (ADDT) rides will call 866-854-8892.

All existing 2026 reservations are being transferred to the new vendor. If your client has already booked a 2026 date with the previous vendor, no further action is required.

Also effective 1/1/26 beneficiaries are required to call the NET broker in their region to schedule their ride at least **72 hours (three whole days)** before their appointment. Saturdays, Sundays, and holidays aren't included in the three days. For example, if a beneficiary needs a ride to their PCP on Monday, they will need to call no later than Thursday to schedule the ride.

For more information about the Non-Emergency Transportation Program, please visit https://afmc.org/individuals/non-emergency-transportation.

# Maternal Life360 HOME

Maternal Life360 HOMEs is an innovative program that supports women with high-risk pregnancies through home-visiting services during pregnancy and for up to two years after birth. The intensive supports available through this program are aimed at improving health outcomes and health-related social needs like food security and housing, and as a result, the long-term health and well-being of women and babies.

A woman is eligible for Maternal Life360 home-visiting services if she is enrolled in Arkansas Medicaid, has a diagnosis of high-risk pregnancy, lives in a Life360 service area, and is not currently receiving other state- or federally-funded home-visiting services. To measure the impact and outcomes of participants in the Maternal Life360 HOME program, DHS plans to monitor hospitals based on several metrics, including the number of home visits performed, linkages to non-medical services needed, hospital admissions and readmissions, non-emergent ER visits, prenatal visits, elective C-section rates, pre-term/term births, birthweight, NICU stays, and the provision of postpartum contraceptive care. For more information about Maternal Life360s, visit ar.gov/life360.

# QUICK GUIDE

## HOW TO BECOME A MATERNAL LIFE360 HOME

STEP 1

### LETTER OF INTENT

Maternal Life360 HOMEs are meant to improve the health and birth outcomes for pregnant women in Arkansas. To be considered, the applicant must be an in-state or border state birthing hospital has an obstetrics unit and an enrolled Arkansas Medicaid provider. The applicant hospital must submit a letter of intent that includes the information listed below to the Arkansas Department of Human Services (DHS).

- Estimated # of eligible clients expected to be served annually
- Counties to be served
- Whether hospital will use its own or contracted staff
- # of women receiving OB/maternity services by hospital
- Name of evidence-based home-visiting model to be used
- Names of home-visiting partners

STEP 2

### APPLY

DHS has an online application for Maternal Life360 HOMEs. You can find it at ar.gov/life360. Documents can be uploaded as part of the online application process. Applications should include:

- Program narrative
- Community network assessment
- Outreach plan
- Proposed referral network
- Two letters of support from community partners
- How program will not duplicate similar programs in service area
- Start up & first year budget
- Signed partner agreements
- Data & outcomes plan

STEP 3 & 4

### STARTUP AND READINESS REVIEW

Maternal Life360s are eligible for startup funds for staff, equipment, and supports outlined in approved startup budget.

- First startup payment will be made upon application approval
- Startup must be complete within 120 days of receiving initial funds
- DHS readiness review required
- Second startup payment upon passing readiness review

**SEE PROVIDER MANUAL FOR COMPLETE REQUIREMENTS**

MATERNAL LIFE360

# Maternal Life360 HOME Portal

The Life360 Provider portal is only available to enrolled providers in the Life360 HOME program and Life360 hospital's Provider account. You can locate the portal guide here.

ARMedicaid HEALTHCARE PORTAL JOB+AID

## Maternal Life360 HOME Portal

***The Life360 Provider portal is only available to enrolled providers in the Life360 HOME program and Life360 hospital's Provider account. To create an Authorization or a request to enroll an individual in the Maternal Life360 HOME program, the Life360 provider will need the following items:***

- Beneficiary information including Full Name, Date of Birth, and Medicaid/insurance ID of the individual that the Life360 provider is requesting to enroll. The portal will accept either Date of Birth or Medicaid/insurance ID.
- A referral, or documentation of the primary Supervision of High-Risk Diagnosis code from the individual's medical provider.
- The individual's consent to participate in the Maternal Life360 HOME services including signature.


1. Go to the portal landing page and log in using your **User ID** and **password**. If you do not have a User ID and password, click **Register Now** or see the JOB+AID "**Registering on the Portal**."

   If you have already logged in, skip to **step 2**.

afmc gainwell ARKANSAS DEPARTMENT OF HUMAN SERVICES

For more information call **1-800-691-6464**



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# 241.000 Activities Tracked for Practice Support (PBPM Care Coordination Payment)

## Activities for the 2026 Performance Period

All PCMHs must meet all activities by the following deadlines, must complete the attestations and submit supporting documentation in the Quality Care Insight (QCI) provider portal in order to be eligible for PBPM care coordination payments.

- 3-month activities by 3/31/2026
- 6-month activities by 6/30/2026
- 9-month activities by 9/30/2026
- 12-month activities by 12/31/2026

For information on remediation, please refer to the PCMH Provider Manual.

| Activity | 3-Month | 6-Month | 9-Month | 12-Month |
|---|---|---|---|---|
| A. Identify top 10% of high-priority patients | ✓ | | | |
| B. Identify Focus Area for Improvement | ✓ | | | |
| C. Make Available 24/7 Access to Care | ✓ | | | |
| D. Prescription Drug Monitoring Program (PDMP) Questions | ✓ | | | |
| E. Capacity to Receive Direct E-Messaging from Patients | | ✓ | | |
| F. Childhood/Adult Vaccination Practice Strategy | | ✓ | | |
| G. Join SHARE or Participate in Network | | ✓ | | |
| H. Model Fidelity/Healthy Steps Participation | | | ✓ | |
| I. Patient Literacy Assessment Tool | | | ✓ | |
| J. Patient and Family Engagement | | | ✓ | |
| K. Care Instructions/After Visit Summary | | | ✓ | |
| L. Social Determinants of Health | | | ✓ | |
| M. Model Fidelity/HealthySteps Practice Performance | | | | ✓ |
| N. Care Plans for High Priority Beneficiaries | | | | ✓ |
| O. Identify Focus Area for Improvement-Follow Up | | | | ✓ |

The PCMH manual and supplemental materials, including the 2026 PCMH Program Policy Addendum, are available at the following website https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/patient-centered-medical-home/.

# What's New for Arkansas Medicaid Providers

Official notices posted from October 1, 2025 – December 31, 2025. Please click here to view details for each notice and other helpful information for Arkansas Medicaid providers.

| Title | Posted Date | Category |
|---|---|---|
| 2026 NUBC/UB04 Changes | 10/15/2025 | Condition Codes |
| Technical Denial Indicator for Prior Authorizations | 10/23/2025 | Prior Authorizations |
| New Coverage for B4100 U1 – SIMPLY THICK FOOD THICKENER ORAL - CONCENTRATE/1 OZ | 11/03/2025 | Procedure Codes |
| Change to Prior Authorization Process for Physician-Administered Drugs – Effective January 1, 2026 | 11/03/2025 | Prior Authorizations |
| REVISED: 2025 Quarter 4 Healthcare Common Procedure Coding System Level II (HCPCS) Code and Current Procedural Terminology (CPT) Code Conversion | 11/14/2025 | Procedure Codes |
| Coverage for Home Sleep Study (Proc Codes 95800, 95801, and 95806) | 12/03/2025 | Procedure Codes |
| Upcoming Changes to Prior Authorization Process for Physician-Administered Drugs – Effective January 1, 2026 | 12/19/2025 | Prior Authorizations |

**OFFICIAL NOTICE**

**TO: Health Care Providers – All Providers**

**DATE: October 23, 2025**

**SUBJECT: Technical Denial Indicator for Prior Authorizations**

## I. General Information

The Arkansas Department of Human Services (DHS) is implementing a new technical denial indicator within the Medicaid Management Information System (MMIS) for Prior Authorization (PA) requests that are denied solely due to technical reasons.

This indicator will be reflected in the adverse action letters sent to providers, clearly identifying that the denial was based on a technical issue. The addition of this indicator is intended to enhance reporting capabilities, streamline the PA process, support data-driven decision-making, and improve provider education and transparency.

## II. PA Technical Denial Indicator Details

- The process for submitting PA requests remains unchanged.
- During the PA review process, if a request is denied for a technical reason, the reviewer will mark the PA accordingly.
  - If applicable, the reviewer will enter a suspension rationale which will allow providers fifteen (15) calendar days to submit the missing information.
  - If no documentation is provided, the request will be assigned back to the respective level one reviewer for verification of the technical deficiency and subsequent denial.

  - If a provider submits documentation, the received date of the request will be updated, per request, and the request will be assigned back to the respective level one reviewer for further review.
- If, after the review of a level one reviewer, the technical deficiency is still present, a denial will be issued with a rationale identifying the reason for denial, instructions for correction, and applicable references.
- A letter will be generated by Gainwell via the MMIS/interChange portal and will be sent out the following business day.
- Examples of technical denial reasons include:
  - No documentation attached.
  - Missing or incomplete beneficiary or provider information.
  - Missing required documentation such as DMS forms, remittance advice, test reports, orders, etc.
  - Incorrect services codes or dates of service.
  - Incorrect type of service.
  - Specific provider manual requirements that are not met will be cited with the manual section and corresponding language.
  - Specific prior-authorization requirements not met will be specifically addressed and cited with applicable reference.
- No medical necessity denials will be issued using this process.

Providers are encouraged to ensure all required documentation is complete and accurate at the time of PA submission to avoid technical denials. DHS remains committed to supporting providers through clear communication and process transparency.

If you have questions regarding this notice, please contact the Provider Assistance Center at

(800) 457-4454 toll-free or locally at (501) 376-2211.

**TO: Health Care Providers – All Providers**

**DATE: December 19, 2025**

**SUBJECT: Upcoming Changes to Prior Authorization Process for Physician-Administered Drugs – Effective January 1, 2026**

Beginning January 1, 2026, Arkansas Medicaid will implement a new prior authorization (PA) process for Physician-Administered Drugs (PAD). This change is part of a broader effort to align with evidence-based clinical guidelines and streamline specialty drug management.

**What's Changing?**

- Beginning January 1, providers who request PAD PAs for medical claims will now submit the PAs to Prime Therapeutics, the existing Pharmacy vendor.
- Providers must submit PAD PA requests to Prime Therapeutics by initiating an electronic request through CoverMyMeds at https://www.covermymeds.health/. Requests can also be faxed to 800-424-7976.
- Providers faxing PAD PA requests should use the PAD PA form. https://ar.primetherapeutics.com/documents/d/arkansas/arrx_general_pad_form-1
- AFMC will continue to process requests RECEIVED through 12/31/2025.
- Reminder: Providers may begin submitting PA requests to Prime Therapeutics beginning on January 1, 2026.

**What You Need to Do:**

- Ensure your staff is aware that as of January 1, 2026, PAD PA requests must be submitted to Prime Therapeutics.
- If you are not yet registered for CoverMyMeds and plan to submit electronic PAD PA requests, please register before January 1, 2026. CoverMyMeds Frequently Asked Questions (FAQs) can be found here and the CoverMyMeds Help Desk can be reached at 1-866-452-5017.

**Additional Information:**

- Currently, some PA modifications are allowed without changing a PA number. Effective 1/1/2026, any modifications to existing PAs requires a new PA number to be assigned with any changes. Billers will need to ensure they are getting the updated PA numbers.
- Contact information for billing issues only does not change.
- The process for billing submissions does not change.

For inquiries regarding this change, please visit the Arkansas Medicaid Pharmacy Portal at https://ar.primetherapeutics.com/home or Provider Documents - Arkansas for PAD information including frequently asked questions, or call 800-424-7895.

# Messages for AR Medicaid Providers

**Messages for Remittance Advices dated October 30, 2025 – November 6, 2025**

| TO: AMBULATORY SURGICAL CENTER (ASC), HOSPITAL, AND PHYSICIAN PROVIDERS | RE: AGE UPDATE FOR PROCEDURE J0219 (INJ AVAL ALFA-NQPT 4MG) |
|---|---|

Effective 10/01/2025, the age limitation for procedure J0219 has been updated to 1-999 (previously 21-999) for the AMBSC, MEDSV, and OUTPA contracts. Prior approval as well as a diagnosis from Diagnosis group 756 [GLYCOGEN STORAGE DISEASE] is also now required for this procedure in the AMBSC contract.

Claims analysis will be performed to identify any claims that may have denied prior to the update being made.

| TO: AREA HEALTH EDUCATION CENTER (AHEC) AND PHYSICIAN PROVIDERS | RE: COVERAGE REACTIVATED FOR J1302, J1303, J1304, AND J1305 |
|---|---|

Coverage for J1302, J1303, J1304, and J1305 was inadvertently inactivated in April of 2025 for the Medical Services (MEDSV) contract. Coverage has been reactivated. Please refer to the Physician Procedure Code Table for coverage. Claims analysis will be performed.

https://humanservices.arkansas.gov/wp-content/uploads/PHYSICN_ProcCodes.xlsx

| TO: ALL PROVIDERS | RE: PRIOR AUTHORIZATION REQUEST FOR DATES OF SERVICE BENEFICIARY IS ENROLLED IN A PASSE |
|---|---|

Providers must submit Prior Authorization (PA) requests directly to the beneficiary's PASSE for dates of service during active PASSE enrollment.

Do NOT submit these requests via the Arkansas Medicaid Provider Portal.

Effective Tuesday, November 25, 2025, PAs submitted incorrectly via the Provider Portal will return the system error:

"According to data in Arkansas' Medicaid interChange data system, this beneficiary was assigned to a PASSE for the dates of service requested. Any prior authorization requests for a beneficiary assigned to a PASSE should be submitted to that individual's PASSE."

This error will prevent submission of the PA request for dates of service during active PASSE eligibility.

If the beneficiary's PASSE eligibility is ending and you wish to submit a PA request, you must:

- update the dates of service on the PA request to be outside the active PASSE eligibility.

- submit the PA request.

If you have questions regarding prior authorizations for beneficiaries in a PASSE, please contact the individual's PASSE or the Provider Assistance Center at (800) 457-4454 toll-free or locally at (501) 376-2211.

**TO: ALL PROVIDERS** **RE: MAIL FORWARDING TO END FOR PO BOXES FORMERLY LOCATED IN MISSOURI**

On May 14, 2025, four PO Boxes changed from the processing center in St. Louis, MO, to a new location in Chicago, IL. The affected PO Boxes included

TEFRA Premium Unit
PO Box 001054
St Louis, MO 63150-1054

Medicaid Drug Rebates
PO Box 505297
St. Louis, MO 63150-5297

Third-Party Liability
AR Dept of Human Services
PO Box 001159
St. Louis, MO 63150-1159

AR Medicaid Refunds
PO Box 505616
St. Louis, MO 63150-5616

As a courtesy, correspondence mailed to the old, Missouri PO Boxes has been forwarded to the new facility in Illinois since May; however, the grace period will end November 30, 2025. After November 30, 2025, any correspondence sent to the incorrect PO Boxes will be returned to the sender.

To avoid delays, please use the following PO Boxes for checks mailed to the TEFRA Premium Unit, Third-Party Liability, Medicaid Drug Rebates, or Arkansas Medicaid Refunds:

TEFRA Premium Unit
PO Box 7411550
Chicago, IL 60674-1550

Medicaid Drug Rebates
PO Box 7411554
Chicago, IL 60674-1554

Third-Party Liability
AR Dept of Human Services
PO Box, 7411552
Chicago, IL 60674-1552

AR Medicaid Refunds 9292
PO Box 7411556
Chicago, IL 60674-1556

**TO: OPHTHALMOLOGIST, OPTICIAN, OPTICAL DISPENSING, AND PASSE PROVIDERS** **RE: VISION BENEFITS FOR PASSE MEMBERS**

The Arkansas Department of Human Services (DHS) wants to inform you about an important change that affects PASSE members and their vision benefits.

What is changing?

Starting January 1, 2026, routine vision services, such as eye exams and glasses, will no longer be provided through PASSE organizations. These services will be covered under the Arkansas Medicaid Fee-for-Service (FFS) program. PASSE members will access routine vision care directly from FFS providers like you.

What stays the same?

• Ophthalmology services (medical eye care) will remain under PASSE coverage. Examples of ophthalmology services include diagnosing and treating conditions such as glaucoma and cataracts and performing procedures such as cataract surgery.

• PASSE Care Coordinators will continue to assist members with all vision services, including helping them schedule appointments with FFS providers for routine vision care.

What this means for you:

• If you are an Arkansas Medicaid Optometrist or Optical Dispenser provider, starting January 1, 2026, all services provided within your scope of practice transition to Medicaid FFS.

• You will bill Medicaid FFS for these services, not the PASSE Health Plans.

• Please ensure your staff understands this change and is ready to assist PASSE members who may have questions.

• If you are an Ophthalmologist, you may continue to provide routine vision services but would bill Medicaid FFS for these services, not the PASSE Health Plans. Ophthalmologist practitioners will continue to provide non-routine vision services, i.e. medical eye care) and submit claims to the Medicaid Health Plans. Please look for communication from the Medicaid Health Plans regarding their approach to ensure claims are routed to the appropriate party for payment.

Why is this happening?

This change is designed to make routine vision care easier to access while keeping medical eye care coordinated through PASSE organizations.

Operational Steps for Vision Providers:

1. Confirm Medicaid Enrollment: Ensure your practice is enrolled as an Arkansas Medicaid FFS provider and your information is up to date in the Medicaid provider directory.

2. Update Billing Processes: Prepare to bill routine vision services (eye exams, glasses, contact lenses) through the Arkansas Medicaid FFS system starting January 1, 2026.

3. Train Staff: Inform front desk and billing staff about the change so they can assist PASSE members who present for routine vision care. Train staff to explain that ophthalmology services remain with PASSE, but routine vision is now FFS.

4. Coordinate with PASSE Care Coordinators: Establish communication channels with PASSE Care Coordinators to ensure smooth scheduling and continuity of care for members. Respond promptly to coordination requests from PASSE organizations.

5. Verify Eligibility: Confirm member eligibility for Medicaid FFS coverage before providing services. Use the Medicaid eligibility verification system to avoid claim denials.

6. Monitor Claims and Payments: Track claims submitted under FFS to ensure timely payment. Address any issues with Medicaid billing promptly.

If you have questions about billing or provider enrollment, please contact the Arkansas Medicaid Provider Help Desk at (501) 682-8501 or visit https://portal.mmis.arkansas.gov/armedicaid/provider/Home/ContactUs/tabid/219/Default.aspx.

Thank you for your continued service to Arkansas Medicaid members.

**TO: NURSE PRACTITIONER AND PHYSICIAN PROVIDERS** **RE: PROCEDURE CODE 36556 PLACE OF SERVICE (POS) UPDATED**

The following POS changes have been made to Procedure Code 36556 (INSERT NON-TUNNEL CV CATH):

CONTRACT - CHANGE

MEDSV - Removed POS 11 (OFFICE)

NURSP - Removed POS 11 (OFFICE), added POS 05 (INDIAN HEALTH SERVICE FREE-STANDING FACILITY), 06 (INDIAN HEALTH SERVICE PROVIDER-BASED FACILITY), 19 (Off Campus-Outpatient Hospital), 21 (Inpatient Hospital), 22 (On Campus-Outpatient Hospital), 23 (Emergency Room-Hospital), and 24 (Ambulatory Surgical Center)

Claims analysis will go back one (1) year.

# Provider Relations Outreach Specialists Information Sheet

1020 W. 4th St., Suite 400 • Little Rock, AR 72201 • **Toll free: 1-877-650-2362** • **Transportation Helpline: 1-888-987-1200**

## AFMC OUTREACH SPECIALISTS

**Refer to the map and the color key below to find your representative.**

### *Director, Provider Relations*

**Tabitha Kinggard** ..... **501-804-3277**
tkinggard@afmc.org

### *Supervisor, Provider Relations*

**Kellie Cornelius** ..... **501-804-2501**
kcornelius@afmc.org

### *Outreach Specialists*

**Shawna Branscum**.....**501-804-2373**
sbranscum@afmc.org

**Kimberly Breedlove** ...**501-553-7642**
kbreedlove@afmc.org

**Jackie Clarkson**.....**501-553-7665**
jclarkson@afmc.org

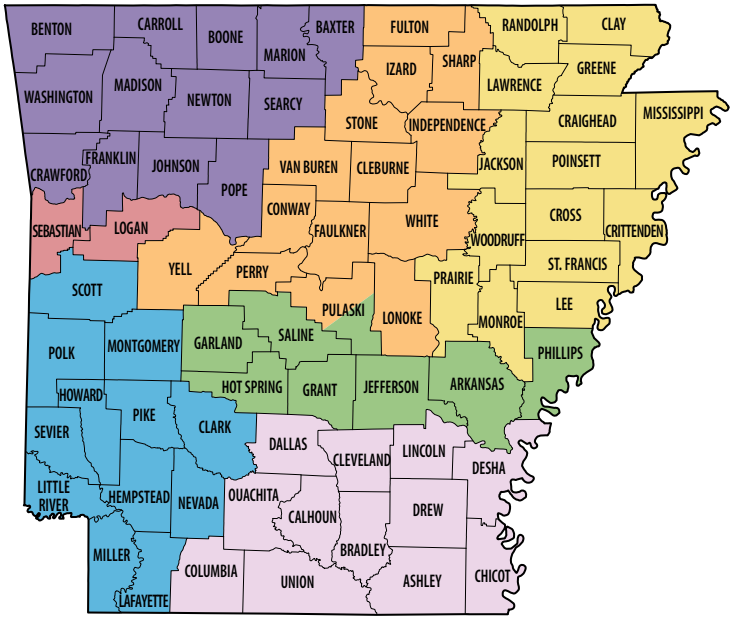
**Carla Hestir**.....**501-804-2901**
chestir@afmc.org

**Toni Humphry** ..... **501-545-7873**
thumphry@afmc.org

**Sonja Savage** ..... **501-554-1328**
sonja.savage@afmc.org

### *Supervisor, Outreach Logistics*

**Tonyia Long** .....**501-212-8686**
tlong@afmc.org




*11/01/2025*

## GAINWELL TECHNOLOGIES (CLAIMS PROCESSING)

### *Gainwell Provider Assistance Center*

**ELECTRONIC DATA INTERCHANGE (EDI), PROVIDER ASSISTANCE CENTER (PAC), AND PROVIDER ENROLLMENT**

In-state toll free ..... **800-457-4454**
Local and out-of-state ..... **501-376-2211**
Monday through Friday 8 a.m. until 5:00 p.m.

## ARKANSAS DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL SERVICES

**CONNECTCARE - BENEFICIARY SERVICES**

- Complaints
- Demographic updates
- Eligibility/Medicaid coverage/ Medicaid card
- Find a doctor/PCP assignment
- Other resources

• Toll free ..... **800-275-1131**

**MEDICAID FRAUD CONTROL UNIT (PROVIDERS)**

• Central Arkansas..... **501-682-8349**

**VOICE RESPONSE SYSTEM - PCP ASSIGNMENT**

• Toll free ..... **800-805-1512**

**PCMH QUESTIONS**..... **PCMH@afmc.org**

**MEDICAID PHARMACY VENDOR: PRIME THERAPEUTICS MANAGEMENT, LLC**

• PDL Call Center ..... **800-424-7895**
ar.primetherapeutics.com

**THIRD PARTY LIABILITY**

• Local..... **501-537-1070**
• Fax ..... **501-682-1644**

DHS Division of Medical Services,
TPL Unit • P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437

# IN THIS ISSUE OF ARMedicaid

# ARKANSAS PROVIDER MEDICAID UPDATE

Q3 SFY 2026
(January–March 2026)

- 2026 PCMH Activities
- Maternal Life360 HOME
- Non-Emergency Transportation (NET) Changes
- Upcoming Changes to Prior Authorization Process for Physician-Administered Drugs
- Vision Benefit Changes for PASSE Members

**Additional resources can be found at www.afmc.org/providerrelations**

- Educational Outreach Updates
- PCP Update Packets/Archived PCP Update Packets
- Webinars

**If you have any questions or if you would like additional information regarding any Medicaid topic, please contact the AFMC Provider Relations team:**

- ProviderRelations@afmc.org
- 501-212-8686