

Arkansas Medicaid Information Interchange (AMII) Field Descriptions

Access Request

Physician Name	REQUIRED. The name of the physician for which the Information Interchange access request is requested (from this point on referred to as "the user"). The last, first and middle initial of the user.
Medicaid PCP Provider #	REQUIRED. The PCP provider number of the user who will access the Information Interchange.
Phone #	REQUIRED. The telephone number where the user can be reached during business hours.
Extension #	The telephone extension number, if applicable, where the user can be reached during business hours.
E-mail Address	REQUIRED. The user's e-mail address at his or her organization.
Security Question	REQUIRED. A question that is easily answered by the user that would be difficult for others to answer. Write the correct answer next to one of the question choices: city of birth, pet's name or mother's maiden name. This question is used for security and password validation purposes, should the user forget the password or need help troubleshooting Information Interchange problems.

Signatures Required for Approval

Applicant Signature	REQUIRED. The signature of the user. The user must sign in the presence of a Notary.
Date	REQUIRED. The date the Information Interchange Registration Form is signed by the user (MM/DD/YYYY).
Notary Public	REQUIRED. The signature of the Notary Public who notarizes the form.
Date	REQUIRED. The date the Notary Public signs the form (MM/DD/YYYY).

Once the registration form has been notarized, please send original registration forms to:

Medicaid Managed Care Services
401 West Capitol Ave, Suite 410
Little Rock, AR 72201