

**This form is also used for facilities that DON'T require credentialing.** The information is necessary to add into the Provider Directory and payment system for claims processing.

**Initial Credentialing**—Failure to legibly complete all sections of this application and submit current copies of all required documentation may result in processing delays. If a question does not apply, please put N/A in that section to ensure a complete application.

**Recredentialing**—Submission of recredentialing information is a contractual obligation. Failure to complete all sections of this application and submit current copies of all required documentation in a timely manner will be considered a request to terminate the facility's participation in our network. If a question does not apply, please put N/A in that section to ensure a complete application.

**PLEASE NOTE:** FOR EVERY ORGANIZATION/FACILITY TYPE/LOCATION, A SEPARATE APPLICATION MUST BE COMPLETED.

- New organizational providers will receive written confirmation of their effective date with the health plan.
  - Members may not be seen until written confirmation has been received and AHCCCS registration has been completed. You cannot receive payment for services provided without AHCCCS registration

**INSTRUCTIONS:**

**PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING PROVIDING ANY ATTACHMENTS, TO PREVENT DELAYS IN PROCESSING YOUR REQUEST. PLEASE NOTE: HANDWRITTEN APPLICATIONS ARE NO LONGER ACCEPTABLE AND WILL NOT BE PROCESSED. PLEASE SUBMIT ALL PAGES.**

**Include the following items for each location with your completed and signed application:**

- ☐ Current State License and business license for each location (if applicable)
- ☐ Medicare Certification letter (if applicable)
- ☐ Certifications and/or Accreditation Certificates (e.g. TJC, CHAP, etc), if applicable
- ☐ CLIA Certificate (if applicable)
- ☐ Current *Professional Malpractice, Comprehensive General Liability and Workers Comp* Insurance Policies
- ☐ IRS form 941 voucher or accurate W9
- ☐ Maintenance vehicle schedule (Transportation only)
- ☐ Documentation of age-appropriate car seats (Transportation only)
- ☐ **Behavioral Health Facilities Only**—if you employ Behavioral Health Technicians (BHTs) and/or Paraprofessionals (BHPP), please **provide your Policies and Procedures** that outlines your process for monitoring/supervision of the BHTs and BHPPs'.

If you have any questions, please contact the Provider Network/Operations Department of the Health Plan (s) you are applying to (see page 12).

**ORGANIZATIONAL/FACILITY APPLICATION**

Each health plan will provide instruction as to where the completed application and required documents should be submitted.

|                                                                                                                               |                      |                          |                          |
|-------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------|--------------------------|
| <b>SUBMISSION DATE:</b>                                                                                                       |                      |                          |                          |
| 1099 Registered Name (Required):                                                                                              |                      | Tax ID#:                 |                          |
| Organizational/Facility Name/DBA (if applicable):                                                                             |                      | Effective Date with TIN: |                          |
| Lines of Business:<br><input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial |                      | License #                | State<br>Exp Date:       |
| AHCCCS ID #                                                                                                                   | AHCCCS Provider Type | Organization NPI#        | CLIA#<br>Expiration Date |
| Is Facility a Medicare participating provider?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                    |                      | Medicare # (PTAN):       |                          |

| <b>ORGANIZATIONAL/FACILITY TYPE AS LISTED ON LICENSE OR ACCREDITATION: Check all that apply</b>              |                                                              |                                                                                 |  |  |  |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------|--|--|--|
| <input type="checkbox"/> Acute Rehab                                                                         | <input type="checkbox"/> Habilitation Providers              | <input type="checkbox"/> Pharmacy                                               |  |  |  |
| <input type="checkbox"/> Ambulatory Surgery Center                                                           | <input type="checkbox"/> Home Health Agency                  | <input type="checkbox"/> PT/ST                                                  |  |  |  |
| <input type="checkbox"/> Attendant Care Agency                                                               | <input type="checkbox"/> Hospice                             | <input type="checkbox"/> Radiology—locations only                               |  |  |  |
| <input type="checkbox"/> Assisted Living Center**Indicate Specialties below                                  | <input type="checkbox"/> Hospital                            | <input type="checkbox"/> Skilled Nursing Facility ** Indicate Specialties below |  |  |  |
| <input type="checkbox"/> Assisted Living Home ** Indicate Specialties below                                  | <input type="checkbox"/> Infusion Agency                     | <input type="checkbox"/> Transportation                                         |  |  |  |
| <input type="checkbox"/> Behavioral Health                                                                   | <input type="checkbox"/> Intensive Outpatient Treatment (BH) | <input type="checkbox"/> Transportation—Air and Non-Emergency                   |  |  |  |
| <input type="checkbox"/> Behavioral Health Residential Facility (BHRF)                                       | <input type="checkbox"/> Laboratory                          | <input type="checkbox"/> Behavioral Health Therapeutic Home                     |  |  |  |
| <input type="checkbox"/> Dialysis                                                                            | <input type="checkbox"/> Medical/Dental Schools              | <input type="checkbox"/> Therapeutic Foster Home                                |  |  |  |
| <input type="checkbox"/> DME/Enteral                                                                         | <input type="checkbox"/> Orthotics & Prosthetics             | <input type="checkbox"/> Urgent Care                                            |  |  |  |
| <input type="checkbox"/> FQHC/RHC                                                                            | <input type="checkbox"/> Outpatient Medical Rehab Center     | <input type="checkbox"/> Other                                                  |  |  |  |
| <b>ORGANIZATIONAL/ FACILITY TYPE SPECIALTIES—HSD SPECIALTY CODE AND SPECIALTY NAME: Check all that apply</b> |                                                              |                                                                                 |  |  |  |
| <input type="checkbox"/> 040 Acute Inpatient Hospitals                                                       | <input type="checkbox"/> 046 Skilled Nursing Facilities      | <input type="checkbox"/> 050 Occupational Therapy                               |  |  |  |
| <input type="checkbox"/> 041 Cardiac Surgery Program                                                         | <input type="checkbox"/> 047 Diagnostic Radiology            | <input type="checkbox"/> 051 Speech Therapy                                     |  |  |  |
| <input type="checkbox"/> 042 Cardiac Catheterization Services                                                | <input type="checkbox"/> 048 Mammography                     | <input type="checkbox"/> 052 Inpatient Psychiatric Facility Services            |  |  |  |
| <input type="checkbox"/> 043 Critical Care Services -Intensive Care Units (ICU)                              | <input type="checkbox"/> 049 Physical Therapy                | <input type="checkbox"/> 057 Outpatient Infusion/Chemotherapy                   |  |  |  |
| <input type="checkbox"/> 045 Surgical Services (Outpatient or ASC)                                           |                                                              |                                                                                 |  |  |  |
| <b>ASSISTED LIVING FACILITY/SNF TYPE SPECIALTIES—SPECIALTY NAME: Check all that apply</b>                    |                                                              |                                                                                 |  |  |  |
| <input type="checkbox"/> Dementia or related disorders                                                       | <input type="checkbox"/> Traumatic Brain Injury              | <input type="checkbox"/> Addiction/Substance Abuse Disorders                    |  |  |  |
| <input type="checkbox"/> Persistent aggressive behaviors                                                     | <input type="checkbox"/> None of the above                   |                                                                                 |  |  |  |

**ORGANIZATIONAL/FACILITY APPLICATION**

**ACCREDITING AUTHORITIES:** Please indicate if this location has been reviewed by any of the accrediting authorities listed below and provide a copy of the most recent accreditation report for each location.

|                          |                                                                         |                          |                                                                                   |
|--------------------------|-------------------------------------------------------------------------|--------------------------|-----------------------------------------------------------------------------------|
| <input type="checkbox"/> | Accreditation Commission for Health Care, INC.                          | <input type="checkbox"/> | Commission on Office Laboratory Accreditation                                     |
| <input type="checkbox"/> | American Association for Accreditation of Ambulatory Surgery Facilities | <input type="checkbox"/> | Community Health Accreditation                                                    |
| <input type="checkbox"/> | American Association for Ambulatory Health Care                         | <input type="checkbox"/> | Det Norske Veritas National Integrated Accreditation for Healthcare Organizations |
| <input type="checkbox"/> | American College of Radiology                                           | <input type="checkbox"/> | Healthcare Facilities Accreditation Program                                       |
| <input type="checkbox"/> | American Osteopathic Association                                        | <input type="checkbox"/> | Joint Commission                                                                  |
| <input type="checkbox"/> | Commission on Accreditation of Rehabilitation Facilities                | <input type="checkbox"/> | Other:                                                                            |

**PRIMARY ADDRESS:** Physical location where services are performed. Complete a supplemental form for each additional location

|                                                                                           |              |            |             |                                                                                      |            |                                                                              |               |
|-------------------------------------------------------------------------------------------|--------------|------------|-------------|--------------------------------------------------------------------------------------|------------|------------------------------------------------------------------------------|---------------|
| Address                                                                                   |              | City       |             | State:                                                                               |            | Zip Code                                                                     |               |
| Appointment Phone (will be listed in directory)                                           |              | Fax        |             | County                                                                               |            | Location NPI (can't be processed without a valid 10 digit NPI) if applicable |               |
| Modalities                                                                                |              |            |             | List Address in Directories <input type="checkbox"/> YES <input type="checkbox"/> NO |            |                                                                              |               |
| <input type="checkbox"/> Check if 24Hrs                                                   | Office Hours | <b>DAY</b> | <b>Open</b> | <b>Closed</b>                                                                        | <b>DAY</b> | <b>Open</b>                                                                  | <b>Closed</b> |
|                                                                                           |              | Mon        |             |                                                                                      | Fri        |                                                                              |               |
|                                                                                           |              | Tues       |             |                                                                                      | Sat        |                                                                              |               |
|                                                                                           |              | Wed        |             |                                                                                      | Sun        |                                                                              |               |
|                                                                                           |              | Thurs      |             |                                                                                      |            |                                                                              |               |
| Special Considerations: (i.e., closed for lunch etc.)                                     |              |            |             |                                                                                      |            |                                                                              |               |
| Languages spoken fluently by Provider/Office Staff when communicating about medical care: |              |            |             |                                                                                      |            |                                                                              |               |

**ORGANIZATIONAL/FACILITY CONTACT**

|                     |  |                                          |  |           |  |
|---------------------|--|------------------------------------------|--|-----------|--|
| Contact Name/Title: |  | Phone:                                   |  | Fax:      |  |
| Org/Facility Email: |  | Organizational/Facility Website Address: |  |           |  |
| Mailing Address:    |  | City:                                    |  | State:    |  |
|                     |  |                                          |  | Zip Code: |  |

**BILLING SERVICE**

|                  |        |               |  |
|------------------|--------|---------------|--|
| Name of Service: |        | Contact Name: |  |
| Address:         |        | Phone:        |  |
| City:            | State: | Zip Code:     |  |

**PAY TO ADDRESS**

|          |       |          |           |
|----------|-------|----------|-----------|
| Name:    |       | Contact: |           |
| Address: | City: | State:   | Zip Code: |
| Phone:   | Fax:  |          |           |

**CREDENTIALING CONTACT**

|          |       |        |           |
|----------|-------|--------|-----------|
| Name:    |       |        |           |
| Address: | City: | State: | Zip Code: |
| Phone:   | Fax:  | Email: |           |



Describe your Medical Record Keeping System(s) (i.e. EMR, Paper, etc)

Describe Your Cost Record Keeping System(s) (i.e. Billing or A/R system):

Electronic Claims Submission?

☐ YES ☐ NO

Electronic Funds Transfer?

☐ YES ☐ NO

Is this a minority or female owned business: ☐ YES ☐ NO

## Organizational/Facility Assessment of Cognitive and Physical Disabilities Accommodations

Please identify what accommodations you provide at **each of your organizational facility locations** for members with cognitive or physical disabilities. If accommodations are the same at all locations, on Practice Location Address, please state ALL. Please, complete a separate Assessment for each location if accommodations vary.

### Organizational/Facility Location Address:

| Accommodation                                                                                                                      | YES | NO | NA | Comments |
|------------------------------------------------------------------------------------------------------------------------------------|-----|----|----|----------|
| Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities                |     |    |    |          |
| Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limitations or wheelchair bound            |     |    |    |          |
| Flexible appointment times available—sick appointments, same day appts—please specify                                              |     |    |    |          |
| Extended appointment times—before 8 am, after 5pm, Sat and/or Sunday—please specify                                                |     |    |    |          |
| Assistance available to members to fill out forms                                                                                  |     |    |    |          |
| Waiting and Examinations rooms are routinely cleaned (MED 3A factor 3)*                                                            |     |    |    |          |
| Waiting room space contains seating sufficient for all scheduled appointments (MED 3A factor 4)*                                   |     |    |    |          |
| Medical/treatment of members is fully documented (MED 3A Factor 5)*                                                                |     |    |    |          |
| Records are securely maintained in a confidential and orderly manner (MED 3 factor 5)*                                             |     |    |    |          |
| Records are in compliance with HIPAA requirements (MED 3 factor 5)*                                                                |     |    |    |          |
| In-home and/or community services                                                                                                  |     |    |    |          |
| Large print materials                                                                                                              |     |    |    |          |
| Materials in electronic format                                                                                                     |     |    |    |          |
| Augmentative/Alternative communication devices                                                                                     |     |    |    |          |
| TDD capabilities                                                                                                                   |     |    |    |          |
| American Sign Language translator                                                                                                  |     |    |    |          |
| Signage with Braille and raised tactile text characters at office, elevator, stairwells and restroom doors mounted 60in from floor |     |    |    |          |
| Visible & Audible alarms – emergency systems                                                                                       |     |    |    |          |
| Dimmable Lights                                                                                                                    |     |    |    |          |

**ORGANIZATIONAL/FACILITY APPLICATION**

| Accommodation                                                                                                                                                                                                                                                                                                                                                                                          | YES | NO | NA | Comments |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|----|----------|
| Ramps have non-slip surface material                                                                                                                                                                                                                                                                                                                                                                   |     |    |    |          |
| Railings between 30 & 38in high. On both sides.                                                                                                                                                                                                                                                                                                                                                        |     |    |    |          |
| Paths are at least 36in wide and free of protruding objects                                                                                                                                                                                                                                                                                                                                            |     |    |    |          |
| Cane detectible objects on ground as a warning barrier                                                                                                                                                                                                                                                                                                                                                 |     |    |    |          |
| Widened doorways (at least 32in clearance)                                                                                                                                                                                                                                                                                                                                                             |     |    |    |          |
| Offset (swing-clear) hinges                                                                                                                                                                                                                                                                                                                                                                            |     |    |    |          |
| Power assisted or automatic door openers                                                                                                                                                                                                                                                                                                                                                               |     |    |    |          |
| Door handles no higher than 48in                                                                                                                                                                                                                                                                                                                                                                       |     |    |    |          |
| Lever or loop handles vs knobs                                                                                                                                                                                                                                                                                                                                                                         |     |    |    |          |
| 5ft circle or T-shaped space for turning a wheelchair completely                                                                                                                                                                                                                                                                                                                                       |     |    |    |          |
| A clear floor space, 30" x 48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer                                                                                                                                                                                                                                                               |     |    |    |          |
| Adjustable height exam table or chair (lowers to 17-19in from floor)                                                                                                                                                                                                                                                                                                                                   |     |    |    |          |
| Positioning and support aids, such as wedges, rolled up blankets, straps and rails                                                                                                                                                                                                                                                                                                                     |     |    |    |          |
| Ceiling or floor based patient lift                                                                                                                                                                                                                                                                                                                                                                    |     |    |    |          |
| Gurneys and/or stretchers                                                                                                                                                                                                                                                                                                                                                                              |     |    |    |          |
| Wheelchair accessible scales                                                                                                                                                                                                                                                                                                                                                                           |     |    |    |          |
| Adjustable height radiologic equipment                                                                                                                                                                                                                                                                                                                                                                 |     |    |    |          |
| Handicap parking                                                                                                                                                                                                                                                                                                                                                                                       |     |    |    |          |
| Handicap accessible restroom                                                                                                                                                                                                                                                                                                                                                                           |     |    |    |          |
| Access ramps                                                                                                                                                                                                                                                                                                                                                                                           |     |    |    |          |
| Accessible by bus                                                                                                                                                                                                                                                                                                                                                                                      |     |    |    |          |
| Accessible by Valley Metro Rail                                                                                                                                                                                                                                                                                                                                                                        |     |    |    |          |
| Accessible by Taxi or similar options i.e., Uber/Lyft                                                                                                                                                                                                                                                                                                                                                  |     |    |    |          |
| Provider/Staff has completed cultural competence training                                                                                                                                                                                                                                                                                                                                              |     |    |    |          |
| <p>Do you provide Field Clinic services?</p> <p>(A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis)</p> |     |    |    |          |
| <p>Do you provide Virtual Clinic services?</p> <p>(Integrated services provided in community settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)</p>                                                                                                                      |     |    |    |          |

\*NCQA Requirements

## DISCLOSURE QUESTIONS

| Please answer the following questions by checking the appropriate box. If the answer to any question is "YES" please provide a complete description of the facts on a separate sheet to be attached to application.  |                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. Has the Organizational/Facility license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed?                                                            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 2. Has the Organizational/Facility been denied participation, suspended from or denied renewal from Medicare or Medicaid?                                                                                            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 3. Has the Organizational/Facility been cited or fined for patient abuse or neglect?                                                                                                                                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 4. Has the Organizational/Facility ever had its professional liability coverage cancelled or not renewed?                                                                                                            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| 5. Has the Organizational/Facility been denied accreditation by its selected accrediting body (e.g. TJC) or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

## Organizational/Facility Attestation, Consent & Release Form

Any alteration or failure to sign and date this form will result in the delay of processing this application. By signing below, I attest that I am the duly authorized representative of the Organizational/Facility, that all information on the Application pertains to the above-named Organizational/Facility, and that such information is current, complete and correct.

ORGANIZATIONAL/FACILITY NAME:

REPRESENTATIVE NAME:

TITLE:

SIGNATURE:

DATE:

**\*\*Must be signed within 180 days of submission to the Plan. Electronic Signatures are acceptable.**

**The organization does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language, and providing the information is optional.**

## AHCCCS INSURANCE CHECKLIST

**AHCCCS INSURANCE REQUIREMENTS** – Required ONLY if requesting to participate in the Plan’s Medicaid Line of Business

**Use this checklist as a tool to address all insurance requirements**

1. Commercial General Liability and Business Automobile Liability—includes limits, endorsement and waiver of subrogation language
2. Worker’s Compensation and Employers’ Liability—includes limits and waiver of subrogation language.

**Commercial General Liability**—policy should include bodily injury, property damage, personal and advertising injury, and broad form contractual liability coverage.

|                           |             |
|---------------------------|-------------|
| General Aggregate         | \$2,000,000 |
| Products Ops Aggregate    | \$1,000,000 |
| Personal & Adv. Injury    | \$1,000,000 |
| Damage to Rented Premises | \$ 50,000   |
| Each Occurrence           | \$1,000,000 |

Policy Number:

EFF Date:

☐ Attached

☐ NA

**Requirements:**

☐ **Endorsement**—The policy shall be endorsed (Blanket Endorsements are not acceptable) to include the following insure language: *“The State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor”*. Such additional insured shall be covered to the full limits of liability purchased by the Subcontractor, even if those limits of liability are in excess of those required by this contract.

☐ **Waiver of Subrogation**—The policy shall contain a waiver of subrogation endorsement (Blanket Endorsements are not acceptable) in favor of the *“State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees”* for losses arising from work performed by or on behalf of the Subcontractor.

☐ **Sexual Abuse and Molestation coverage (SAM)**—If direct services are provided to children and/or vulnerable adults as defined by A.R.S. 46-451(A)(9), the policy shall include coverage for SAM. This SAM coverage may be sub-limited to no less than \$500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits.

The following statement must provide on their Certificate(s) of Insurance: *“Sexual Abuse and Molestation coverage is included” or “Sexual Abuse and Molestation coverage is not excluded.”*

If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should it be included with the Professional Liability

**Business Automobile Liability**—Bodily injury and property damage for any owned, hired, and/or non-owned vehicles used in the performance of the services under contract.

(required only if you provide transportation to members)

Combined Single Limit \$1,000,000

Policy Number:

EFF Date:

☐ Attached

☐ NA

☐ **Endorsement**—The policy shall be endorsed (Blanket Endorsements are not acceptable) to include the following insured language: *“The State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor”*. Such additional insured shall be covered to the full limits of liability purchased by the Subcontractor, even if those limits of liability are in excess of those required by this contract.

☐ **Waiver of Subrogation**—The policy shall contain a waiver of subrogation endorsement (Blanket Endorsements are not acceptable) in favor of the *“State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees”* for losses arising from work performed by or on behalf of the Subcontractor.

### **Workers' Compensation Liability**

Each Accident \$1,000,000

Disease—Each Employee \$1,000,000

Disease—Policy Limit \$1,000,000

Policy Number:

EFF Date:

☐ Attached

☐ NA

☐ **Waiver of Subrogation**—The policy shall contain a waiver of subrogation endorsement (Blanket Endorsements are not acceptable) in favor of the *“State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees”* for losses arising from work performed by or on behalf of the Subcontractor.

### **Professional Liability** (if applicable)

Each Claim \$1,000,000

Annual Aggregate \$2,000,000

Policy Number:

EFF Date:

☐ Attached

☐ NA

☐ **Sexual Abuse and Molestation coverage (SAM)**—If direct services are provided to children and/or vulnerable adults as defined by A.R.S. 46-451(A)(9), the policy shall include coverage for SAM. This SAM coverage may be sub-limited to no less than \$500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits.

If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should be included with the Professional Liability

The following statement must provide on their Certificate(s) of Insurance: *“Sexual Abuse and Molestation coverage is included” or “Sexual Abuse and Molestation coverage is not excluded.”*

The fax number and phone number for each participating plan is listed in the table below.

**If your intent is to apply for participation in a Health Plan network**, please send only to the Plan(s) you are interested in joining. NOT ALL Plans provide services in every county. Please contact the Plan directly to verify that they provide services in your county and that they are accepting new providers.

**If you are adding a practitioner under an existing Health Plan contract**, please only send to the Plan(s) you are contracted with.

| HEALTH PLAN                                                                                    | PHONE                                  | FAX/EMAIL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | WEBSITE                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Arizona Complete Health - Complete Care Plan                                                   | (888)788-4408                          | (866)687-0514<br><a href="mailto:AzCHProviderData@azcompletehealth.com">AzCHProviderData@azcompletehealth.com</a><br>New contract:<br><a href="mailto:AzCHPotentialProvider@azcompletehealth.com">AzCHPotentialProvider@azcompletehealth.com</a>                                                                                                                                                                                                                                                                                                                                                   | <a href="http://www.azcompletehealth.com">www.azcompletehealth.com</a>                                                                                                                                                                                           |
| Banner University Health Plans                                                                 | (520) 874-5290<br>or<br>(800) 582-8686 | Email is preferred method to send completed PDFs: <a href="mailto:BUHPDATATEAM@Bannerhealth.com">BUHPDATATEAM@Bannerhealth.com</a><br><br>(520) 874-7142                                                                                                                                                                                                                                                                                                                                                                                                                                           | <a href="http://www.BannerUFC.com/ACC">www.BannerUFC.com/ACC</a><br><a href="http://www.BannerUFC.com/ALTCS">www.BannerUFC.com/ALTCS</a><br><a href="http://www.BannerUFC.com">www.BannerUFC.com</a><br><a href="http://www.BannerUHP.com">www.BannerUHP.com</a> |
| Blue Cross Blue Shield of Arizona Health Choice (ACC plan)<br><br>Health Choice Pathway (DSNP) | 480-760-4651                           | Request Credentialing-E-apply:<br><a href="https://www.azblue.com/medicaid/providers/provider-portal">https://www.azblue.com/medicaid/providers/provider-portal</a><br><br>Request Participation/New Contract E-apply:<br><a href="https://www.azblue.com/medicaid/providers/provider-portal">https://www.azblue.com/medicaid/providers/provider-portal</a><br>OR<br>Email Credentialing Forms to:<br><a href="mailto:hchcredentialing@azblue.com">hchcredentialing@azblue.com</a><br>Email Request to Participate to:<br><a href="mailto:hchcontracting@azblue.com">hchcontracting@azblue.com</a> | <a href="http://azblue.com/medicaid">azblue.com/medicaid</a> (ACC)<br><br><a href="http://azblue.com/health-choice-pathway">azblue.com/health-choice-pathway</a> (DSNP)                                                                                          |
| DentaQuest                                                                                     | (800) 233-1468                         | <a href="mailto:credenrollment@greatdentalplans.com">credenrollment@greatdentalplans.com</a><br>(262)241-7401                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <a href="http://www.dentaquest.com/state-plans/regions/arizona/az-dentist-page">http://www.dentaquest.com/state-plans/regions/arizona/az-dentist-page</a>                                                                                                        |
| Molina Healthcare of Arizona                                                                   | (800) 424-5891                         | (888)656-0369<br><a href="mailto:MCCAZ-Provider@molinahealthcare.com">MCCAZ-Provider@molinahealthcare.com</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <a href="http://www.molinahealthcare.com/members/az/en-us/pages/home.aspx">http://www.molinahealthcare.com/members/az/en-us/pages/home.aspx</a>                                                                                                                  |
| Mercy Care                                                                                     | (602) 263-3000                         | Network Management (Provider Relations and Contracting)<br><a href="mailto:MercyCareNetworkManagement@MercyCareAZ.org">MercyCareNetworkManagement@MercyCareAZ.org</a><br>Fax: (860)975-3201                                                                                                                                                                                                                                                                                                                                                                                                        | <a href="http://www.mercycareaz.org">www.mercycareaz.org</a>                                                                                                                                                                                                     |
| UnitedHealthcare Community Plan                                                                | 866-842-3278, option 1                 | N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | United Healthcare provider portal access using your One Healthcare ID. Don't have a One Healthcare ID? <a href="#">Register</a> now.                                                                                                                             |

## Electronic Visit Verification (EVV)

Per AHCCCS EVV: Pursuant to Section 1903 of the Social Security Act (42 U.S.C. 1396b), also known as the 21st Century Cures Act, in order to prevent a reduction in the Federal Medical Assistance Percentage (FMAP), AHCCCS is mandated to implement Electronic Visit Verification (EVV) for non-skilled in-home services (attendant care, personal care, homemaker, habilitation, respite) and for in-home skilled nursing services (home health.) AHCCCS has mandated EVV for personal care and home health services beginning January 1, 2021.

The EVV system, must at a minimum, electronically verify the:

- Type of service performed
- Individual receiving the service
- Date of the service
- Location of service delivery
- Individual providing the service
- Time the service begins and ends

The list of provider types, services and places of service that are mandated to use EVV is found on the EVV website under the “New to EVV” tab. A list is also below.

To comply, providers must contract with an EVV vendor of their choosing and require the vendor to share visit data to the AHCCCS Aggregator. A list of the EVV vendors can be found on the Resource link

The health plan you contract with to provide services will require you to complete an EVV Attestation form during your credentialing process to ensure you understand what processes must be completed before you can bill for EVV services. Please note, you cannot onboard with EVV until you have an AHCCCS Provider ID number. Additionally, you will not be able to bill for services until after you have completed credentialing with a health plan and have your EVV system in place (i.e., access to the system, people trained, devices deployed, etc.) and are recording visits.

### Resource:

[Electronic Visit Verification \(EVV\) Website \(azahcccs.gov\)](https://www.azahcccs.gov)

If you are in the process of becoming a new provider or you are an existing provider that is going to provide EVV services, the information in the documents below will help you in preparing to comply with the EVV mandate:

- EVV One Pager
- EVV Attestation
- EVV Contact and Update
- Your agency must have an EVV Contact on file. Please use the directions above to add your EVV Contact. You can also use this process if you need to update your EVV Contact.

### NOTE:

- Please identify who will serve as the primary EVV Office Contact on page 4 of this application. This person will be responsible for receiving communications and notices from AHCCCS.
- The Electronic Visit Verification (EVV) Compliance Attestation on page 15, MUST be signed by the Organizational/Facility Chief Executive.

Provider types, services, and places of service subject to EVV:

| Provider Description         | Provider Type | Provider Description                      | Provider Type |
|------------------------------|---------------|-------------------------------------------|---------------|
| Attendant Care Agency        | PT 40         | Home Health Agency                        | PT 23         |
| Behavioral Outpatient Clinic | PT 77         | Integrated Clinic                         | PT IC         |
| Community Service Agency     | PT A3         | Non-Medicare Certified Home Health Agency | PT 95         |
| Fiscal Intermediary          | PT F1         |                                           |               |
| Habilitation Provider        | PT 39         | Private Nurse                             | PT 46         |

| Service                                                                                  | HCPSC Service Code |
|------------------------------------------------------------------------------------------|--------------------|
| Attendant Care                                                                           | S5125              |
| Companion Care                                                                           | S5135              |
| Habilitation                                                                             | T2017              |
| <b>Home Health Services (aide, therapy, and part-time/intermittent nursing services)</b> |                    |
| Nursing                                                                                  | G0299 and G0300    |
| Home Health Aide                                                                         | T1021              |
| Physical Therapy                                                                         | G1051 and S9131    |
| Occupational Therapy                                                                     | G0152 and S9129    |
| Respiratory Therapy                                                                      | S5181              |
| Speech Therapy                                                                           | G0153 and S9128    |
| Private Duty Nursing (continuous nursing services)                                       | S9123 and S9124    |
| Homemaker                                                                                | S5130              |
| Personal Care                                                                            | T1019              |
| Respite                                                                                  | S5150 and S5151    |

| Place of Service Description | POS Code |
|------------------------------|----------|
| Home                         | 12       |
| Assisted Living              | 13       |
| Other                        | 99       |



**Electronic Visit Verification (EVV) Compliance Attestation**

**As the Chief Executive of a provider agency that provides services to AHCCCS members subject to Electronic Visit Verification (EVV), I attest to the following:**

1. My agency will utilize an EVV system for all EVV applicable services as outlined on the AHCCCS website. I understand that my agency will need to have a contract in place with an EVV vendor of my choice and share visit data with the AHCCCS aggregator.
2. I understand I will not get paid for EVV services until my agency is using an EVV system to record visits and the required visit data is present for claimed services.
3. I understand and will adhere to the AHCCCS Medical Policy Manual (AMPM) Electronic Visit Verification policy (540)

|                              |  |
|------------------------------|--|
| <b>Chief Executive Name:</b> |  |
| <b>Title:</b>                |  |
| <b>Organization:</b>         |  |
| <b>Provider ID #:</b>        |  |
| <b>Direct Email:</b>         |  |
| <b>Signature:</b>            |  |
| <b>Date:</b>                 |  |

Provider—please return this form directly to your health plan and maintain a copy for your records. Do NOT send to AHCCCS if you are contracting with a Managed Care Organization. If the organization has multiple AHCCCS Provider The attestation is only required as part of initial request to join the network and is not required for recredentialing.

If the organization has multiple AHCCCS Provider Registration IDs that may be subject to EVV, please list all relevant Provider IDs.

| AHCCCS Provider IDs |  |
|---------------------|--|
|                     |  |
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