Credentialing Alliance

AZAHP PRACTITIONER DATA FORM

Directions for completing the AzAHP Practitioner Data Form (AzAHP). Any questions regarding this form, please check with your Health Plan representative.

1. **The information is necessary to add into the Provider Directory and payment system for claims processing**. This form is also used for providers that may not require credentialing due to their provide type. If you do not have a Professional license (MD, DO, NP, etc), please disregard the CAQH Registration requirements.

2. **CAQH Registration is required** (http:/www.caqh.org—for assistance please contact the CAQH HELP DESK at 1-888-599-1771)

3. Your CAQH application and attestation MUST be up to date and each health plan you are requesting participation in is authorized to access your data

4. **Ensure you provide an ACCURATE CAQH number, or your application may be delayed or rejected**

5. **PLEASE TYPE OR PRINT CLEARLY AND COMPLETE THE APPLICATION IN ITS ENTIRETY. ALL PAGES MUST BE SUBMITTED**
   a. Additional office locations-please indicate any additional locations in space allowed

6. Please complete the Provider Assessment of Cognitive and Physical Disabilities Accommodations tool (pages 6-7). A separate assessment must be completed for each location.

7. **The following ATTACHMENTS are required to be submitted with the AzAHP FORM SO YOUR REQUEST MAY BE PROCESSED TIMELY**
   a. IRS 941 voucher or accurate W-9
   b. Copy of your Board Certification (if applicable)
      i. Copy of Date of Board Certification Examination
      ii. If not Board Certified, please provide documentation of CMEs
   c. Physician Assistants—must provide agreement with supervising physician
   d. Copy of your Certificates of Insurance information that include the minimum requirements
      i. See page 8 for the Insurance Requirement Checklist
      ii. See page 9 and 10 for complete details regarding AHCCCS Insurance Requirements

8. New providers receive written confirmation of their effective date with the health plan(s).
   a. Members may not be seen until written confirmation has been received
   b. AHCCCS registration is required. You cannot receive payment for services provided without an active AHCCCS registration
   c. Please notify the health plan(s) of your AHCCCS registration if not available at time application was completed

Credentialing Alliance

AZAHP PRACTITIONER DATA FORM

PLEASE TYPE OR PRINT CLEARLY AND COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST

This form includes Personally Identifiable information (PHI) such as practitioner name, date of birth and SSN and should be sent in a secure manner.

To:

Fax: Phone: Submission Date:

Post the following items (as applicable) to CAQH-Please check box(es) to indicate items posted:

☐ IRS 941 coupon or accurate W-9 ☐ Documentation of board certification or scheduled exam date

☐ Medicaid required insurance certificates as applicable (see page 3 for requirements)

DENTAL PROVIDERS ONLY

. General Anesthesia Permit, Conscious Sedation Permit and/or Oral Conscious Sedation Permit

Practitioner's Name and Degree: (Last) (First) (M.I.) (Degree)

DOB:

CAQH #

☐ Female
☐ Male
☐ NB-identifies with neither/both M/F
☐ TF -Transgender female
☐ TM-Transgender male
☐ ND-does not wish to disclose gender identity

1099 Registered Name (Required)

Tax ID #

Group Practice Name (DBA) if applicable:

Practitioner's Effective Date w/Practice

Group Type (*check all that apply*)
☐ FQHC/RHC ☐ Integrated Clinic ☐ Multi Specialty
☐ Single Specialty Group ☐ Other

Practitioner Type:
☐ PCP ☐ OBGYN ☐ Specialist ☐ BH
☐ Dentist ☐ MAT Prescriber
☐ Other_____

Lines of Business:
☐ Medicaid ☐ Medicare ☐ Commercial

Does provider participate in Medicare?
☐ YES ☐ NO

Is provider Hospital Based Only?
☐ YES ☐ NO

SSN:

Individual NPI#

Organizational NPI#

AHCCCS I.D.#

License #
State: Exp Date:

DEA#
State: Exp Date:

If MAT Prescriber XDEA#
State: Exp Date:

Primary Practicing Specialty:

Board Certification: ☐ YES ☐ NO
Date of Exam:

Secondary Practicing Specialty:

Board Certification: ☐ YES ☐ NO
Date of Exam:

New Graduate *(licensed to practice dentistry for the first time in your career and/or completed post-graduate training for the first time **within the last 6 months.**)*: ☐ YES ☐ NO

Graduation/Completion Date **MUST BE INCLUDED**_____

Dental Hygienist Affiliated Dentist Name:

Visits by: ☐ Telemedicine ☐ In-person ☐ Both

Credentialing Alliance

AZAHP PRACTITIONER DATA FORM

Accepting New Patients: ☐ YES ☐ NO	Patient Age Range:	Patient Gender: ☐ Male ☐ Female ☐ All ☐ NB-Non Binary ☐ TF-Transgender female ☐ TM-Transgender male	Any PCP panel size and restrictions (accepting only referrals, etc.): YES ☐ NO ☐ Explain

Do you provide services to individuals with special needs/chronic conditions? (*check all that apply*) ☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional ☐ Autism Spectrum Disorder ☐ None	Trained in the use and scoring of the developmental screening tools as indicated by the AAP: ☐ YES ☐ NO	Specialized training/Certifications in: . ☐ Health Equity ☐ Diversity ☐ Equity ☐ Inclusion ☐ Trauma Informed Care Physician Assistant Supervising Physician Name Collaborative PA Practice ☐ YES ☐ NO
Do you provide services/accommodations to individuals who have difficulty communicating or cooperating (i.e.,) those with autism or intellectual disabilities? ☐ YES ☐ NO		Do you provide services to individuals with mobility limitations (i.e., wheelchair bound? ☐ YES ☐ NO

Do you treat any of the following diagnoses? (*check all that apply*): ☐ Anxiety ☐ AHDS ☐ EPSDT ☐ Depression ☐ HIV ☐ Addiction/ Substance Abuse ☐ None

PCPs and OBS ONLY: Do you provide any of the following services? ☐ EPSDT ☐ OB ☐ None

Do you participate in VFC (Vaccines for Children)? (*PCPs seeing AHCCCS members 18 & < must participate*) ☐ YES ☐ NO	VFC PIN CODE:	Do you E-Prescribe? ☐ YES ☐ NO

Languages other than English practitioner is fluent when communicating about medical care:

Race: ☐ Black or African American ☐ Asian ☐ White ☐ American Indian or Alaska Native	☐ Native Hawaiian or Pacific Islander ☐ Middle Eastern or North African ☐ Prefer not to disclose ☐ Other _____	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Not Latino ☐ Prefer not to disclose

Names of Practitioners in Call Group (*Must be contracted with plan)*	Hospital & Ambulatory Surgery Center(s) where practitioner has privileges

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AZAHP PRACTITIONER DATA FORM

BILLING SERVICE (if applicable)	Name:		Contact:	
	Address:			Phone:
	City:	State:	Zip Code:	Fax:

PAY TO ADDRESS (all payments sent to this address)	Address:	City:	State:
	Phone:	Fax:	Zip Code:

PRIMARY ADDRESS (Physical location where services are performed)

Address: | City: | State: | Zip Code:

Phone: | Fax: | County:

Office Hours:	DAY	Open	Closed	DAY	Open	Closed
	Mon			Fri		
	Tues			Sat		
	Wed			Sun		
	Thurs					

Special Considerations: (i.e., closed for lunch, etc)

List Practitioner in Directories at this address? ☐ YES ☐ NO

Languages other than English spoken by OFFICE STAFF:

ADDITIONAL LOCATION (Physical location where services are performed)

*A separate Provider Assessment of Cognitive and Physical Disabilities Accommodations must be completed for each location unless are the same as the Primary location

☐ Secondary

☐ Tertiary

Address: | City: | State: | Zip Code:

Phone: | Fax: | County:

Office Hours:	DAY	Open	Closed	DAY	Open	Closed

Special Considerations: (i.e., closed for lunch, etc)

List Practitioner in Directories at this address? ☐ YES ☐ NO

Languages other than English spoken by OFFICE STAFF:

Credentialing Alliance

AZAHP PRACTITIONER DATA FORM

ADDITIONAL LOCATION (Physical location where services are performed) *A separate Provider Assessment of Cognitive and Physical Disabilities Accommodations must be completed for each location unless are the same as the Primary location ☐ Secondary ☐ Tertiary	Address:			City:		State:	Zip Code:
	Phone:			Fax:			County:
	Office Hours:	**DAY**	**Open**	**Closed**	**DAY**	**Open**	**Closed**
	Special Considerations: (i.e., closed for lunch, etc)						
	List Practitioner in Directories at this address? ☐ YES ☐ NO						
	Languages other than English spoken by OFFICE STAFF:						

ADDITIONAL LOCATION (Physical location where services are performed) *A separate Provider Assessment of Cognitive and Physical Disabilities Accommodations must be completed for each location unless are the same as the Primary location ☐ Secondary ☐ Tertiary	Address:			City:		State:	Zip Code:
	Phone:			Fax:			County:
	Office Hours:	**DAY**	**Open**	**Closed**	**DAY**	**Open**	**Closed**
	Special Considerations: (i.e., closed for lunch, etc)						
	List Practitioner in Directories at this address? ☐ YES ☐ NO						
	Languages other than English spoken by OFFICE STAFF:						

OFFICE CONTACT	Name/Title:		Phone:	Fax:
	E-mail:		Practice Website Address:	
	Address:	City:	State:	Zip Code:

CREDENTIALING CONTACT:	Name:		Phone	Fax:
	Email:			
	Address:	City	State:	Zip Code:

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	Internet Access? ☐ YES ☐ NO		Is this a minority or female owned business? ☐ YES ☐ NO		
Electronic Funds Transfer? ☐ YES ☐ NO					

Provider Assessment of Cognitive and Physical Disabilities Accommodations

Please identify what accommodations you provide at **each of your practice 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.

Practice 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				
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				

Accommodation	YES	NO	NA	Comments
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 Taxis or other similar options (Uber/Lyft)				
Accessible by Valley Metro Rail				
Provider/Staff has completed cultural competence training				
Do you provide Field Clinic services? (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)				
Do you provide Virtual Clinic services? (Integrated services provided in community settingsthrough the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)				

*NCQA Requirement

INSURANCE REQUIREMENT CHECKLIST

Prior to submitting your insurance information complete this checklist, use it as a tool to address everything that's required and send it on top of your insurance document(s). See pages 7 and 8 for all AHCCCS Insurance Requirements

Commercial General Liability	**Professional Liability**
☐ ATTACHED ☐ NA	☐ ATTACHED
POLICY NUMBER: **EFF DATE:**	**POLICY NUMBER:** **EFF DATE:**
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	Each Claim $1,000,000 Annual Aggregate $2,000,000
Business Automobile Liability	**Workers' Compensation Liability**
☐ ATTACHED ☐ N/A	☐ ATTACHED ☐ N/A
POLICY NUMBER: **EFF DATE:**	**POLICY NUMBER:** **EFF DATE:**
Combined Single Limit $1,000,000	Each Accident $1,000,000 Disease – Each Employee $1,000,000 Disease – Policy Limit $1,000,000

Your Certificates of Insurance must include the minimum requirements outlined in the tables above and the following endorsement, waiver of subrogation and/or SAM language as applicable.

☐ **Endorsement – Required for Commercial General and Business Auto Liability**
This policy contains an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ **Waiver of Subrogation – Required for Commercial General, Business Auto Liability and Workers' Compensation Liability**
This policy contains a waiver of subrogation endorsement 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 the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ **Sexual Abuse and Molestation (SAM) – Required for Commercial General Liability or Professional Liability when providing services to children and/or vulnerable adults**
Insurance Certificate(s) must provide the following statement "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 be included with the Professional Liability.

AHCCCS Insurance Requirements

This communication outlines the additional insurance requirements and provides examples to assist you.

AHCCCS Insurance Requirements
The AHCCCS insurance requirements include Commercial General Liability, Business Automobile Liability and Worker's Compensation and Employers' Liability.

Your commercial general liability policy and your business automobile policy (if applicable), need to include an endorsement (see letter a. below under Commercial General Liability and letter a. below under Business Automobile Liability) and a waiver of subrogation (see letter b. below under Commercial General Liability and letter b. below under Business Automobile Liability) in the Description field of your policy.

Your worker's compensation and employers' liability policy requires only the waiver of subrogation language.

Outlined below are the minimum requirements. Policy examples follow

Commercial General Liability – Occurrence Form
Policy should include bodily injury, property damage, personal and advertising injury and broad form contractual liability coverage. The amounts below are the minimum requirements.

- General Aggregate $2,000,000
- Products – Completed Operations Aggregate $1,000,000
- Personal and Advertising Injury $1,000,000
- Damage to Rented Premises $50,000
- Each Occurrence $1,000,000

a. The policy shall be endorsed (**Blanket Endorsements are not acceptable**) to include the following additional 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."*** 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.

b. 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.

c. 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 Sexual Abuse and Molestation (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 it be included with the Professional Liability.

d. 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."

Business Automobile Liability—(If no, automobiles are used in the performance of this Contract or Subcontract, then this is not applicable)

Bodily Injury and Property Damage for any owned, hired, and/or non-owned vehicles used in the performance of the services under contract. The amount below is the minimum required.

- Combined Single Limit (CSL) $1,000,000

a. The policy shall be endorsed (**Blanket Endorsements are not acceptable**) to include the following additional 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 requiredby this contract.

b. 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.

Worker's Compensation and Employers' Liability

- Workers' Compensation Statutory
- Employers' Liability
  - Each Accident $500,000
  - Disease – Each Employee $500,000
  - Disease – Policy Limit $1,000,000

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."

We are required to verify your adherence to these insurance requirements. We appreciate you submitting Certificates of Liability with required coverage levels, endorsements and waivers along with the attached checklist

Credentialing Alliance

AZAHP PRACTITIONER DATA FORM

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 AzCHProviderData@azcompletehealth.com	www.azcompletehealth.com
Banner University Health Plans	(520) 874-5290 or (800) 582-8686	Email is preferred method to send completed PDFs: BUHPDATATEAM@Bannerhealth.com (520) 874-7142	www.BannerUFC.com/ACC www.BannerUFC.com/ALTCS www.BannerUFC.com www.BannerUHP.com
BCBSAZ Health Choice	(800) 322-8670 (options in order 4, 7)	Preferred: E-apply through the BCBSAZ Health Choice Provider Portal Alternate: Request to participate/Contract: hchcontracting@azblue.com Request to credential/Already Contracted: hchcredentialing@azblue.com	www.healthchoiceaz .com www.healthchoicepathway.com
DentaQuest	(800) 233-1468	credenrollment@greatdentalplans.com (262)241-7401	http://www.dentaquest.com/state-plans/regions/arizona/az-dentist-page
Molina Healthcare of Arizona	(800) 424-5891	(888)656-0369 MCCAZ-Provider@molinahealthcare.com	http://www.molinahealthcare.com/members/az/en-us/pages/home.aspz
Mercy Care	(602) 263-3000	Network Management (Provider Relations and Contracting) MercyCareNetworkManagement@MercyCareAZ.org Fax: (860)975-3201	www.mercycareaz.org
UnitedHealthcare Community Plan	For questions please email networkhelp@uhc.com	Submission to the RFP Portal is the preferred method for accepting the pdf UHC RFP Portal (855) 523-9998 Cred_applications@uhc.com	www.uhcprovider.com

SIGNATURE PAGE

Practitioner Data Form completed by:

Name:	
Title:	
Date:	

Signature:

**Must be signed within 180 days of submission to the Plan