Credentialing Alliance

ORGANIZATIONAL/FACILITY APPLICATION

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 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).

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

SUBMISSION DATE:			
1099 Registered Name (Required):			Tax ID#:
Organizational/Facility Name/DBA (if applicable):			Effective Date with TIN:
Lines of Business: ☐ Medicaid ☐ Medicare ☐ Commercial	License #	State	Exp Date:
AHCCCS ID #	AHCCCS Provider Type	Organization NPI#	CLIA# Expiration Date
Is Facility a Medicare participating provider? ☐ YES ☐ NO		Medicare # (PTAN):	

ORGANIZATIONAL/FACILITY TYPE AS LISTED ON LICENSE OR ACCREDITATION: Check all that apply

☐ Acute Rehab	☐ Habilitation Providers	☐ Pharmacy
☐ Ambulatory Surgery Center	☐ Home Health Agency	☐ PT/ST
☐ Attendant Care Agency	☐ Hospice	☐ Radiology—locations only
☐ Assisted Living Center**Indicate Specialties below	☐ Hospital	☐ Skilled Nursing Facility ** Indicate Specialties below
☐ Assisted Living Home ** Indicate Specialties below	☐ Infusion Agency	☐ Transportation
☐ Behavioral Health	☐ Intensive Outpatient Treatment (BH)	☐ Transportation—Air and Non-Emergency
☐ Behavioral Health Residential Facility (BHRF)	☐ Laboratory	☐ Behavioral Health Therapeutic Home
☐ Dialysis	☐ Medical/Dental Schools	☐ Therapeutic Foster Home
☐ DME/Enteral	☐ Orthotics & Prosthetics	☐ Urgent Care
☐ FQHC/RHC	☐ Outpatient Medical Rehab Center	☐ Other

ORGANIZATIONAL/ FACILITY TYPE SPECIALTIES—HSD SPECIALTY CODE AND SPECIALTY NAME: Check all that apply

☐ 040 Acute Inpatient Hospitals	☐ 046 Skilled Nursing Facilities	☐ 050 Occupational Therapy
☐ 041 Cardiac Surgery Program	☐ 047 Diagnostic Radiology	☐ 051 Speech Therapy
☐ 042 Cardiac Catheterization Services	☐ 048 Mammography	☐ 052 Inpatient Psychiatric Facility Services
☐ 043 Critical Care Services -Intensive Care Units (ICU)	☐ 049 Physical Therapy	☐ 057 Outpatient Infusion/Chemotherapy
☐ 045 Surgical Services (Outpatient or ASC)		

ASSISTED LIVING FACILITY/SNF TYPE SPECIALTIES—SPECIALTY NAME: Check all that apply If Applicable

☐ Dementia or related disorders	☐ Traumatic Brain Injury	☐ Addiction/Substance Abuse Disorders
☐ Persistent aggressive behaviors	☐ None of the above	

Credentialing Alliance

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. If Applicable	
☐ Accreditation Commission for Health Care, INC.	☐ Commission on Office Laboratory Accreditation
☐ American Association for Accreditation of Ambulatory Surgery Facilities	☐ Community Health Accreditation
☐ American Association for Ambulatory Health Care	☐ Det Norske Veritas National Integrated Accreditation for Healthcare Organizations
☐ American College of Radiology	☐ Healthcare Facilities Accreditation Program
☐ American Osteopathic Association	☐ Joint Commission
☐ Commission on Accreditation of Rehabilitation Facilities	☐ 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 ☐ YES ☐ NO

Office Hours ☐ Check if 24Hrs

DAY	Open	Closed	DAY	Open	Closed
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				

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				
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 settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)				

*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?	☐ Yes ☐ No
2. Has the Organizational/Facility been denied participation, suspended from or denied renewal from Medicare or Medicaid?	☐ Yes ☐ No
3. Has the Organizational/Facility been cited or fined for patient abuse or neglect?	☐ Yes ☐ No
4. Has the Organizational/Facility ever had its professional liability coverage cancelled or not renewed?	☐ Yes ☐ 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?	☐ Yes ☐ 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

D **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.

D **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	Policy Number: EFF Date: ☐ Attached ☐ NA
Disease—Each Employee	$1,000,000	
Disease—Policy Limit	$1,000,000	

D **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	Policy Number: EFF Date: ☐ Attached ☐ NA
Annual Aggregate	$2,000,000	

D **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 it 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 AzCHProviderData@azcompletehealth.com New contract: AzCHPotentialProvider@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
Blue Cross Blue Shield of Arizona Health Choice (ACC plan) Health Choice Pathway (DSNP)	480-760-4651	Request Credentialing-E-apply: https://www.azblue.com/medicaid/providers/provider-portal Request Participation/New Contract E-apply: https://www.azblue.com/medicaid/providers/provider-portal OR Email Credentialing Forms to: hchcredentialing@azblue.com Email Request to Participate to: hchcontracting@azblue.com	azblue.com/medicaid (ACC) azblue.com/health-choice-pathway (DSNP)
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	866-842-3278, option 1	N/A	United Healthcare provider portal access using your One Healthcare ID. Don't have a One Healthcare ID? Register 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)

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	HCPCS Service Code
Attendant Care	S5125
Companion Care	S5135
Habilitation	T2017
Home Health Services (aide, therapy, and part-time/intermittent nursing services	
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

If Applicable

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)

Chief Executive Name:	
Title:	
Organization:	
Provider ID #:	
Direct Email:	
Signature:	
Date:	

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 If Applicable	