www.BannerHealth.com/BHPProvider
800-582-8686, TTY 711
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Provider Update

November 2025

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Blue Cross Blue Shield of AZ Medicare Members 2025 Wellness Rewards program

Blue Cross Blue Shield of AZ Medicare members still have time to access their 2025 rewards for obtaining their 2025 screenings/exams.

Blue members receive a dual-purpose card, which will be loaded with their OTC allowance and the reward(s) they earn. Members can self-attest to all screenings either online or by calling the health plan. If plan members do not self-attest to the APE/AWV or IHA, their reward(s) will be applied once their claim is processed. Screenings must be completed by Dec. 31, 2025; eligible screenings are the same for all plans.

Screening/Exam	Reward Benefit
Annual Physical Exam OR Annual Wellness Visit	$50
In-Home Health Assessment (Adobe Pop Health & Homebase)	$50
Breast Cancer Screening (Mammogram)	$30
Colorectal Cancer Screening	$30
Diabetic Retinal Eye Exam	$30

Dispatch Health to Discontinue Services in Phoenix Market Effective December 5, 2025

Dispatch Health, a provider of mobile urgent care and emergency department alternatives, will discontinue all services in the Phoenix, Arizona market after December 5, 2025. However, the organization will maintain its operations in the Tucson area. Physicians and care teams in Phoenix should prepare for this transition, as patients who previously relied on Dispatch Health for in-home urgent care will soon need alternative solutions.

It is recommended that physicians update referral lists and care plans to ensure continuity of care. For further information on the discontinuation or ongoing services in Tucson, please visit the Dispatch Health website: https://www.dispatchhealth.com/

Banner – University Family Care Provider Manual Updates

- Verbiage updates regarding member rights
- Language revision in the "Prior Authorization Guidelines" section and the inclusion of new phone numbers

Update to Peer-to-Peer Communications Guidelines

A requesting provider may request a peer-to-peer discussion with the Health Plan Medical Director or Health Plan Pharmacist, however it can only be used to inform the provider of the reasons for the denial and to provide information needed by the requesting provider to determine whether to appeal the decision. The peer-to-peer cannot be used to overturn the initial service authorization denial. Any redetermination of the denial must be treated as an appeal and B – UFC must obtain member consent on the providers' behalf and accurately report appeal information to AHCCCS.

To request a peer-to-peer conversation call:

- Banner – University Family Care/ACC: 800-582-8686
- Banner – University Family Care/ALTCS: 833-318-4146
- Banner – University Family Care Behavioral Health: 800-582-8686
- Banner – University Family Care Pharmacy: 800-582-8686

United HealthCare Community & State (C&S) (UHCCP) 2025 Member Rewards Program

The United HealthCare C&S Member Rewards programs is an incentive program designed to influence members with gaps in care for specific targeted HEDIS measures. UHCCP is encouraging members to make an appointment with their providers to complete their checkups and/or screenings and providing them a reward for completing their preventive care/screenings.

The program focuses on the following HEDIS measures:

1. GSD-A1c Testing – applicable population is DD members only
2. BCS – Mammography – applicable population is ACC, DD and LTC
3. WCV – Well Child Visit – applicable population is ACC, DD and LTC

UHCCP members is reaching to their members via email, in either English or Spanish; if no email was on file, the members were mailed letters.

Members must complete their preventive care/screenings by December 31, 2025 to receive the reward.

Banner Health Network Nurse On Call

The Banner Health Network Nurse On Call (NOC) program operates 365 days a year with registered nurses available 24/7. The NOC is an extension of the Emergency Department experience and is licensed in every state where Banner operates. The call is toll-free at 888 -747-7990. Nurses assess conditions, provide recommendation or care advice, help connect callers with appropriate care needed, communicate with provider/specialist (call or via Cerner if applicable) and follow-up with ALL patients via phone. There is no charge to your patient for making this call.

Whether a parent has concerns regarding a child's fever, or a patient has questions about a prescription and/or needs guidance about visiting the emergency room or urgent care, NOC staff can help with immediate health care questions. This service is available exclusively to members of health plans that are served by the Banner Health Network; this service supports the care provided by the primary care physician offices. Call examples include, but are not limited to, fever, rash, rapid heartbeats, change in vision, inability to urinate, trouble with swallowing and post-op questions/concerns. Nurses, however, are unable to prescribe medications/treatments, diagnose, admit to the hospital or go against the triage guidelines. The staff at NOC uses Schmitt-Thompson Guidelines.

Stigma Speaks

The CDC defines stigma as the negative attitudes, beliefs, and stereotypes people may hold towards those who experience health conditions.

Stigma manifests in various forms that can significantly impede an individual's ability to receive appropriate health care. Structural stigma encompasses laws, regulations, or institutional policies that impose unjust limitations on individual rights. Public stigma occurs when individuals with health conditions encounter negative attitudes and discriminatory beliefs from health care providers or community members. Self-stigma refers to the internalized negative beliefs or attitudes that individuals may develop about themselves because of their health conditions.

When stigma escalates to discrimination, individuals living with health conditions may face adverse treatment. For instance, provider bias may prevent individuals with a history of substance use from receiving necessary pain management for legitimate medical conditions, despite their clinical need for such care.

Member Voice

We interviewed four Banner Member Advocacy Council Ambassadors to learn more about their experiences with stigma.

Question One: What does stigma mean to you?

- Raven: When I think of "stigma" I think of the overall negative stereotype of a group of people (and in this case) usually by person that may not know much on substance abuse, mental health issues, etc. The person who gets "stigmatized" can have tattoos, be homeless, have a history with drug abuse/mental health issues, and an unhealthy mouth/teeth.
- Wesley: Stigma means to me. When someone looks at you with a negative connotation, or label. Like judging a book by its cover. Or a person by the environment he/ she comes from. Or strictly based on their past experiences.
- Isabel: What stigma means to me, is to be judged and discriminated against due to my past circumstances."

- Jacqueline: Well, to me, stigma is basically just people passing judgment on what they don't know about. That may be because I don't look like you, or sound like you, or act like you, or do things the way you do. You look at me like there's something wrong with me.

Question Two: What does stigma look like to you?

- Raven: To me stigma includes being treated poorly, to be looked at sideways or with negative looks, being spoken to with complete disrespect or disregard for care. Basically, to be treated less than, like you don't even deserve the same love, respect, and compassion as others.
- Wesley: It doesn’t really have a certain look. I would say it’s more of a feeling you get when someone looks at you with disgust, or a side eye. They may whisper something under their breath. But you can hear it with their actions. Maybe a condescending remark. Or following you around in a store.
- Isabel: What does stigma look like to me? You are not taken seriously.
- Jacqueline: It looks like a lot of things, like making people not feel comfortable or wanted. This doesn’t make them want to accept or ask for help. I remember once, when I was working, this gentleman came in and he wanted a glass of water, but he was talking to himself, and he looked like he wasn't as clean. And I remember my boss saying that's scary. She asked what do you think? Is that scary? And I said yes, but it really didn't scare me. I went and got him his water. Since then, it made me look at myself. He didn’t scare me, but I said he did because she said it. Today I look at myself and am more aware of the stigma I experience and see others experience.

Question Three: Have you experienced or observed stigma related to mental illness or some other health condition?

- Raven: It's actually pretty sad for me to say how many times that I or someone close to me has fallen victim to stigma. In fact, and in just recent events, my fiancé was receiving dental care in a Marana Health facility. And the front desk lady would treat him like garbage when she'd see him walking in with tattoos and a bald head. Then one day he walked in with his "Marana Health" badge (because he was also a Marana employee) and all of a sudden, she treated him like gold. And that's just one instance, sadly I could go on all day with stories about doctors / health care workers, DCS workers, family members, and even people I pass by daily. All who have changed my life in a negative stereotype or stigma type of way.
- Wesley: I personally have never experienced this. But I have a cousin that suffers from mental illness, and she lived with me for 3 years. I have seen the way people take advantage of her, whether it be “friends’ or others, take advantage of her kindness and her inability to say no. Or stores or businesses thinking she doesn’t comprehend things when she does or not wanting to help her at all.

- Isabel: I have both experienced and observed others being stigmatized by health care and law enforcement and government agencies due to chemical dependency. How did stigma interfere with me getting health care? Due to my newborn being exposed to Methamphetamines, I was not offered any type of services, the nurses treated me coldly and did not attend to me. I was left on the delivery table after giving birth for about one hour with no one in the room with me. I was shivering from being cold. When someone finally came into the room, it was as though they had forgotten about me in the room. I also experienced watching my husband being denied pain medication due to being dependent on drugs over 10 years ago. He is no longer an active user and was stigmatized just last month after his appendix was removed and was given misinformation.
- Jacqueline: Absolutely! I have experienced stigma from a lot of doctors and other people in health care. Trying to tell me that the things I was experiencing weren't real even when my body was the evidence. Or when I was trying to get off of methadone and they kept telling me I couldn't and should go up on my dosing. They did not listen to me. Ultimately, I left there and detoxed all alone because, if they weren't going to help me, I was going to do it myself.

Question Four: What is one thing that you think can be done to end stigma?

- Raven: Unfortunately, I think there will always be stigma in some form or another. But education on mental health and substance abuse could be a start along with some conversation and communication to bring this topic to life! As long as it keeps getting ignored or the stories of stigma are unheard, it will only keep happening. As will the continued lack of help and empathy that's needed for one another in society.
- Wesley: I wish it was possible to end stigma in society. But I just believe that the way the world is, its dang near impossible. Although we can change some people's perception of others by educating them. People are usually just uncomfortable about the things they know nothing about or have limited experience in dealing with. I'm not going to lie before my cousin moved in with me. I didn't understand mental illness too much. I would tell her at first that the voices she was hearing was just her conscience, and everyone has that. All she had to do was just ignore the bad thoughts and not feed into them. But after spending a lot of time with her I could see that it is uncontrollable for her and made her very uncomfortable and nervous around people. Now I understand how real mental health is and how serious of a situation it can be. So, all I would say is just educating people that are willing to listen and learn more about it. And maybe recommend that they spend some time being around the affected people and their families. Maybe they would benefit and become more compassionate and connected with the world.
- Isabel: I feel that informing agencies with shared testimonies can help. I believe the story telling should be told by those who have experienced the stigma so that others can see that we are people, not just drug addicts. I believe it could change the hearts of the people in agencies so that they can provide more resources to those who are in need of the resources. The change it would or could bring would be that services are offered to people to address these issues. A compassionate heart is what motivates change. From

experience, when someone saw something in me that was good and planted a seed of compassion, that seed sprouted in due season.

- Jacqueline: Everybody should look at themselves. Nobody is perfect, we all have room to grow and improve. We have all had an issue with something and shouldn't point fingers at others in judgement. Storytelling can help too. If people were able to see into another's life, what it was like for them, they could learn to accept them.

Stigma Can Stop with Us

- Real-world experiences shared by participants reveal troubling patterns across multiple settings, particularly in healthcare where staff treated people differently based on appearance until discovering their employee status, or medical professionals dismissing a person's symptoms and treatment preferences. The participants also observed vulnerable populations, especially those with mental illness, being taken advantage of or facing assumptions about their cognitive abilities from law enforcement and government agencies.
- To combat stigma, participants suggest education about mental health and substance abuse, encouraging direct interaction with affected individuals and their families, sharing personal stories and testimonies, and promoting self-reflection to examine personal biases. While several acknowledge that completely eliminating stigma may be unrealistic, they believe meaningful progress is possible through these targeted efforts. The responses highlight how stigma operates systemically across healthcare, social services, and everyday interactions, ultimately preventing people from seeking help and receiving the respect and compassion they deserve.

Banner Plans & Networks "Call Me First" ED Reduction Pilot

Unnecessary Emergency Department visits create a strain on health care resources. Many conditions, which are seen by the ED, could be treated in a primary care or urgent care setting.

Reasons why patients go to the ED instead of a lower level of care vary, but research shows many patients don't know where to go for their condition, don't "want to bother" their primary care doctor or think their doctor might be too busy. The BPN "Call Me First" pilot aims to help patients get the right care at the right time.

PCP pilot offices were supplied vinyl card holders with the message "Before you go to the ED, call your PCP" and the Banner Health Network Nurse On Call 24-hour advice phone number. The holder also includes a "Choosing the right care at the right time" card, which helps guide patients if their need is a true emergency. There is also space for the primary care office to put their business card.

Thus far, the response from offices and patients has been positive. The patients like knowing that their PCP is there for them, even after hours or when they can't get an immediate appointment.

If your office is interested in participating in the "Call Me First" program next year, please email Krista.Schaeffer@BannerHealth.com.

Resources for Refugees

Safe Healing and Learning Spaces Toolkit by IRC

A Safe Healing and Learning Space (SHLS) is a secure, caring, and predictable place where children and adolescents living in conflict and crisis settings can learn, develop, and be protected. The SHLS Toolkit (https://tinyurl.com/f6wm3xep) provides child protection and education practitioners with all of the content needed to initiate an SHLS program.

After a Crisis: Helping Young Children Heal by the National Child Traumatic Stress Network

NCTSN Parent and caregiver handout (https://tinyurl.com/4j987dvh) offering tips to help young children, toddlers, and preschoolers heal after traumatic events. Available in English, Spanish, Dari, Pashto, Ukrainian, Russian, Arabic, Hebrew, and many other languages.

Talking to Children When Scary Things Happen by the National Child Traumatic Stress Network

NCTSN fact sheet (https://tinyurl.com/5n7arr8n) offering guidance on how to talk to children and youth when scary things happen. Also available in Spanish.

Trauma-informed Care, Tools, and Treatment Strategies for Afghan Refugee Children by Minnesota's Center of Excellence in Newcomer Health

(https://tinyurl.com/3mjpsnne)

This report is designed as an introduction to a child rights approach to trauma-informed care for Afghan refugee children and youth. It provides an overview of the trauma experienced by these families as they begin their readjustment to Minnesota and the United States. In addition, it introduces the various emotional and behavioral issues that may arise, as well as therapeutic approaches that have been used with this population. Included are appendices with a number of the screenings and assessment tools that have been tested and validated with this population of children. Versions have been provided in English and, where available, in Dari and Pashto.

Oral Health Resources by Various Organizations

For clinicians: CDC: Domestic Refugee Screening Guidance: Oral Health (https://tinyurl.com/bdcjdhmf)

For newcomers: The MN COE Newcomer Education for Wellness (NEW) video series (https://tinyurl.com/yfks56y3) includes an oral health educational video offered in 11 languages.

Recent oral health publications: Harnessing technology to enhance oral health literacy among Afghan women: an interprofessional community-engaged initiative (https://tinyurl.com/yzcmj7s5) and The Oral Health Disparity Among Refugee Children: A Systematic Review. (https://tinyurl.com/bdfd4eds).

Annual Model of Care Training Requirement for all Banner Medicare Advantage Dual HMO D-SNP Providers

The Model of Care Training and Attestation is ***required annually*** **every calendar year**. We strongly encourage you to complete the training and submit the attestation as soon as possible! By doing so, you will be better equipped to implement the content and incorporate the requirement into the care you provide.

All new providers joining your group should attest **within 60 days of hire**.

Contracted providers, Subcontractors, and Non-participating providers with ***Banner Dual*** are required to complete the Annual Model of Care Training and submit the Attestation per CMS.

This training and attestation take a minimal amount of time to complete (approximately 30 minutes).

Instructions:

1. Review the training content located here: https://tinyurl.com/3f2n38zz.
2. Complete the ***Annual Attestation***: https://tinyurl.com/mvr48htx.

*When completing your online attestation, please ensure you are documenting each practitioner's *individual NPI* on the attestation form.

Advanced Directives

- The law requires doctor and health care facilities to inform patients, in writing, of the patients' right to create "Advance Directives" relating to their medical care.
- Advanced Directives are used to allow patients to make medical decisions about themselves should they no longer be able to do so.
- The two most common Advanced Directives are the **Living Will** and the **Durable Power of Attorney**. The Living Will gives information about whether patients want or don't want life sustaining procedures if they have a condition that cannot be cured or improved. A Medical Power of Attorney allows a patient to name a person they trust to decide what type of treatment you will receive if you are unable to decide for yourself.
    - These forms can be found at two state approved websites:
        - **Arizona Attorney General's Office - Life Care Planning** - www.azag.gov
        - **Arizona Healthcare Directives Registry -** Arizona Healthcare Directives Registry (https://azhdr.org/)
- Even though a patient has made Advanced Directives, a PCP may still choose whether to follow a patient's wishes.
- A patient cannot be denied care without these documents, but without written instructions, a judge may have to make a personal and medical decision for a patient. A patient may ask a PCP to make the Advance Directive a part of their medical record.

Appointment Availability Standards Requirement

The Appointment Availability Standards are important to ensure Medicaid and Medicare members receive access to care timely. **It is important to share these requirements with your scheduling team and office staff.**

You can find the applicable Appointment Availability Standards in the Provider Manuals below as well as the AHCCCS website here: https://tinyurl.com/ycxf2u3s

- **ACC and ALTCS:** Banner – University Family Care Provider Manual
- **Banner Dual:** Banner Medicare Advantage Provider Manual

We would also like you to be aware that participation in the telephone surveys is **required** and conducted on a semi-annual basis by Contact One. Contact One is the vendor used to complete the surveys, who will identify themselves when calling your office. Failure to comply could result in a resurvey and/or a Corrective Action Plan (CAP).

Should you have any questions, please reach out to your Care Transformation Consultant or Specialist.

Translation and Interpretation Services

Banner University Health Plans provides language interpretive services and translation assistance at no-cost.

If a member cannot speak with us or one of our health plan providers because of a language barrier, please contact our Customer Care Center at least *5 working days* prior to the member's office visit.

- Customer Care Center hours of operation: Monday – Friday, from 7:30 a.m. to 5 p.m.
- Provide the representative with the member's AHCCCS ID number and the nature of the interpretation services required.
- You will be placed on hold while the representative connects you with the interpretation services.
- **Customer Care Center phone numbers:**
    - Banner – University Family Care/ACC: 800-582-8686, TTY 711
    - Banner – University Family Care/ALTCS: 833-318-4146, TTY 711
    - Banner Medicare Advantage Dual HMO D-SNP: 877-874-3930, TTY 711

Compliance Corner

Cybersecurity in Health Care and the Improper Use Of Artificial Intelligence (AI)

The Healthcare Industry is a targeted area for cybercriminals. Use of insider threats, ransomware, phishing, AI-driven attacks can result in not only financial loss but interference to systems and the delivery of care and can ultimately put the safety of members and outcomes at risk. They are targets due to their dependency on technology, their size, and the use of protected health information.

The internet and use of online systems has increased from 1,023 in 2005 to 5,500 in 2024 (users in millions) and is expected to reach 7.9 billion users by 2029. The specific type of info these criminals target includes credentials used for logging in, vendor and customer data, protected health information, other types of person information including any identifying targets such as names, dates of birth, social security numbers, addresses, banking or other finance information and other classified/sensitive data.

For Ransomware attacks the average payment for the second quarter of 2025 was approximately $1,130,070. The Internet Crime Complaint Center received reports of $16.6 Billion total losses in 2024 which rose approximately 33% from 2023.

Use of AI in the healthcare setting requires additional safeguards and care to reduce risk of HIPAA violations. It is important to validate that AI-powered chatbots, tools for transcription, and other types of technology resources are compliant with HIPAA and if not, it could result in legal consequences. There have been recent cases where lawyers are involved in lawsuits against healthcare companies and AI vendors. The lawsuits focus on violations of privacy due to improper handling of Protected Health Information (PHI) when using artificial intelligence.

Putting any proprietary, confidential, or PHI information into a chatbot could result in the information becoming public or retained by the chatbot to enhance their algorithms, if not appropriately vetted.

Organizations must train their workforce appropriately on the use of AI and how to watch for scams and schemes such as phishing to enable unauthorized use of their data. Healthcare organizations should establish an AI Governance and provide real examples to employees in trainings.

If You Identify or Suspect FWA or Non-Compliance Issues

Immediately notify the Banner Plans and Networks Compliance Department:

24- hour hotline (confidential and anonymous reporting): 888-747-7989

- Email: BHPCompliance@BannerHealth.com
- Secure Fax: 520-874-7072
- Compliance Department Mail:
  Banner Plans & Networks Compliance Department
  5255 E Williams Circle, Ste 2050
  Tucson, AZ 85711
- Contact the Medicaid Compliance Officer via phone 520-874-2847 (office) or 520-548-7862 (cell).
- Contact the Medicare Compliance Officer via phone 213-248-2980 or email BMAComplianceOfficer@BannerHealth.com

Banner Plans & Networks Customer Care Center Contact Information

- Banner – University Family Care/ACC: 800-582-8686, TTY 711
- Banner – University Family Care/ALTCS: 833-318-4146, TTY 711
- Banner Medicare Advantage Dual HMO D-SNP: 877-874-3930, TTY 711
- Banner Medicare Advantage Prime HMO: 844-549-1857, TTY 711

AHCCCS Office of the Inspector General

Providers are required to report any suspected FWA directly to AHCCCS OIG:

Provider Fraud:

- In Arizona: 602-417-4045
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686
- Website - https://www.azahcccs.gov (select Fraud Prevention)

Mail:

Inspector General
801 E Jefferson St.
MD 4500
Phoenix, AZ 85034

Member Fraud:

- In Arizona: 602-417-4193
- Toll Free Outside of Arizona Only: 888-ITS-NOT-OK or 888-487-6686

Medicare

Providers are required to report all suspected fraud, waste, and abuse to the Banner Medicare Advantage Compliance Department or to Medicare

- Phone: 800-HHS-TIPS (800-447-8477)
- FAX: 800-223-8164

Mail:

US Department of Health & Human Services
Office of the Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington, DC 20026

ACC/ALTCS Members

It is the policy of Banner – University Family Care (B – UFC) to make certain that the organization and its providers have the necessary information to ensure that all **Incidents, Accidents, and Deaths (IADs) are reported timely to the health plan per AHCCCS MEDICAL POLICY MANUAL (AMPM) 961.**

Incident, accident, and death (IAD) reporting

B – UFC Contracted Providers shall ensure reportable **IADs** are submitted via the AHCCCS QM Portal **within two business days** of the occurrence or notification of the occurrence. **Sentinel IADs** shall be submitted by the Provider into the AHCCCS QM Portal **within one business day** of the occurrence or becoming aware of the occurrence. Please refer to the **AHCCCS MEDICAL POLICY MANUAL (AMPM) 961**-for specific reportable incidents and time frames for reporting.

All providers shall register an account in the AHCCCS QM Portal within 30 days of becoming an AHCCCS registered provider. For new user registration to the AHCCCS QM Portal go to https://qmportal.azahcccs.gov and click on Create New Account link.

We encourage all B-UHP Providers to reach out for any questions, or if you would like the health plan to arrange technical assistance, regarding submission of IAD reports by **Email to:** BUHPRequests@BannerHealth.com.

Skilled nursing facilities (SNF's), subacute and post acute rehabilitation incidents reporting requirements

It is the policy of Banner – University Family Care (B – UFC) to make certain that the organization and its providers have the necessary information to ensure that all **Incidents, Accidents, and Deaths (IADs) are reported timely to the health plan.**

B – UFC Providers shall ensure reportable IADs are submitted via the AHCCCS QM Portal **within 48 hours** of the occurrence or notification to the provider of the occurrence. Sentinel IADs shall be submitted by the Provider into the AHCCCS QM Portal **within 24 hours** of the occurrence or becoming aware of the occurrence.

Please refer to the **AHCCCS MEDICAL POLICY MANUAL 961**- **INCIDENT, ACCIDENT, AND DEATH (IAD) REPORTING *AMPM Policy 961*** for specific reportable incidents and time frames for reporting.

All providers shall register an account in the AHCCCS QM Portal within 30 days of becoming an AHCCCS registered provider. For new user registration to the AHCCCS QM Portal go to https://qmportal.azahcccs.gov and click on Create New Account link.

We encourage all B – UFC SNF, SUBACUTE AND POST ACUTE Providers to reach out for any questions, or if you would like the health plan to arrange technical assistance, regarding submission of IAD reports by Email to: BUHPRequests@BannerHealth.com.

ACC/ALTCS Behavioral Health Services

Technical assist available for seclusion and restraint (SAR) reporting requirements

It is the policy of Banner – University Family Care (B – UFC) to make certain that the organization and its providers have the necessary information to ensure **Behavioral Health Inpatient Facilities (BHIFs) and Mental Health Agencies (MHAs) authorized to conduct Seclusion and Restraint report to the proper authorities as well as the Health Plan all Seclusion and Restraints of plan members.** The use of seclusion and restraint can be a high-risk behavioral health intervention; facilities should only implement these interventions when less restrictive approaches have failed. **The Health Plan requires BHIFs and MHAs to submit each individual report of incidents of Seclusion and Restraint to the Plan within (5) five business days of the incident utilizing AHCCCS Seclusion and Restraint Individual Reporting Form (Attachment A) or the agency's electronic medical record that includes all elements listed on Attachment A.**

https://tinyurl.com/spmb7ys5

Please submit the completed form to B – UFC: Email: BUHPRequests@BannerHealth.com. or Fax: 520-874-3567.

Providers are required to submit a separate **Incident/Accident/Death (IAD) report for Seclusion and/or Restraints resulting in an injury to the member**, to the Health Plan and to the AHCCCS Quality Management (QM) Team. Contracted BHIFs and MHAs licensed to conduct Seclusion and Restraints must submit these IADs to the AHCCCS QM Portal **within 24 hours** of becoming aware of the incident.

All Reporting requirements are specified in the B – UFC Behavioral Health Provider Manual at: https://tinyurl.com/5d6xfrrb, based upon **AHCCCS MEDICAL POLICY MANUAL (AMPM) 962.**

We encourage all B – UFC Providers to reach out for any questions, or if you would like the health plan to arrange technical assistance, regarding submission of SAR and/or IAD reports by Email to: BUHPRequests@BannerHealth.com.

Discharge hour on 21x final bills

This is a long standing NUBC guideline that is now being enforced by AHCCCS. Skilled Nursing Providers should be following the UB04 NUBC guidelines for final claims as noted below. It is not our intention at this time to recoup any claims already adjudicated by AHCCCS as Encounters (i.e. we don't intend to data mine for this issue and initiate wide recoupments). All claims that have been recouped, due to encounter pends/rejections, will require clean claim submissions.

We received the following from AHCCCS from the NUBC manual for UB04 2025.

FL16 – Discharge Hour Usage note in 005010 837: Required on all inpatient claims	Required on all **final** inpatient claims ("IP") ***except*** for 021x. This includes claims with a Frequency Code of 1 (Admit through Discharge, 4 (Interim – Last Claim) and 7 (Replacement of Prior Claim) ***when the replacement is for a prior final claim.***

Looking for more terminology and FAQ's? Please visit any of the links listed below to download infographics on Title 36 Court Ordered Evaluation (COE) and Court Ordered Treatment (COT), available in English and Spanish.

Quick Links:

Banner Provider Website https://tinyurl.com/2pcc6nc9

Member Portal (ACC) https://tinyurl.com/32ufymtv

Member Portal (ALTCS) https://tinyurl.com/mw43et5x

Member Experience (MX)

The Member Experience (MX) Team is here to support you in providing an exceptional experience to your patients. Our team has several tools and resources that can support in improvement in CAHPS and HOS related measures. If you would like additional information on any of the MX tools or have questions for our team, we are happy to help! Please reach out to your dedicated Member Experience (MX) Sr. Advisor or email us at BPNMemberExperienceTeam@BannerHealth.com!

Annual Wellness Visits

Annual Wellness Visits can set the tone for the patients' care over the year. Wellness visits can help build trust between the patient and the provider, resulting in the patient understanding when they may need to see a different provider or wait for the provider of their choice. The Let's Talk Questionnaire is a great resource to use during this visit! Reach out to your MX Sr. Advisor if you would like a copy of the Let's Talk Questionnaire.

Title 36 Court Order Terms and Resources

The Title 36 Court Orders system can be a mystery for individuals and providers who are not familiar with the processes and terminology. The table below introduces the terms used in the Title 36 Court Order system.

Core Orders	
Court Ordered Evaluation (COE)	Court-mandated mental health evaluation, conducted inpatient or outpatient
Court Ordered Treatment (COT)	Court-mandated behavioral health treatment (typically inpatient + outpatient) lasting up to one year
Modifications:	
Amendment/Revocation/Rescission	Court order returning a patient from outpatient to inpatient treatment due to non-compliance or worsening symptoms. Can be emergent or non-emergent
Toll Order	Court order "pausing" the time on a COT when a patient cannot be located and is not engaging in treatment. Lifted when patient is found and re-engaged (if <180 days)
Key Documents	
Outpatient Treatment Plan	Document outlining compliance conditions and non-compliance consequences
Minute Entry/Minute Entry Order (ME/MEO):	Official court record summarizing hearing proceedings, findings, and rulings
Patient Rights	
Judicial Review (JR)	An individual under COT may request case review by a judge, every 60 days. The outpatient provider must offer/remind a member of this right and their right to consult with their attorney.
Miscellaneous	
Guardian ad Litem (GAL)	"Best interests" attorney who advises the court on what is best for the patient's health and well-being (differs from defense attorney who advocates for client's wishes)

Arizona Disability Benefits 101 (DB101): An AHCCCS Compliance Requirement

Do you have a member who is hesitant to work because they fear losing their benefits?

AZ DB101 is an online tool that helps members make informed choices about working while receiving benefits. It also supports providers in giving accurate, up-to-date information. On one website, members can:

- Understand how working impacts benefits
- Learn about programs that can help them work
- Explore health coverage and education options

Visit https://az.db101.org today!

AHCCCS requirements

All provider employment staff must utilize AZ DB101 and document its use in the member's file. This includes:

- Create and maintain a professional profile
- Assisting members in creating their own account
- Completing estimator sessions with members
- Using DB101 results to help members access AHCCCS and/or Social Security Work Incentives

Documenting these activities in the member's record is **mandatory** to ensure compliance with AHCCCS standards and support employment goals.

AZ DB101 for Professionals Trainings are free and available throughout the year. For more information or training on using DB101, contact Sara Hernandez at Sara.Hernandez@BannerHealth.com or visit https://wid.org.

Why this matters

This requirement aligns with the Employment First Principals under AHCCCS, ensuring members receive accurate information about how work impacts benefits and have access to tools that reduce fear of losing essential supports.

Physical Health Best Practice Guidelines

By Sheena Sharma, MD, Medical Director

Banner Plans & Networks has devised a set of Physical Health Best Practice Guidelines that are founded in the most current evidenced-based literature. The guidelines are member-centric, population outcome-based, and focused on quality improvement. Primary care physicians, specialists and other health care providers are expected to utilize these Best Practice Guidelines to achieve excellence in patient care and service delivery. These guidelines will be disseminated widely, and their implementation will be monitored on an

ongoing basis. We have recently presented on Obstructive Sleep Apnea with pertinent information being discussed including the most up-to-date diagnosis and treatment options. Guidelines from the *American Academy of Sleep Medicine* published in 2017 were utilized.

Additional information and resources on best practice guidelines are available on the Medical Necessity Criteria & Clinical Practice Guidelines webpage: https://tinyurl.com/3nvk2b62.

We welcome any feedback regarding the adoption of the Obstructive Sleep Apnea Best Practice Guidelines for BPN. Feel free to contact me via email at Sheena.Sharma@BannerHealth.com with any questions or concerns.

Practitioner's Rights

Every practitioner going through the initial credentialing and recredentialing process has the right to:

1. Review of information submitted to support credentialing application. In the verification process, if any discrepancies are found in the information provided by a practitioner, the Credentialing Specialist contacts the practitioner by phone or in writing to validate the correct information. The Credentialing Specialist must notify the practitioner if there is a substantial variation in information regarding actions on licenses, malpractice claims history or board certification. The practitioner may not review references or recommendations or other information that is peer review protected, and the Credentialing Department is not required to reveal the source of information if law prohibits disclosure.
2. Correct any erroneous information in their credentialing application by phone or in writing, prior to the Credentialing Committee meeting date. The practitioner is also notified by email or phone of the deadline for submitting the corrections. The notification includes the following:
    a. Erroneous information must be corrected within seven calendar days
    b. Submission of corrections must be in the correct format
    c. Corrections must be submitted to the Credentialing Specialist
    d. Receipt of the corrections is documented
    e. Receive the status of his or her credentialing or recredentialing application
    f. Receive notification of these rights

Banner MD Anderson begins Phase II study on Unique Glioblastoma Immunotherapy

Study aims to use first-of-its-kind, personalized immunotherapy on brain tumors

Banner MD Anderson Cancer Center has opened enrollment for a Phase II clinical trial for a first-of-its-kind, double-loaded autologous dendritic cell therapy for the treatment of patients with glioblastoma.

Despite decades of research, glioblastoma remains a complex cancer for patients and physicians alike, with median survival of 14-16 months after diagnosis. Now experts are studying a cell therapy at Banner MD Anderson that represents a novel strategy for engaging a complete immune response against a patient's cancer.

"Most research on glioblastoma therapeutics have focused on common single targets, but everyone's tumor is different. So, we aimed to make a personalized therapeutic for each patient based on their tumor, which teaches their body's immune system to target the full compliment of tumor antigens," said neurosurgeon Joseph Georges, DO, PhD, of Banner MD Anderson.

Dr. Georges has worked for a decade with immunologist William Decker, PhD, of Baylor College of Medicine in Houston and Diakonos Oncology on the development of personalized immunotherapies for the treatment of glioblastoma. Neuroncologist Ramya Tadipatri, MD, of Banner MD Anderson will lead this study on the cell-based immunotheraputic DOC1021, also known as Dubodencel.

This study follows a Phase I trial with this approach for glioblastoma. In the first phase, personalized therapeutics were created by removing a piece of a patient's tumor via surgery. After receiving the standard of care, the patient received three doses of activated immune cells over a six-week period. Phase I findings demonstrated a favorable safety profile and encouraging signs of efficacy, with a 12-month overall survival rate of 88% -- substantially higher than the approximate 60% typically seen with standard of care. Notably, four patients remain alive at 22 to 33 months of follow-up.

Phase II will take two to three years, with plans for following up on each patient long after the trial. There has been a strong demand by many hospital systems to participate in this trial. Twenty sites around the country have been selected to start enrolling for Phase II. After a certain number of patients have enrolled, this can be rolled into a Phase III trial.

"We are delighted to offer access to this cutting-edge clinical trial in our community that may provide a new treatment option for patients with glioblastoma," said Nicholas Theodore, MD, MS, chairman of the University of Arizona College of Medicine – Phoenix's department of neurosurgery at Banner – University Medical Center Phoenix, which is one of the enrolling sites for Banner.

Dr. Decker praised the participation of Banner MD Anderson noting, "We're extremely fortunate to have garnered interest from such an expert and high volume center like Banner."

Mike Wicks, chief executive officer of Diakonos Oncology, added, "We're proud to partner with Banner MD Anderson, an institution known for clinical excellence and innovation, and grateful for the vision of Dr. Georges and Dr. Decker, and the dedication of our passionate team at Diakonos Oncology. As a cancer survivor, I'm inspired by the potential of this personalized immunotherapy to change outcomes for glioblastoma patients."

Most newly diagnosed glioblastoma patients are eligible to participate in the trial, said Dr. Georges, who is also an assistant professor of neurosurgery at the U of A College of Medicine – Phoenix. To learn more, visit https://tinyurl.com/24hyfdnc.

FQHC/RHC Billing for Secondary

AHCCCS has specific guidance for billing as secondary in the FFS Provider Manual, Chapter 10 addendum. Although not all provisions in the FFS manual apply to MCOs, this is also a policy requirement for Banner AHCCCS lines of business. Please ensure you are billing according to this guidance.

AHCCCS
Arizona Health Care Cost Containment System

FEE-FOR-SERVICE PROVIDER BILLING MANUAL

CHAPTER 10 ADDENDUM - FQHC/RHC

FFS Billing Instructions with a Primary Payer

When Medicare is primary payer

Crossover claims are received electronically from the Medicare plan with Medicare's specified coding, which will not match to AHCCCS coding requirements.

The FQHC/RHC provider must first void the crossover claim and then submit on a 1500 claim form with the AHCCCS specified coding and include a copy of the EOMB.

On the 1500 claim form Medicare's deductible/coinsurance/copay **total** amounts ***must*** be reported on the T1015 claim line for reimbursement in the correct Medicare fields. The appropriate EM codes must be billed on successive lines with 0.00 billed amounts, while leaving the Medicare fields blank (do **not** enter 0's).

If the Medicare claim did not crossover, the FQHC/RHC must submit the claim with the EOMB, even though the codes billed will not match the EOMB. **The Medicare deductible/coinsurance/copay *total* amounts *must* be reported on the T1015 service line, in the correct Medicare fields, for reimbursement. The appropriate EM**

codes must be billed on successive lines with 0.00 billed amounts, leaving the Medicare deductible/coinsurance/copay fields blank (do *not* enter 0's.)

When other coverage paid as primary

The full other coverage *paid* by the other primary payer will be associated with the T1015 service line only.

The appropriate EM codes must be billed on successive lines with 0.00 billed amounrs. A copy of the primary payer's EOB must be included with the claim. Since AHCCCS specifies the T1015 coding,t he billing and the EOB coding will not match.

Box 19 population for FQHC/RHC, Provider types IC, 77 and 05

Guidelines for populating the participating provider information in Box 19 can be found in the AHCCCS FFS Provider Manual Chapter 10 Addendum FQHC/RHC and Chapter 10 Exhibit 10-1 (https://tinyurl.com/37wc5rau) for provider types IC, 77, 05. Please review for correct billing of participating provider information.

- One Participating/Performing Provider – XXNPI Provider Name (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first, 20 characters)
- Two Participating/Performing Providers – XXNPI ProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider (last, first, 20 characters) 3 blanks XXNPIProviderName (NPI if a registerable Provider) or 9999999999ProviderName (no NPI if not a registerable Provider) (last, first, 20 characters)

Points to remember

- Participating provider NPI/name cannot be the same as the Rendering or the Billing NPI/name
- Atypical providers cannot bill 9xxxx codes except 97151-97156
- If billing POS 03, the school code needs to be included in box 19 as a data element. School codes may be found on the Medical Coding Resources page in the Coding Related Exhibits and Policy Reference link (https://tinyurl.com/pxhrarye).

Example

One Participating/Performing Provider –

0BNNNNNNNNNN XXNPI/Provider Name

OR

XXNPI/Provider Name 0BNNNNNNNNNN

Traditional Healing Services Approved for AHCCCS Members

The Arizona Health Care Cost Containment System (AHCCCS) announced the launch of Medicaid-covered Traditional Healing services beginning October 1, 2025. Traditional Healing is a system of care deeply rooted in the cultural traditions of Tribal communities and passed down through generations of Tribal healers and knowledge keepers. These practices include physical, mental, emotional, and spiritual wellness and may now be reimbursed under Arizona's Medicaid program through a federally approved Section 1115 waiver.

Under the new policy:

- Traditional Healing services may be provided in both inpatient and outpatient settings.
- Services must be delivered by practitioners employed or contracted by Indian Health Service (IHS) or Tribal 638 facilities.
- Each facility, in partnership with its Tribal community, defines the scope of services eligible for reimbursement.
- Services are billable under specific codes and subject to encounter limits consistent with Medicaid guidelines.

For additional information about traditional healing services or this new policy reach out to Associate Director, Tribal Coordination Kimberly.Yellowrobe@BannerHealth.com.

Skilled Nursing Facility (SNF) audit announcement

Banner Plans & Networks (BPN) is currently conducting annual skilled nursing facility audits from October to December 2025. This is to ensure that our members continue to receive the quality care they need in a safe environment.

This audit is comprised of three sections: personnel review, medical record review, and an on-site inspection. The on-site visit will include a facility inspection that will assess general areas of health and safety. The medical record review will evaluate documentation pertaining to patient assessment and care planning, admission documentation, medication administration, as well as patient condition monitoring areas. The personnel file review will focus on required training, credentials, and skill verification. Both the personnel and medical record reviews will be conducted remotely.

SNF directors will receive notices at least two weeks prior to the scheduled audit. Please respond to audit notices in a timely manner due to the audit time frame noted above. It is helpful to have staff available to set up the audit, provide access to medical records, and answer questions.

Thank you for helping our members get the quality care they deserve.

AHCCCS Medical Policy Manual (AMPM) Updates

Several AHCCCS Medical Policy Manual (AMPM) policies were updated and went into effect on 10/1/25. B – UFC encourages providers to review and become familiar with the AMPM sections that pertain to their lines of business. Recently updated AMPM sections include:

- AMPM 320 X Adult Behavioral Health Therapeutic Homes
- 320 T1 Block Grants and Discretionary Grants
- 320 T2 Non-Title XIX XXI Services and Funding
- 320 W Therapeutic Foster Care for Children
- 550 Serious Emotional Disturbance for Children
- 582 Support and Rehabilitation Services for Children, Adolescents and Young Adults
- 570 Provider Case Management

If you have questions about what was updated in the new policy, refer to the AMPM Revision Memos https://tinyurl.com/yasn8aky.

If you have any questions, please contact the Adult System of Care team at ASOC@BannerHealth.com or the Children's System of Care Team at CSOC@BannerHealth.com.

Behavioral Health Intervention and Suicide Prevention for Older Adults

As the proportion of aging adults increases, so does the urgency to address the unique behavioral health needs of this population. Suicide rates among adults aged sixty-five and older are disproportionately high, with older men—especially those over 85—facing the greatest risk. Providers play a pivotal role in recognizing, responding to, and preventing mental health crises among aging adults.

Aging adults often face complex challenges that elevate suicide risk, these challenges include:

- Depression and anxiety often underdiagnosed or misattributed to aging.
- Social isolation, especially following the loss of a spouse or close friends.
- Chronic illness and pain, which can lead to feelings of hopelessness.
- Cognitive decline, including dementia, which may impair judgment and increase impulsivity.
- Access to lethal means, such as firearms, which are more commonly used in older adult suicides.

There are a variety of best practices that address the complex needs of this population, including:

- Routine Screening and Assessment
  Incorporate validated tools like the PHQ-9 and GAD-7 during visits/appointments.
  Screen for depression, anxiety, substance use, and suicidal ideation regularly.
- Integrated Behavioral Health Models
- Evidence-Based Interventions and Programs:
  - Healthy IDEAS: A depression self-management program.
  - PEARLS: Problem-solving therapy delivered in-home.
  - SBIRT: Screening and brief intervention for substance use.
  - WRAP®: Wellness Recovery Action Plan for illness self-management.
- Provider Education and Training in geriatric mental health, suicide prevention, and postvention strategies.
- Culturally Appropriate and Equitable Care that addresses disparities in access and outcomes among older adults from diverse backgrounds.

Depending on the needs of the individual and community, suicide prevention strategies could include:

- Universal Prevention: The promotion of mental wellness through community education, social engagement programs, and stigma reduction.
- Selective Prevention: Targeting high-risk groups such as recently bereaved individuals, those with chronic illness, or those living alone.
- Indicated Prevention: Provision of intensive support for individuals showing signs of suicidal ideation or behavior.

Expanding Care for Autism Through Behavioral Health Services

Behavioral health services offer important support for individuals and families living with autism. While some might benefit from specialized treatment such as Applied behavior Analysis (ABA), other options such as family support, skills training, individual or family therapy and psychiatric care can also make a meaningful difference. These services help promote emotional well-being, communication, and balance at home and in the community. Expanding access to a full range of behavioral health services helps ensure that every member and family have the tools they need to thrive.

For more information on behavioral health services that are available to individuals and families living with autism, visit: https://tinyurl.com/k5f3tp22.

As a reminder, secret shopper calls will take place throughout the year to ensure the accuracy of provider information and the quality of member experience. For questions, updates or to be added to the directory, please contact Children's System of Care at CSOC@BannerHealth.com.

DUGless Required for SED Identification Process

Banner Health is proud to support our providers in delivering coordinated, high-quality care. One key tool in that effort is the AHCCCS DUGless form. This form helps capture essential member demographic and outcome data—including Social Determinants of Health (SDOH)—which play a critical role in shaping health outcomes.

By keeping the DUGless up to date, providers help drive smarter care management, track service utilization, and identify health disparities across our communities. Timely and accurate submission also ensures we stay aligned with AHCCCS requirements and contribute to system-wide quality improvement.

A reminder the DUGless is required to complete the new SED process. This new process went into effect October 1, 2025.

Banner Health encourages all service providers to regularly review member demographics and update the DUGless portal when appropriate. Your efforts make a meaningful difference!

Information about the DUGless can be found on the AHCCCS website or on the DUGless Portal Guide, https://tinyurl.com/msfz8wvt. If you have any questions, please contact the Adult System of Care team at ASOC@BannerHealth.com or the Children's System of Care Team at CSOC@BannerHealth.com.

Supporting Military Families and Children

Clinical Guidance for Behavioral Health Providers

Military families face unique psychological challenges that require specialized clinical understanding and intervention approaches. The phenomenon known as "Military Families Syndrome," first identified during the Vietnam War, continues to significantly impact children and families in military communities today.

Key Clinical Findings

Prevalence and Impact:

- Approximately **30% of military children** experience significant difficulties related to parental deployment
- Higher rates of anxiety, depression, and academic decline compared to civilian populations
- Increased risk of substance misuse and behavioral problems

Primary Presentations:

- Separation anxiety disorders
- Sleep disturbances and somatic complaints
- Academic performance deterioration
- Behavioral regression or acting out

Critical Risk Factors

Compounding Variables:

- Parental PTSD, depression, or traumatic brain injury upon return
- Multiple, back-to-back deployments creating chronic instability
- Personality changes in returning parents
- Disrupted family dynamics and support systems

Clinical Recommendations

Immediate Actions:

- **Prioritize Mental Health Screening** - Implement routine assessments for military-connected families
- **Enhance Resilience Education** - Integrate coping strategies and psychoeducation into treatment plans
- **Utilize Specialized Resources** - Connect families with veteran-specific programs and support networks

Treatment Considerations:

- Address both child and family system dynamics
- Incorporate trauma-informed care principles
- Consider the cyclical nature of deployment-related stress
- Facilitate peer support connections with other military families

Available Resources

Key Organizations:

- Zero to Three www.zerotothree.org - Early childhood military family support
- TAPS – www.TAPS.org Suicide prevention and postvention services
- NIMH – www.NIMH.NIH.gov ADHD and related behavioral health resources
- Veteran-specific nonprofit organizations

Next Steps

All providers are encouraged to:

- Review current caseloads for military-connected families
- Enhance clinical knowledge through military family-focused training
- Establish referral pathways to specialized military family services
- Collaborate with community veteran support networks

Where to Get Help: Educate Individuals & Families

Don't wait to ask for support:

- Family Readiness Groups in your unit
- Base family support centers
- Military OneSource (24/7 support)1-800-342-9647
- Military Crisis Line: 1-800-273-8255
- Rally Point Arizona: Hotline: 1-855-RALLY4U (725-5948)
- Be Connected: 1-866-4AZ-VETS (429-8387)
- 211 Arizona: Dial 2-1-1 within Arizona
  Dial 877-211-8661 from anywhere

Telehealth Policy Changes Following Government Shutdown

Important Update for Health Care Providers: Medicare Fee-For-Service and Medicare Advantage Effective 10/01/2025

Due to the government shutdown, effective October 1, 2025, telehealth services for Medicare Fee-For-Service (FFS) patients are now limited to those in rural areas and patients receiving behavioral health services. (Medicare requires that new mental health patients receive an in-person visit within six months of their first telehealth encounter with at least one in-person visit annually thereafter.)

Patients attributed to Banner Health Network's (BHN) MSSP ACO primary care providers are exempt from these restrictions and may continue telehealth visits as before. Health care providers must also note that Medicare Advantage plans will set their own telehealth coverage policies, so checking each patient's plan status is vital when verifying eligibility.

To ensure compliance, health care providers should review their patient panels and scheduling protocols to identify who is affected by the new regulations. Confirm patient eligibility under the revised rules—including rural status, behavioral health needs, ACO attribution, or Medicare Advantage policies—before conducting telehealth visits.

AMPM 570: Provider Case Management Update

The System of Care team would like to inform our contracted providers that the previously published version of AMPM 570, effective 10/1/2025, has been WITHDRAWN as of 10/29/2025.

The prior AMPM 570 version from 2/12/2024 has been reinstated with revisions to the Contractor Reporting requirements.

Please review the updated policy on the AHCCCS Medical Policy Manual webpage:

https://tinyurl.com/yasn8aky

If you have any questions, please reach out to the Adult System of Care team at ASOC@BannerHealth.com or the Children's System of Care team at CSOC@BannerHealth.com.

New HCPCS Codes H0052 and H0053

In alignment with new 2025 CMS HCPCS coding determinations, AHCCCS will be opening two HCPCS codes, H0052 and H0053, on January 1, 2026, as descriptor codes.

- H0052 Missing and Murdered indigenous persons (MMIP) - mental health and clinical care
- H0053 Historical trauma - mental health and clinical care for indigenous persons

These codes apply to all tribal members regardless of whether they are enrolled in AIHP or with an MCO. The codes also apply to all provider types.

Please refer to and share the attached information within your organizations and with your provider communities as appropriate.

Questions should be directed to: codingpolicyquestions@azahcccs.gov.

News of Note

- **Reminder:** Please review the list of users from your practice who have access to either the BHN web portal or eServices. If you need to make any changes (additions or deletions), please reach out to the ProviderExperienceCenter@BannerHealth.com to ensure our user records are current.