AZ AHP

Credentialing Alliance
PRACTITIONER DATA FORM

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

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

New providers receive written confirmation of their effective date with the health plan. Members may not be seen until the provider receives written confirmation that a request or change is approved and completed (this includes approval by the Credentialing Committee if applicable).

To:	Return To:
Fax: Phone:	Fax: Phone:

DIRECTIONS:

- Please type or print this form clearly and return the completed form with attachments
- Certification in your requested specialty or documentation of your examination date is required in order to successfully complete the contracting process

Post the following items (as applicable) to CAQH - Check box to indicate items posted:

- ☐ IRS 941 coupon or accurate W9
- ☐ Documentation of board certification or scheduled exam date
- ☐ Medicaid required insurance certificates as applicable (*see page 3 for requirements*)
- ☐ Fluoride Varnish Application Training Certificate *(PCPs only)*
- ☐ Developmental Screening Tool Training Certificate-PEDS/ASQ/M-CHAT *(PCPs only)*
- ☐ General Anesthesia Permit, Conscious
- ☐ Sedation Permit and/or Oral Conscious
- ☐ Sedation Permit (*Dental providers only*)

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

CAQH # _____ *Please ensure your application and attestation is up to date and that each health plan you are requesting participation in is authorized to access your data.*

Practitioner's Name & Degree: (Last) (First) (M.I.) (Degree)	☐ Female ☐ Male DOB:	Practitioner's Effective Date w/Practice:
1099 Registered Name (Required):		Tax ID #:
Group Practice Name (DBA) if applicable:		
Are you associated with any of the following: ☐ IPA ☐ PHO ☐ N/A If IPA or PHO marked please provide Name:	Group Type (*check all that apply*): ☐ PCP ☐ OBGYN ☐ Dentist ☐ Specialist	
Lines of Business: ☐ Medicaid ☐ Medicare ☐ Commercial	Individual NPI#:	Organizational NPI#: / Malpractice Policy #:
SSN:	DEA #: State: Exp. Date:	License #: State: Exp. Date:
Is provider a Medication Assisted Treatment (MAT) prescriber? ☐ Yes ☐ No *(if yes):* XDEA #: State: Exp. Date:		
Is provider a Medicare participating provider? ☐ Yes ☐ No		AHCCCS I.D.#:
Primary Practicing Specialty:	Board Certification: ☐ Yes ☐ No Date of Exam:	New Graduate [1]: ☐ Yes ☐ No Graduation/Completion Date:
Secondary Practicing Specialty:	Board Certification: ☐ Yes ☐ No Date of Exam:	Dental Hygienist Affiliated Dentist Name:
Want Contract as PCP? ☐ Yes ☐ No	Accepting New Patients? ☐ Yes ☐ No	Patient Age Range: / Patient Gender: ☐ M ☐ F ☐ B
Do you provide services to individuals with special needs/chronic conditions (*check all that apply*)? ☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional ☐ None		Physician Assistant Supervising Physician Name:
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 ☐ ADHD ☐ Depression ☐ HIV ☐ None		
PCPs & OBs ONLY: Do you provide any of the following services (*check all that apply*)? ☐ EPSDT ☐ OB ☐ None		
Do you participate in VFC (Vaccines for Children)? ☐ Yes ☐ No (*PCPs seeing AHCCCS members 18 & < must participate*)		VFC PIN Code:
Is Practice/Practitioner FQHC or RHC? ☐ FQHC ☐ RHC ☐ N/A	Do you E-Prescribe? ☐ Yes ☐ No	
Hospitals & Ambulatory Surgery Center(s) where practitioner has privileges:		
Names of Practitioners in Call Group *(Must be contracted with plan)*:		

[1] licensed to practice medicine or dentistry for the first time in your career and or completed post-graduate training for the first time within the last 6 months

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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:	Zip Code:
	Phone:	Fax:	County:
	Office Hours:	Is Office Accessible to Persons with Disabilities? ☐ Yes ☐ No	
	List Practitioner in Directories at this Address? ☐ Yes ☐ No		

ADDITIONAL OFFICE: (Indicate other additional offices on an separate sheet)	Address:	City:	Zip Code:
	Phone:	Fax:	County:
	Office Hours:	Is Office Accessible to Persons with Disabilities? ☐ Yes ☐ No	
	List Practitioner in Directories at this Address? ☐ Yes ☐ No		

PRACTICE CONTACT/ MAILING ADDRESS:	Contact Name/Title:	Phone:	Fax:
	E-mail Address:	Website Address:	
	Address:	City:	Zip Code:

CREDENTIALING CONTACT:	Name:	E-mail Address:		
	Address:			Phone:
	City:	State:	Zip Code:	Fax:

Languages other than English spoken by PRACTITIONER:	☐ N/A
Languages other than English spoken by OFFICE STAFF:	☐ N/A
Any other Name(s) Possible in Records?	☐ N/A

Describe Your Medical Record Keeping System(s) (i.e. EMR system, 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		

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

The AHCCCS Minimum Subcontract Provisions include insurance requirements for Acute Care, RBHA, DCS/CMDP, CRS, ALTCS/EPD and DES/DDD Subcontractors. The AHCCCS insurance requirements include Commercial General Liability, Business Automobile Liability, Worker's Compensation and Employers' Liability and Professional Liability. The AHCCCS insurance requirements are outlined below:

For the purpose of this Attachment, the following definition applies:
"Subcontractor" means any third party with a contract with the Contractor (AHCCCS Plan) for the provision of any or all services or requirements specified under the Contractor's contract with AHCCCS, or any entity which has a Provider Participation Agreement or Group Biller Agreement with AHCCCS.

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 (see letter a. below under Worker's Compensation and Employers' Liability). For Subcontractors providing direct services 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 SAM 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. SAM coverage must be noted with the following statement on the Certificate(s) of Insurance: "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded."

A. **MINIMUM SCOPE AND LIMITS OF INSURANCE:** Subcontractor shall provide coverage with limits of liability not less than those stated below as applicable in accordance with the services provided by the Subcontractor.

1. **Commercial General Liability (CGL) – Occurrence Form**
   Policy shall include bodily injury, property damage, and broad form contractual liability coverage.
   - 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. Policy shall be endorsed, as required by this written agreement, to include 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.

   b. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, 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.

   c. For Subcontractors providing direct services 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 be included on the Certificate(s) of Insurance: "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded."

2. **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.

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

   a. Policy shall be endorsed, as required by this written agreement, to include 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 involving automobiles owned, leased, hired and/or non-owned by the Subcontractor.

b. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, 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.

3. **Worker's Compensation and Employers' Liability**

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

a. Policy shall contain a waiver of subrogation endorsement, as required by this written agreement, 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.

4. **Professional Liability (Errors and Omissions Liability)**

Each Claim	$1,000,000
Annual Aggregate	$2,000,000

a. In the event that the professional liability insurance required by this Subcontract is written on a claims-made basis, Provider warrants that any retroactive date under the policy shall precede the effective date of the contract and the Subcontract; and that either continuous coverage will be maintained or an extended discovery period will be exercised for a period of two (2) years beginning at the time work under the contract or the Subcontract is completed, whichever is later.

b. The policy shall cover professional misconduct or wrongful acts for those positions defined in the Scope of Work of the contract or Subcontract.

B. **NOTICE OF CANCELLATION:** Applicable to all insurance policies required within the Insurance Requirements of this Contract or the Subcontract, Subcontractor's insurance shall not be permitted to expire, be suspended, be canceled, or be materially changed for any reason without thirty (30) days prior written notice the Prime Contractor.

C. **ACCEPTABILITY OF INSURERS:** Subcontractor's insurance shall be placed with companies licensed in the State of Arizona or hold approved non-admitted status on the Arizona Department of Insurance List of Qualified Unauthorized Insurers. Insurers shall have an "A.M. Best" rating of not less than A- VII. The State of Arizona in no way warrants that the above-required minimum insurer rating is sufficient to protect the Contractor or Subcontractor from potential insurer insolvency.

If the Subcontractor utilizes the Social Service Contractors Indemnity Pool ("SSCIP") or other approved insurance pool for insurance coverage, SSCIP or the other approved insurance pool is exempt from the A.M. Best's rating requirements listed in this section. If the Subcontractor chooses to use SSCIP or another approved insurance pool as its insurance provider, the Subcontract would be considered in full compliance with insurance requirements relating to the A.M. Best rating requirements.

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
Care1st Health Plan Arizona	(602) 778-1800 (options in order 5, 7)	(602) 778-1875 SM_AZ_PNO@care1stAZ.com	www.care1staz.com
Comprehensive Medical and Dental Program (CMDP)	(602) 351-2245 or (800) 201-1795 (options in order 1, 2, 3)	(602) 264-3801 CMDPProviderServices@azdcs.gov	https://dcs.az.gov.cmdp
Cenpatico Integrated Care	1-866-495-6738 x 26164	CAZCREDENTIALING@cenpatico.com	www.cenpaticointegratedcareaz.com/providers/join-our-network.html
Health Choice Arizona	(800) 322-8670 (options in order 4, 7)	(480) 760-4975	www.healthchoiceaz.com
Health Net Access	(800) 289-2818	(866) 687 0514 azproviderdata@centene.com	www.healthnet.com
Mercy Care Plan	(602) 263-3000 (Express Code 631)	(860) 975-3201	www.mercycareplan.com
Mercy Maricopa	(800) 564-5465	(860) 975-0841	www.mercymaricopa.org
United Healthcare Community Plan	(877) 842-3210	(612) 234-0211	www.uhccommunityplan.com
The University of Arizona Health Plans/Banner University Health Plans	(520) 874-5290 or (800) 582-8686	(520) 874-7142	www.ufcaz.com www.bannerufc.com www.universitycareadvantage.com www.uahealthplans.com

Each plan retains the right to make their own contracting decisions (whether or not to add practitioners to their network) and also will make their own credentialing committee decisions (review of the primary source verification information obtained by Aperture Credentialing, LLC resulting in approval/denial by the plan's committee). You will receive separate communication from each plan regarding the effective date of your credentialing and the effective date of your contract.