AzAHP
Arizona Association of Health Plans

Credentialing Alliance
PRACTITIONER DATA FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST. 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). **Please Type or Print Clearly.**

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 Medicare participating provider? ☐ Yes ☐ No	AHCCCS I.D.#:

Primary Specialty:	Board Certification: ☐ Yes ☐ No Date of Exam:	New Graduate [1]: ☐ Yes ☐ No Graduation/Completion Date:
Secondary Specialty:	Board Certification: ☐ Yes ☐ No Date of Exam:	

Want Contract as PCP? ☐ Yes ☐ No	Accepting New Patients? ☐ Yes ☐ No	Patient Age Range:

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 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

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:			
	Address:			Phone:
	City:	State:	Zip Code:	Fax:

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

PRIMARY ADDRESS (Physical location where services are performed)	Address:	City:	Zip Code:
	Phone #:	Fax #:	County:
	Office Hours:	Office Contact (*All Other*):	

ADDITIONAL OFFICE: (Indicate other additional offices on an separate sheet)	Address:	City:	Zip Code:
	Phone #:	Fax #:	County:
	Office Hours:		

MAILING ADDRESS: (All correspondence will be sent to this address)	Address:	City:	Zip Code:
	E-mail Address:		County:

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, 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

AHCCCS updated its Minimum Subcontract Provisions to include additional insurance requirements for Acute Care, ADHS/DBHS, CMDP and CRS Subcontractors. The AHCCCS insurance requirements include Commercial General Liability, Business Automobile Liability, Worker's Compensation and Employers' Liability and Professional Liability.

For the purpose of this Attachment, the following definition applies:
"Subcontractor" means any 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.

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 require only the waiver of subrogation language (see letter a. below under Worker's Compensation and Employers' Liability).

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. As required by AHCCCS, the policy shall include an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor.

b. Policy also shall contain a waiver of subrogation endorsement, as required by AHCCCS, for 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.

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. As required by AHCCCS, the policy shall include an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor involving automobiles owned, leased, hired and/or non-owned by the Contractor.

b. Policy shall contain a waiver of subrogation endorsement, as required by AHCCCS, 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.

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

Workers' Compensation Statutory
Employers' Liability

Each Accident	$ 500,000
Disease – Each Employee	$ 500,000
Disease – Policy Limit	$1,000,000

a. Policy shall contain a waiver of subrogation endorsement, as required by AHCCCS, 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.

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

Each Claim	$1,000,000
Annual Aggregate	$3,000,000

a. In the event that the professional liability insurance required by contract 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 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 is completed.

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

B. **NOTICE OF CANCELLATION:** For each insurance policy required by the insurance provisions of this Contract, the subcontractor must provide to the Contractor, within two (2) business days of receipt, a notice if a policy is suspended, voided, or cancelled for any reason.

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. Insurer shall have an "A.M. Best" rating of not less than A- VII.

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	WEBSITE
Bridgeway Health Solutions	(866) 475-3129	(866) 687-0514	www.bridgewayhs.com
Care1st Health Plan Arizona	(602) 778-1800 (options in order 5, 7)	(602) 778-1875	www.care1st.com/az
Comprehensive Medical and Dental Program (CMDP)	(602) 351-2245 or (800) 201-1795 (options in order 1, 2, 3)	(602) 264-3801	www.azdes.gov/cmdp
Health Choice Arizona	(800) 322-8670 (options in order 4, 7)	Maricopa/Pima/Pinal/Gila: (480) 760-4975	www.healthchoiceaz.com
Health Net Access	(800) 289-2818	Apache/Coconino/Gila/LaPaz/ Maricopa/Mohave/Navajo/ Yavapai: (602) 794-1803 Cochise/Graham/Greenlee/Pima/Pinal Santa Cruz/Yuma: (520) 258-5172	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
Phoenix Health Plan	(602) 824-3720	(602) 674-6670	www.phoenixhealthplan.com
UnitedHealthcare Community Plan	(877) 842-3210	(612) 234-0211	www.uhccommunityplan.com
The University of Arizona Health Plans	(520) 874-5290 or (800) 582-8686	(520) 874-7142	www.ufcaz.com www.mhpaz.com www.universitycareadvantage.com www.universityhealthcaregroup.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 OptumInsight™ 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.

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