

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:

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

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)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Practitioner's Effective Date w/Practice:
	DOB: _____	

1099 Registered Name (Required):	Tax ID #:
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Group Practice Name (DBA) if applicable: _____

Are you associated with any of the following: <input type="checkbox"/> IPA <input type="checkbox"/> PHO <input type="checkbox"/> N/A	Group Type (<i>check all that apply</i>):
If IPA or PHO marked please provide Name: _____	<input type="checkbox"/> PCP <input type="checkbox"/> OBGYN <input type="checkbox"/> Dentist <input type="checkbox"/> Specialist

Lines of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	Individual NPI#: _____	Organizational NPI#: _____	Malpractice Policy #: _____
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SSN: _____	DEA #: _____	State: _____	Exp. Date: _____	License #: _____	State: _____	Exp. Date: _____
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Is provider a Medication Assisted Treatment (MAT) prescriber? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>if yes</i>):	XDEA #: _____	State: _____	Exp. Date: _____
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Is provider a Medicare participating provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	AHCCCS I.D.#: _____
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Primary Practicing Specialty: _____	Board Certification: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Exam: _____	New Graduate ¹ : <input type="checkbox"/> Yes <input type="checkbox"/> No Graduation/Completion Date: _____
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Secondary Practicing Specialty: _____	Board Certification: <input type="checkbox"/> Yes <input type="checkbox"/> No Date of Exam: _____	Dental Hygienist Affiliated Dentist Name: _____
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Want Contract as PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Age Range: _____	Patient Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> B
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Do you provide services to individuals with special needs/chronic conditions (<i>check all that apply</i>)? <input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Emotional <input type="checkbox"/> None	Physician Assistant Supervising Physician Name: _____
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Do you provide services/accommodations to individuals who have difficulty communicating or cooperating (i.e. those with autism or intellectual disabilities)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you provide services to individuals with mobility limitations (i.e. wheelchair bound)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Do you treat any of the following diagnoses (<i>check all that apply</i>)? <input type="checkbox"/> Anxiety <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> HIV <input type="checkbox"/> None
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PCPs & OBs ONLY: Do you provide any of the following services (<i>check all that apply</i>)? <input type="checkbox"/> EPSDT <input type="checkbox"/> OB <input type="checkbox"/> None

Do you participate in VFC (Vaccines for Children)? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>PCPs seeing AHCCCS members 18 & < must participate</i>)	VFC PIN Code: _____
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Is Practice/Practitioner FQHC or RHC? <input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> N/A	Do you E-Prescribe? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	List Practitioner in Directories at this Address? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	List Practitioner in Directories at this Address? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> N/A
Languages other than English spoken by OFFICE STAFF:	<input type="checkbox"/> N/A
Any other Name(s) Possible in Records?	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Internet Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a minority or female owned business? <input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic Funds Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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 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.