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## PROVIDER INFORMATION[1]

~~Please c~~Check the purpose of the request: ☐ Intial Application (Date of Application _____/_____/_____)

Initial Application Directions: Providers must submit an application for each facility location providing services to members. Information on where to send the submission(s) is provided below. If applicable, ~~the~~ ~~MCOs~~ Contractors~~/ AHCCCS~~ will jointly determine a Lead Contractor to perform credentialing reviews and approals on behalf of all the ~~MCOs~~ Contractors who intend to contract with the specific provider location. The provider will be notified, within 30 days of the initial application submission, by the Contractor about next steps in the credentialing process. Reference the "Application for Initial Approval and Initial Desk Audit" section of the Community Service Agency Chapter in the AHCCCS Medical Policy Manual, 965.

~~Please c~~Check the purpose of the request: ☐ Credentialing Amendment (Date of Request _____/_____/_____)
Effective Date of Change _____/_____/_____

Credentialing Amendment Directions: Providers must submit a credentialing amendment along and associated required documentation under specific circumstances.

1) Change in agency name, address or telephone number
2) Change in the provider's NPI and/or tax identification number
3) Change in ownership, governing board, or Chief Executive of the program
4) Adding or removing a Contractor the providers contracts with or intends to contract with for the provision of services

Only update information in the "Provider Information" section that needs to be updated. DO NOT update the "Services Provided" or "Program Description" sections. I~~i~~nformation on where to send the submission is provided below. The provider will be notified, within 30 days of the credentialing amendment request submission, by the Contractor about next steps in the credentialing process. Reference the "Credentialing Amendment" section of the Community Service Agency Chapter in the AHCCCS Medical Policy Manual, 965.

National Provider Identification (NPI): _____

Provider Name: _____ _____

Provider Phone Number: (  ) _____ - _____

Provider E-Mail Address: _____

Provider Administrative Address (if applicable): City: _____ State: _____

Street _____ Zip: _____ County: _____



[1] Created new form for both the initial application (using the old version as a framework) and credentialing amendment to comport with the new credentialing processes outlined in the revised. The Direct Service Staff Member matrix and checklist and Training Attestation Forms have been deleted from the initial application package. Contractors will develop auditing tool for the intial application and credentialing amendment. Documentation standards are outlined in the new Attachment C – Documentation Submission Standards.

Provider Facility Address: City: _____ State: _____

Street _____ Zip: _____ County: _____

Program Director:

Name:
Title:
Phone Number:
Email Address:

Tax ID#:_____

***OR***

Social Security Number:_____

**~~Please put~~Place an "X~~x~~" next to the ~~MCO~~ Contractor for which the provider intends to contract.**

**AHCCCS Complete Care (ACC) Contractors**
☐ – Arizona Complete Care
☐ – Banner University Family Care
☐ – Care1st
☐ – Magellan Complete Care
☐ – Mercy Care
☐ – Steward Health Choice Arizona
☐ – United Healthcare Community Plan

**Regional Behavioral Health Authorities~~y~~ (RBHA) Contractors**
☐ – Arizona Complete Health
☐ – Mercy ~~Maricopa~~ Care
☐ – Steward Health Choice Arizona

**Arizona Long Term Care System (ALTCS) Contractors**
☐ – Banner University Family Care
☐ – Mercy Care ~~Plan~~
☐ – United Healthcare Community Plan

☐ – ~~Please~~ M~~m~~ark with an "X" if the applicant will be providing services to American Indian members through Arizona Indian Health Program or Tribal ALTCS fee-for-service programs.

## Provider Enclosures

Enclose the following with this application: (***~~please c~~Check the box beside each document enclosed)***

☐ – Copy of provider incorporation documents
☐ – Copy of provider charter, if any
☐ – Occupancy Permit of Physical Facility Address
☐ – C~~C~~opy of Passed Fire Inspection of Physical Facility Address

## Services Provided

Check all services below that the provider intends to provide to AHCCCS members:

☐ ~~☒~~ Behaviorial Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)
☐ ~~☐~~ Comprehensive Community Support (Supervised Day)
☐ Home Care Training (Family Support)
☐ On going Support to Maintain Employment
☐ Personal Care
☐ Psychoeducational Service (pre-job training and development)
☐ Psychosocial Rehabilitation Living Skills Training Services
☐ Self-help/Peer Services (Peer Support) or Comprehensive Community Peer Support

☐ Supervised Behavioral Health Day Treatment and Day Program

☐ Transportation
☐ Other _____

A complete list of services that can be provided by Community Service Agencies may be found on the AHCCCS website under a document entitled "B-2: Allowable Procedure Codes and Provider Types."

Check the following age groups for which your agency will be providing services:
☐ 0-17 years ☐ 18 years and older

**Program Description**

~~Please d~~Describe the purpose, goals and objectives of the program, including the populations that will be served

_____ _____

Program Director, Signature Submission Date

Send completed forms to ~~credentialing@azahp.org~~credentialing@azahp.org~~the following email address~~. The Managed Care Organizations are using th~~is~~ central email inbox to coordinate the credentialing process through the Arizona Association of Health Plans (AZAHP). The provider will be notified, within 30 days, by the Contractor about next steps in the credentialing process.

~~credentialing@azahp.org~~

***If the applicant will be providing services to American Indian members through Arizona Indian Health Program or Tribal ALTCS fee-for-service programs and not contracting with an MCO, contact the CSA Compliance Program Specialist below for information on where to send the application.***[2]

For technical assistance on the CSA credentialing process, ~~please~~ contact the AHCCCS/DHCM, CSA Compliance Program Specialist:

Arizona Health Care Cost Containment System
Division of Health Care Management
Attention: CSA Compliance Program Specialist
701 E. Jefferson, MD 6500
Phoenix, Arizona 85034
602-417-4286



[2] Added submission directions specific for tribal providers who are not going to contract with an MCO. Per APC recommendation.