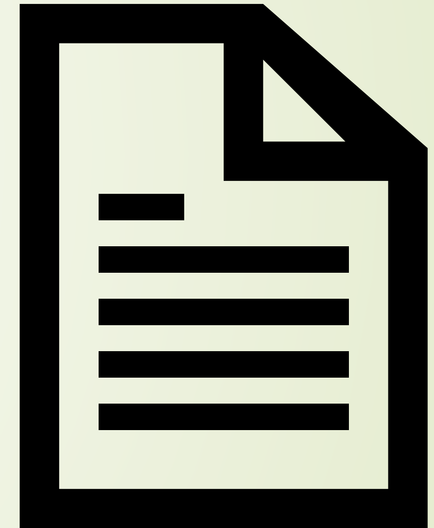
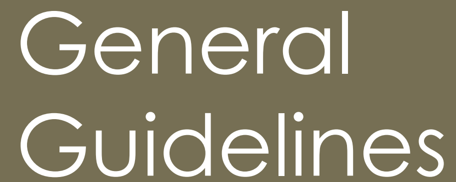
PROVIDER EDUCATION SERIES Presented by AzAHP and AHCCCS Health Plans

Session #3 AzAHP Form

AzAHP Form

- AzAHP Form
  - Practitioner Data Form
  - PDF
  - Alliance Form
  - Enrollment Form
- Required by all plans to assist in determining network need





General Guidelines

Complete

Complete the form in its entirety

- Leave no blank spaces
- Use NA in any space that doesn't apply

Follow

Follow the instructions

- Ask questions of any plan

Read through

Read through the document to prepare properly

Ensure

Ensure your CAQH application and attestation is up to date

- For more information, please see session #4 CAQH session

Print

Print clearly or responses may be typed into the PDF fillable form

Further Guidelines

Please use a separate sheet of paper to include other Practitioners in your practice

Please use a separate sheet of paper for additional offices

Provider Assessment of Cognitive and Physical Disabilities Accommodations must be completed—a separate Assessment for each location

One form and required documents are needed regardless of the number of plans you which to obtain a contract

Required Attachments

- Copy of Board Certification or CMEs in your specialty
- Copy of W9
- Copy of Certificates of Insurance information
  - Commercial General Liability
  - Business Automobile Liability
  - Workers' Compensation Liability
  - Professional Liability
- Practicing OB/GYN performing Detailed Anatomic Fetal Ultrasounds?
  - Provide documentation of 30 hours of CME in fetal anatomic ultrasound (30 hours of CME every 3 years)

The Form

1. Enter CAQH #
2. Multiple providers in your practice—just complete this section for the additional providers

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.

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*): ☐ FQHC ☐ RHC ☐ BH ☐ PCP ☐ OBGYN ☐ Dentist ☐ Specialist ☐ MAT

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 Practicing Specialty: | Board Certification: ☐ Yes ☐ No Date of Exam: | **New Graduate: ☐ Yes ☐ No** **Graduation/Completion Date:**

Secondary Practicing Specialty: | Board Certification: ☐ Yes ☐ No Date of Exam: | Dental Hygienist Affiliated Dentist Name:

Check any that apply to the practice/practitioner: ☐ **FQHC** ☐ **RHC** ☐ **MAT prescriber** ☐ **Dental** ☐ **Behavioral Health** | **If MAT Prescriber XDEA #: State: Exp. Date:**

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 ☐ Substance Use ☐ None

PCPs & OBs ONLY: Do you provide any of the following services (*check all that apply*)? ☐ EPSDT ☐ OB ☐ None

OBs ONLY: Do you perform Detailed Anatomic Fetal Ultrasound? ☐ Yes ☐ No - if yes, please provide documentation of 30 hours of Fetal anatomic u/s CMEs

Do you participate in VFC (Vaccines for Children)? ☐ Yes ☐ No (*PCPs seeing AHCCCS members 18 & < must participate*) | VFC PIN Code:

Names of Practitioners in Call Group (*Must be contracted with plan*): | Do you E-Prescribe? ☐ Yes ☐ No | Hospitals & Ambulatory Surgery Center(s) where practitioner has privileges:

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

Additional Location

Room to include one additional office location - please use a separate sheet of paper if needed.

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 will 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).

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 a 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		

Provider Assessment of Cognitive and Physical Disability Accommodations

Assessment must be completed for each location

Provider Assessment of Cognitive and Physical Disabilities Accommodations

Please identify what accommodations you provide at **each of your practice locations** for members with cognitive or physical disabilities. If accommodations are the same at all locations, on Practice Location Address, please state ALL. Please, complete a separate Assessment for each location if accommodations vary.

Practice Location Address:

Accommodation	YES	NO	Comments
Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities			
Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limitations or wheelchair bound			
Flexible appointment times available—sick appointments, same day appts—please specify			
Extended appointment times—before 8 am, after 5pm, Sat and/or Sunday—please specify			
Assistance available to members to fill out forms			
In-home and/or community services			
Large print materials			
Materials in electronic format			
Augmentative/Alternative communication devices			
TDD capabilities			
American Sign Language translator			
Signage with Braille and raised tactile text characters at office, elevator, stairwells and restroom doors mounted 60in from floor			
Visible & Audible alarms – emergency systems			
Dimmable Lights			
Ramps have non-slip surface material			
Railings between 30 & 38in high. On both sides.			
Paths are at least 36in wide and free of protruding objects			
Cane detectible objects on ground as a warning barrier			
Widened doorways (at least 32in clearance)			
Offset (swing-clear) hinges			
Power assisted or automatic door openers			
Door handles no higher than 48in			
Lever or loop handles vs knobs			
5ft circle or T-shaped space for turning a wheelchair completely			
A clear floor space, 30" X 48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer			
Adjustable height exam table or chair (lowers to 17-19in from floor)			
Positioning and support aids, such as wedges, rolled up blankets, straps and rails			
Ceiling or floor based patient lift			
Gurneys and/or stretchers			
Wheelchair accessible scales			
Adjustable height radiologic equipment			

SEE PAGE 11 FOR FAX AND PHONE INFORMATION

AHCCCS Insurance Requirements

Use checklist to ensure all insurance requirements are addressed

Prior to submitting your insurance information complete this checklist, use it as a tool to address everything that's required and send it on top of your insurance document(s).

Commercial General Liability	Professional Liability
☐ ATTACHED	☐ ATTACHED ☐ N/A
☐ General Aggregate $2,000,000 ☐ Products Ops Aggregate $1,000,000 ☐ Personal & Adv. Injury $1,000,000 ☐ Damage to Rented Premises $50,000 ☐ Each Occurrence $1,000,000	☐ Each Claim $1,000,000 ☐ Annual Aggregate $2,000,000
Business Automobile Liability	**Workers' Compensation Liability**
☐ ATTACHED ☐ N/A	☐ ATTACHED ☐ N/A
☐ Combined Single Limit $1,000,000	☐ Each Accident $1,000,000 ☐ Disease – Each Employee $1,000,000 ☐ Disease – Policy Limit $1,000,000

Your Certificates of Insurance must include the minimum requirements outlined in the tables above and the following endorsement, waiver of subrogation and/or SAM language as applicable.

☐ **Endorsement – Required for Commercial General and Business Auto Liability**
This policy contains 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 the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ **Waiver of Subrogation – Required for all**
This policy contains a waiver of subrogation endorsement 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.

☐ **Sexual Abuse and Molestation (SAM) – Required for Commercial General Liability or Professional Liability when providing services to children and/or vulnerable adults**
Insurance Certificate(s) must provide the following statement "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded".

- 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.

AHCCCS Insurance Requirements

- Communication found on pages 7 and 8 of the AzAHP Form provides additional information concerning insurance requirement
- Review the Certificates of Liability exampled on pages 9 and 10
  - Indicates the various limits and required language
  - Talk with your contact at the health plans for any questions regarding the insurance requirements

Final Notes

- Health Plan contact list can be found on the last page (page 11)
- Each Plan retains the right to make their own contracting decisions
- Each Plan will make their own independent credentialing committee decisions
- Separate communication from each plan regarding the effective date of your credentialing and effective date of your contract

- Thank you for taking time to listen to Session # 3. If you have additional general questions, please go to www.azahp.org, click on AzAHP Credentialing Alliance and click on "Ask Pat". Please note, I cannot answer specific questions regarding your credentialing status with any plan.

Proprietary