AZAHP

ARIZONA ASSOCIATION OF HEALTH PLANS

PROVIDER EDUCATION SERIES

Presented by AzAHP and AHCCCS Health Plans

Session #5 Credentialing Process for Organizations/Facilities

AzAHP Organization Data Form and Facility Application

AzAHP Organization Data Form and Facility Application

Organizations and Facilities need to be credentialed just as the practitioners

2 forms are required

- Organization Data Form
- Facility Application

Both will be covered in this session since they go together

Please note: Organization and Facility are used interchangeably

Things to Keep in Mind…

- It is important to begin with contacting the health plan(s)
  - Most often the Provider Network or Contracting area
  - See final page of Organizational Data Form for Health Plan Contacts
- Some processes with Organizational/Facility credentialing may vary slightly for plan to plan
  - Follow directions provided by your contact at the plan
- Let's review the Organizational Data Form

Organizational Data Form

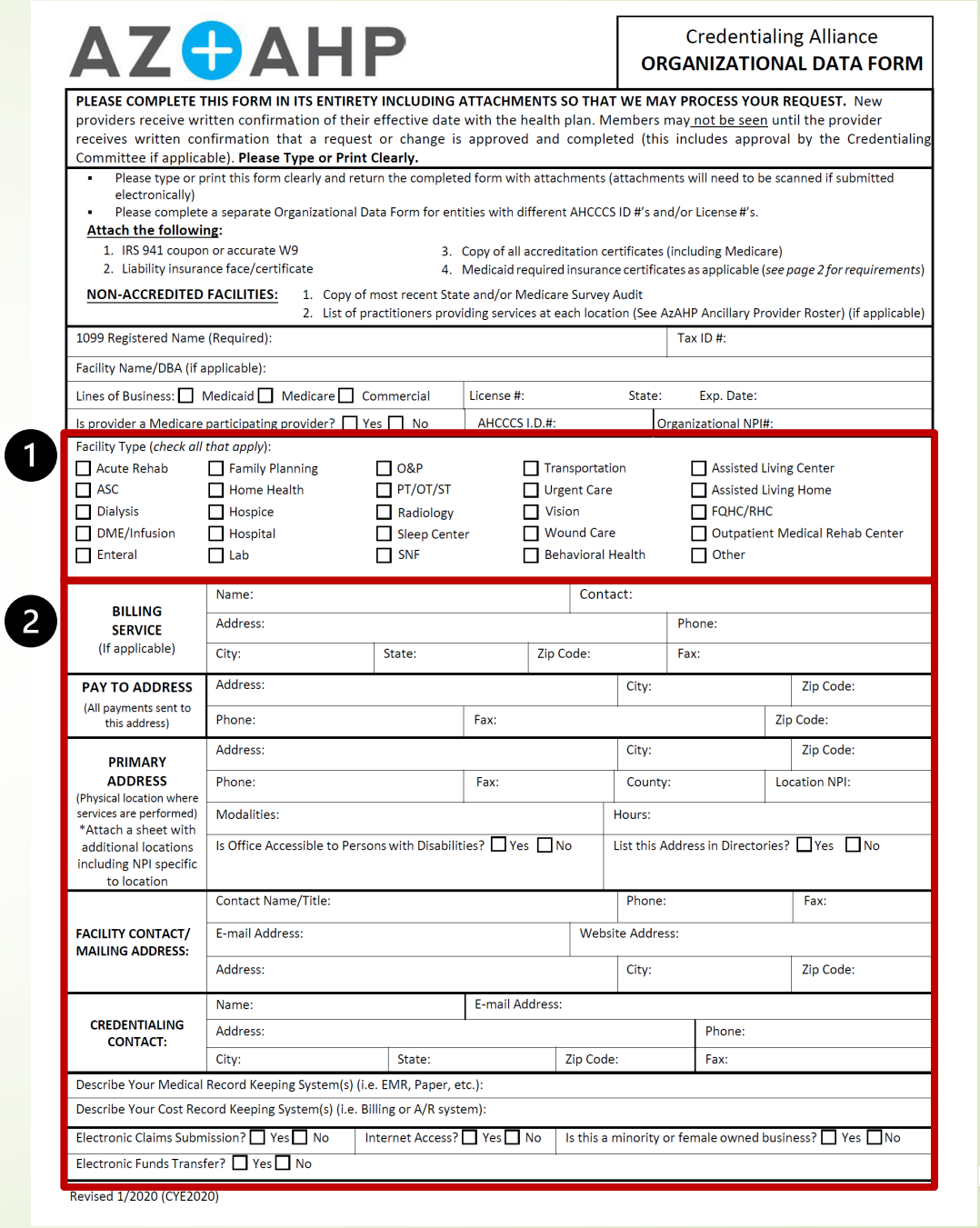
- All Organizations and Facilities must fill out this form in its entirety
- Please complete a separate Organizational Data Form for locations with different AHCCCS ID #'s and/or License #'s.
- Form can be found on any health plan webpage or at www.azahp.org
  - Click on Credentialing Alliance and then Organizational Data Form
- Forms are fillable PDFs but could be printed off
- Follow instructions:
  - 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

Organizational Data Form

- Required Documents—Attach the Following:
  - 1. IRS 941 coupon or accurate W9
  - 2. Liability insurance face/certificate
  - 3. Copy of all accreditation certificates (including Medicare)
  - 4. Medicaid required insurance certificates as applicable (see page 2 for requirements)
- Non-Accredited Facilities—Attach the following:
  - 1. Copy of most recent State and/or Medicare Survey Audit
  - 2. List of practitioners providing services at each location (See AzAHP Ancillary Provider Roster) (if applicable)

Organizational Data Form

1. Indicate Facility type
2. General information



AZ AHP

Credentialing Alliance
ORGANIZATIONAL 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.**

- Please type or print this form clearly and return the completed form with attachments (attachments will need to be scanned if submitted electronically)
- Please complete a separate Organizational Data Form for entities with different AHCCCS ID #'s and/or License #'s.

Attach the following:

1. IRS 941 coupon or accurate W9
2. Liability insurance face/certificate
3. Copy of all accreditation certificates (including Medicare)
4. Medicaid required insurance certificates as applicable (*see page 2 for requirements*)

NON-ACCREDITED FACILITIES:

1. Copy of most recent State and/or Medicare Survey Audit
2. List of practitioners providing services at each location (See AzAHP Ancillary Provider Roster) (if applicable)

1099 Registered Name (Required):		Tax ID #:
Facility Name/DBA (if applicable):		
Lines of Business: ☐ Medicaid ☐ Medicare ☐ Commercial	License #: State:	Exp. Date:
Is provider a Medicare participating provider? ☐ Yes ☐ No	AHCCCS I.D.#:	Organizational NPI#:

1

Facility Type (*check all that apply*):

☐ Acute Rehab	☐ Family Planning	☐ O&P	☐ Transportation	☐ Assisted Living Center
☐ ASC	☐ Home Health	☐ PT/OT/ST	☐ Urgent Care	☐ Assisted Living Home
☐ Dialysis	☐ Hospice	☐ Radiology	☐ Vision	☐ FQHC/RHC
☐ DME/Infusion	☐ Hospital	☐ Sleep Center	☐ Wound Care	☐ Outpatient Medical Rehab Center
☐ Enteral	☐ Lab	☐ SNF	☐ Behavioral Health	☐ Other

2

BILLING SERVICE (If applicable)	Name:		Contact:	
	Address:			Phone:
	City:	State:	Zip Code:	Fax:
PAY TO ADDRESS (All payments sent to this address)	Address:		City:	Zip Code:
	Phone:	Fax:		Zip Code:
PRIMARY ADDRESS (Physical location where services are performed) *Attach a sheet with additional locations including NPI specific to location	Address:		City:	Zip Code:
	Phone:	Fax:	County:	Location NPI:
	Modalities:		Hours:	
	Is Office Accessible to Persons with Disabilities? ☐ Yes ☐ No		List this Address in Directories? ☐ Yes ☐ No	
FACILITY 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:

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

Revised 1/2020 (CYE2020)

Organizational Data Form

- Facility Assessment of Cognitive and Physical Disability Accommodations
  - Pages 2 and 3 of the packet
  - Required by all Plans
  - Must be completed for each location

Facility Assessment of Cognitive and Physical Disabilities Accommodations

Please identify what accommodations you provide at **each of your facility 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.

Facility 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)			

Revised 1/2020 (CYE2020)

Organizational Data Form
Insurance Requirements

- Checklist to help with insurance Requirements can be found on page 4
  - "Check off" as you gather the documents to verify requirements met
  - Recommended the check list be submitted when you submit packet to plans
  - Next few pages include examples of the insurance requirements and what the Certificates should look like

Organizational Data Form

- Insurance Checklist

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.

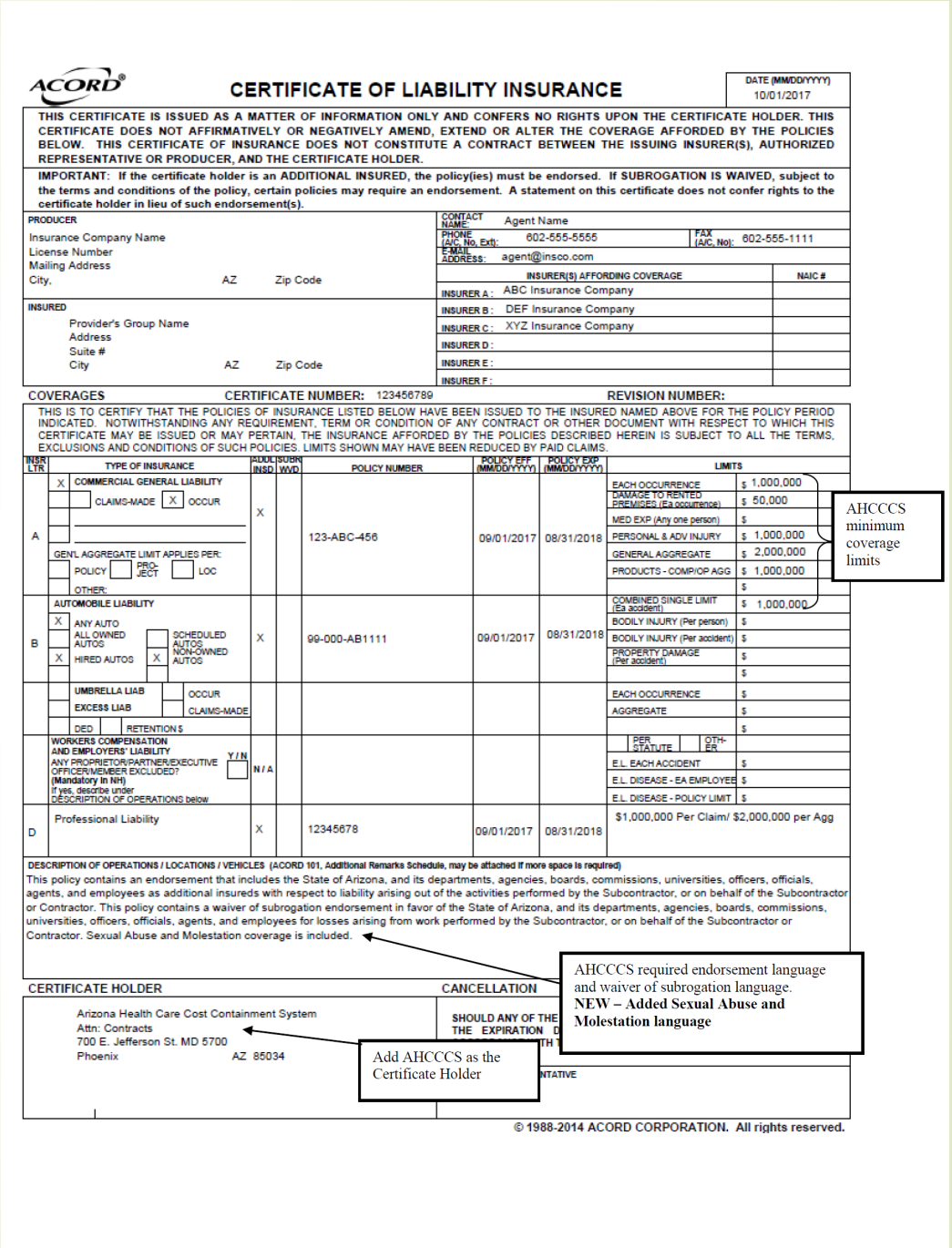
☐ ****Sexual Abuse and Molestation (SAM) – Required for Commercial General Liability or Professional Liability when providing services to children and/or vulnerable adults**
Insurance Certificate(s) must provide the following statement "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse 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.

**Please check with health plan if SAM coverage is required for your specific provider type*

Organizational Data Form

- Insurance requirements example



ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/01/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Insurance Company Name
License Number
Mailing Address
City, AZ Zip Code

CONTACT NAME: Agent Name
PHONE (A/C, No, Ext): 602-555-5555 FAX (A/C, No): 602-555-1111
E-MAIL ADDRESS: agent@insco.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ABC Insurance Company	
INSURER B : DEF Insurance Company	
INSURER C : XYZ Insurance Company	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Provider's Group Name
Address
Suite #
City AZ Zip Code

COVERAGES CERTIFICATE NUMBER: 123456789 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY [ ] PRO-JECT [ ] LOC OTHER:	X		123-ABC-456	09/01/2017	08/31/2018	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50,000 $ $ 1,000,000 $ 2,000,000 $ 1,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS X HIRED AUTOS SCHEDULED AUTOS X NON-OWNED AUTOS	X		99-000-AB1111	09/01/2017	08/31/2018	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
	UMBRELLA LIAB [ ] OCCUR EXCESS LIAB [ ] CLAIMS-MADE DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) Y / N [ ] N / A If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
D	Professional Liability	X		12345678	09/01/2017	08/31/2018	$1,000,000 Per Claim/ $2,000,000 per Agg	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
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. 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 coverage is included.

CERTIFICATE HOLDER
Arizona Health Care Cost Containment System
Attn: Contracts
700 E. Jefferson St. MD 5700
Phoenix AZ 85034

CANCELLATION
SHOULD ANY OF THE ... THE EXPIRATION ...
...NTATIVE

AHCCCS minimum coverage limits

AHCCCS required endorsement language and waiver of subrogation language. **NEW – Added Sexual Abuse and Molestation language**

Add AHCCCS as the Certificate Holder

Final Steps for Organizational Data Form

Submit the packet with all required documents to any health plans you wish to obtain a contract

You will be contacted by the plan for next steps if they wish to proceed with contracting with your agency

You should have a contact name from each plan you are working with and finalizing your contract

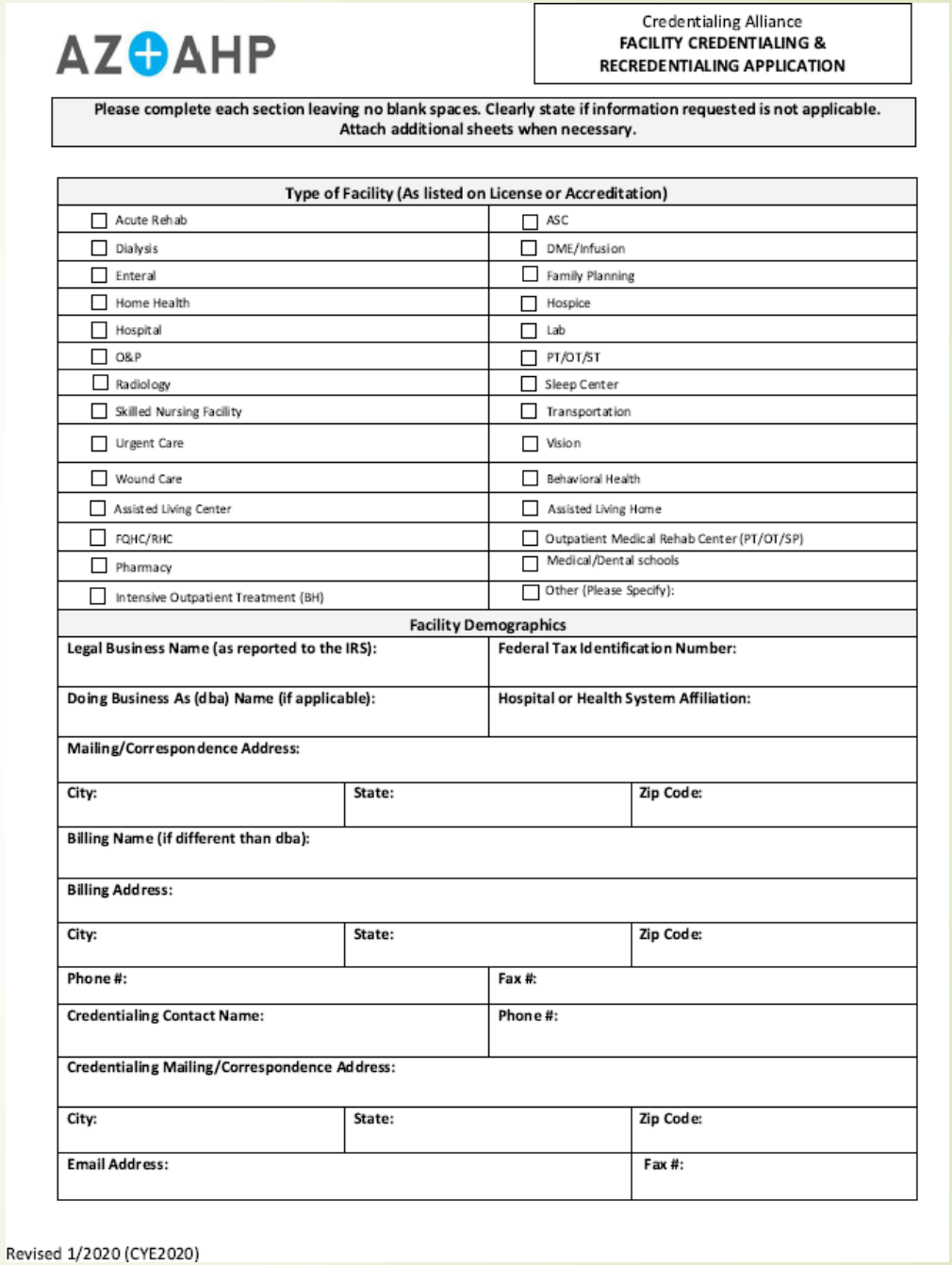
Next step is completing the Facility Application form as directed by the plan

Facility Application
Facility Credentialing and Re-Credentialing Application

- In most cases, the Facility Credentialing and Re-Credentialing Application must be filled out
- Form can be found on all health plans' webpages and www.azahp.org
  - (click on Credentialing Alliance and than form)
- Form must be filled out completely
  - Clearly indicate if a statement doesn't apply. Mark NA if necessary
- Identify the type of facility you have
  - Should match what is on your License or Accreditation
- Fill in all demographic information

Facility Application

Facility Credentialing & Recredentialing Application



AZ AHP

Credentialing Alliance
FACILITY CREDENTIALING & RECREDENTIALING APPLICATION

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable. Attach additional sheets when necessary.

Type of Facility (As listed on License or Accreditation)	
☐ Acute Rehab	☐ ASC
☐ Dialysis	☐ DME/Infusion
☐ Enteral	☐ Family Planning
☐ Home Health	☐ Hospice
☐ Hospital	☐ Lab
☐ O&P	☐ PT/OT/ST
☐ Radiology	☐ Sleep Center
☐ Skilled Nursing Facility	☐ Transportation
☐ Urgent Care	☐ Vision
☐ Wound Care	☐ Behavioral Health
☐ Assisted Living Center	☐ Assisted Living Home
☐ FQHC/RHC	☐ Outpatient Medical Rehab Center (PT/OT/SP)
☐ Pharmacy	☐ Medical/Dental schools
☐ Intensive Outpatient Treatment (BH)	☐ Other (Please Specify):

Facility Demographics		
Legal Business Name (as reported to the IRS):	**Federal Tax Identification Number:**	
Doing Business As (dba) Name (if applicable):	**Hospital or Health System Affiliation:**	
Mailing/Correspondence Address:		
City:	**State:**	**Zip Code:**
Billing Name (if different than dba):		
Billing Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Fax #:**	
Credentialing Contact Name:	**Phone #:**	
Credentialing Mailing/Correspondence Address:		
City:	**State:**	**Zip Code:**
Email Address:		**Fax #:**

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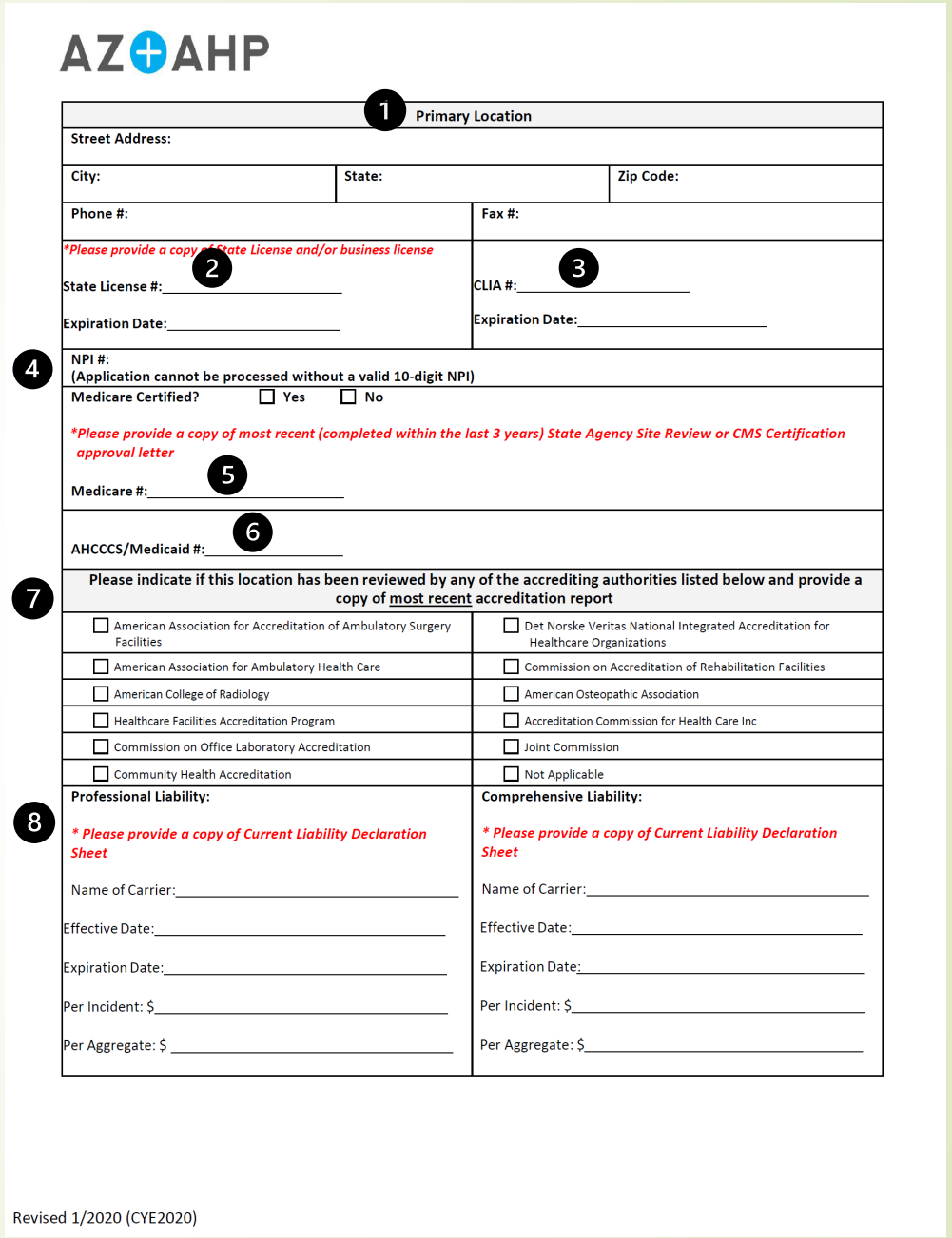
Facility Application

Facility Credentialing & Recredentialing Application

1. Indicate Primary location
2. State License
3. CLIA
4. NPI
5. Medicare Number
6. AHCCCS/Medicaid Number
7. Indicate if location has been reviewed by any of the listed accrediting authorities
8. Insurance information



AZ AHP

1 Primary Location		
Street Address:		
City:	State:	Zip Code:
Phone #:		Fax #:
*Please provide a copy of State License and/or business license 2 State License #:_____ Expiration Date:_____		3 CLIA #:_____ Expiration Date:_____
4 NPI #: (Application cannot be processed without a valid 10-digit NPI)		
Medicare Certified? ☐ Yes ☐ No *Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter 5 Medicare #:_____		
6 AHCCCS/Medicaid #:_____		
7 Please indicate if this location has been reviewed by any of the accrediting authorities listed below and provide a copy of most recent accreditation report		
☐ American Association for Accreditation of Ambulatory Surgery Facilities		☐ Det Norske Veritas National Integrated Accreditation for Healthcare Organizations
☐ American Association for Ambulatory Health Care		☐ Commission on Accreditation of Rehabilitation Facilities
☐ American College of Radiology		☐ American Osteopathic Association
☐ Healthcare Facilities Accreditation Program		☐ Accreditation Commission for Health Care Inc
☐ Commission on Office Laboratory Accreditation		☐ Joint Commission
☐ Community Health Accreditation		☐ Not Applicable
8 Professional Liability: * Please provide a copy of Current Liability Declaration Sheet Name of Carrier:_____ Effective Date:_____ Expiration Date:_____ Per Incident: $_____ Per Aggregate: $_____		Comprehensive Liability: * Please provide a copy of Current Liability Declaration Sheet Name of Carrier:_____ Effective Date:_____ Expiration Date:_____ Per Incident: $_____ Per Aggregate: $_____

Revised 1/2020 (CYE2020)

Facility Application

Facility Credentialing & Recredentialing Application

- Supplemental Form – Page 3
  - Complete for any additional addresses.
  - A separate Supplemental Form is required for each address

Supplemental Form

For each additional address copy and complete this Supplemental Form

Return all copies with the completed application

Street Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Fax #:**	
Please provide a copy of State License and/or business license **State License #:** _____ **Expiration Date:** _____	**CLIA #:** _____ **Expiration Date:** _____	
NPI #: **(Application cannot be processed without a valid 10-digit NPI)**		
Medicare Certified? ☐ **Yes** ☐ **No** ***Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter*** **Medicare #:** _____		
AHCCCS/Medicaid #: _____		
Accreditation: **Does this site have the same accrediting agency as the primary address?** ☐ **Yes** ☐ **No - Please specify accrediting agency or NONE:** _____		

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Disclosure Questions and Facility Attestation

Disclosure Questions	Four Disclosure Questions
	"Yes"—to any question, please provide a description of the facts on a separate sheet and attach when submitting the packet to the plan(s)
Attestation	An authorized representative of the facility must sign the Attestation
	By signing, you are attesting to all information on the Application as being current complete and correct
	Signature must be within 180 days of submission

Facility Application

Facility Credentialing & Recredentialing Application

1. Disclosure Questions
2. Attestation & Consent

1

Disclosure Questions

Please answer the following questions by checking the appropriate box. If the answer to any question is yes, please provide a complete description of the facts on a separate attached sheet.	
1. Has the facility license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed?	☐ Yes ☐ No
2. Has the facility been denied participation, suspended from or denied renewal from Medicare or Medicaid?	☐ Yes ☐ No
3. Has the facility ever had its professional liability coverage cancelled or not renewed?	☐ Yes ☐ No
4. Has the facility been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?	☐ Yes ☐ No

2

Facility Attestation/Consent & Release Form

Any alteration or failure to sign and date this form will result in the delay of processing this application. By signing below, I attest that I am the duly authorized representative of the Facility, that all information on the Application pertains to the above-named Facility, and that such information is current, complete and correct.

Your signature is required to complete this application.

Facility Name: _____

Name (Please Print): _____

Title: _____

Signature: _____

Date: _____

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Final Steps

- Please include with your completed/signed application the following items for each location:
  - Copy of current State License and/or business license (if applicable)
  - Copy of Medicare Certification letter (if applicable)
  - Copy of Certifications and/or Accreditation Certificates (e.g. TJC, CHAP, etc)
  - Copy of your CLIA Certificate (if applicable)
  - Copy of Declaration Sheet and/or Certificate of Insurance for BOTH Current Professional Malpractice and Comprehensive General Liability Insurance Policies
- If you have any questions, please contact our Provider Network/Operations
- Please submit completed application with all required documents to Provider Network/Operations of plans you are working with
  - See page 6 of the application for Health Plan contact information
  - **PLEASE NOTE**: Only submit to the Credentialing Vendor Aperture, if directed by plan.

Final Thoughts…

- Initial Credentialing
  - Failure to legibly complete all sections of this Application and submit current copies of all required documentation will result in processing delays.
  - Each Health Plan will send notification of your effective contract date
- Recredentialing
  - This Facility Credentialing and Re-Credentialing form will need to be filled out during each re-credentialing cycle and is a contractual requirement
    - Please note: The Organizational Data Form may not need to be filled out each time. Follow the Health Plan's direction
  - Failure to complete all sections of the Application and submit current copies of all required documentation in a timely manner will be considered a request to terminate the facility's participation in a plan's network
- Health Plan Contact information can be found on the last page of either the Organizational Data Form or the Facility Application
- A list of Health Plans and the communities/regions they serve can be found on www.azahp.org

- Thank you for taking time to listen to Session #5
- If you have additional general questions, please go to www.azahp.org
  - Click on Credentialing Alliance and click on "Ask Pat"
    - Please note, I cannot answer specific questions regarding your credentialing status with any plan.
- AzAHP wishes to thank all the AHCCCS Health Plans for their assistance in developing the Provider Education Series.