

Electronic Visit Verification (EVV) Compliance Attestation

As the Chief Executive of a provider agency that provides or will provide services to AHCCCS members subject to Electronic Visit Verification (EVV), I attest to the following:

1. My agency will utilize an EVV system for all EVV applicable services as outlined on the AHCCCS website. I understand that my agency can choose to use the AHCCCS supplied statewide system through Sandata Technologies or an alternate EVV system that my agency procures. _____ Initial

2. I understand that I will not get paid for EVV services until my agency is using an EVV system to record visits and the required visit data is present for claimed services. _____ Initial

3. For EVV services that don't require prior authorization, my agency will input/upload required information including updates and changes into the AHCCCS Service Confirmation Portal to inform AHCCCS and Managed Care Organizations (MCOs) of the following information to support monitoring access to care through the EVV system

- Service codes, units, and modifiers
- Beginning and end date of the services
- Medical necessity determination date _____ Initial

4. I understand and will adhere to the AHCCCS Medical Policy Manual (AMPM) Electronic Visit Verification policy (540). _____ Initial

Name: _____ Title: _____

Organization: _____ Provider ID: _____

Direct Email: _____

Signature: _____ Date: _____

If the organization has multiple AHCCCS Provider Registration IDs that may be subject to EVV, please list all relevant Provider IDs.

AHCCCS Provider IDs	

Provider - please return this form directly to your health plan (AHCCCS or a Managed Care Organization) and maintain a copy for your records. Do NOT send to AHCCCS if you are contracting with a Managed Care Organization.

NOTE FOR Managed Care Organizations - Please maintain this document in the organization's credentialing and contact files. Send to AHCCCS once the credentialing process is complete (evv@azahcccs.gov).