



**Modification Request:  
Steps on how to complete a modification in APEP.**

**08/2021**



# Modification Request

This guide explains how to manage provider information and submit modification requests, when:

- A provider is approved within the AHCCCS Provider Enrollment Portal.
- A provider needs to report new information or a change of information.

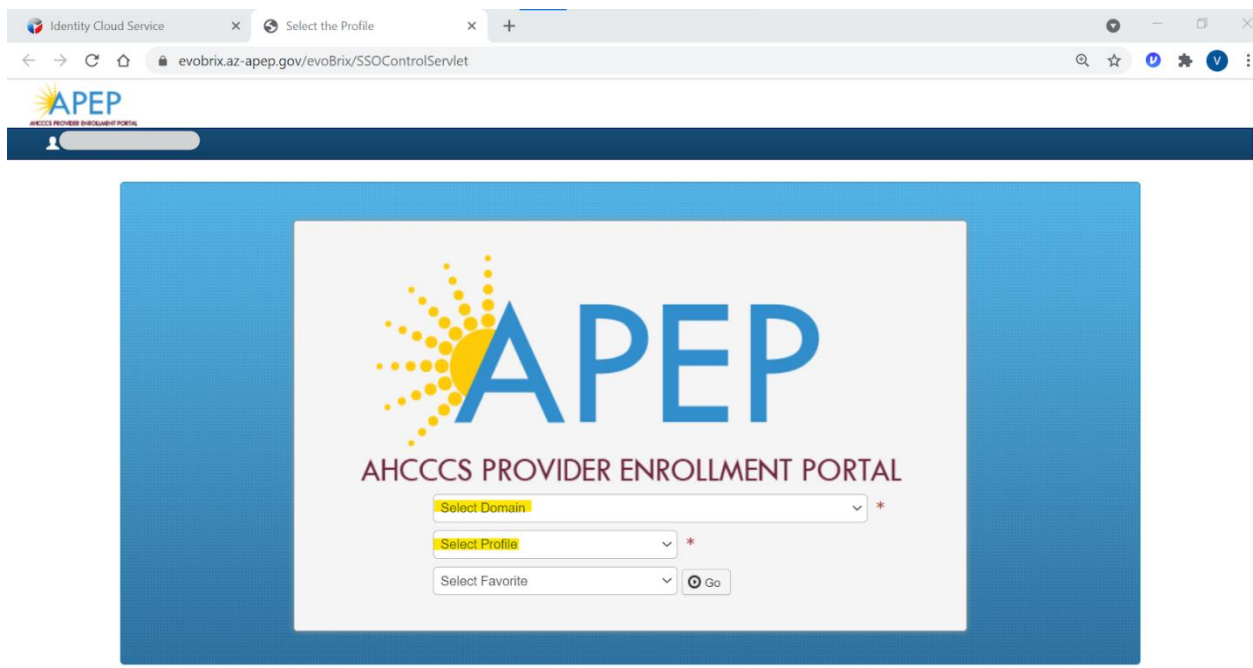
A “Modification” is a change or update.

Some examples of a “Modification”:

- A change in Correspondence, Pay-To, and Service location addresses.
- Group NPI/Tax ID Association
- Adding an owner or managing employee.
- Updating a license/certificate

## Beginning a Modification

To begin a modification, select the provider Domain and ‘Provider Enrollment Access’ profile:

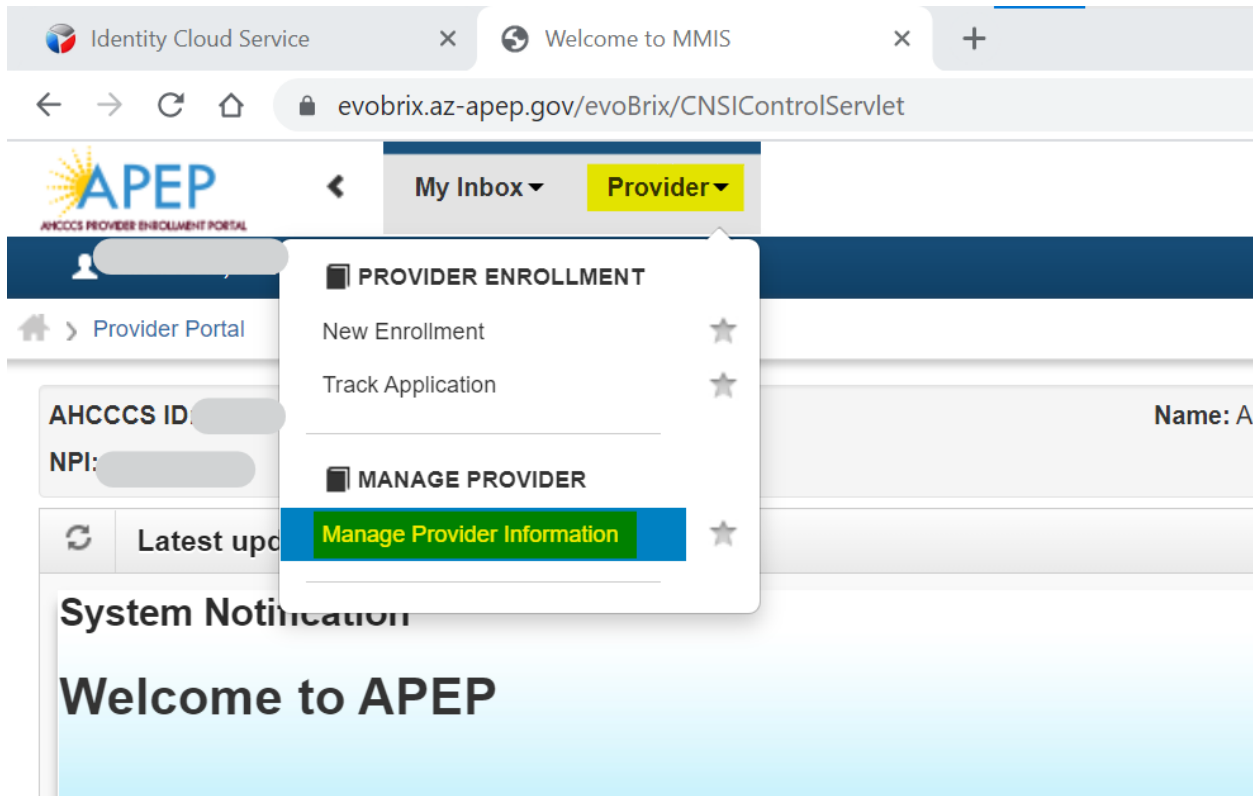


**Note:** If you don't see the provider's name listed in the “Select Domain” dropdown menu, this is an indication that the user needs to obtain domain permissions to the provider's file. This can be done through a Domain request. Please send an email, include provider NPI and APEP username requesting domain permission. Email [APEPTrainingQuestions@azahcccs.gov](mailto:APEPTrainingQuestions@azahcccs.gov)

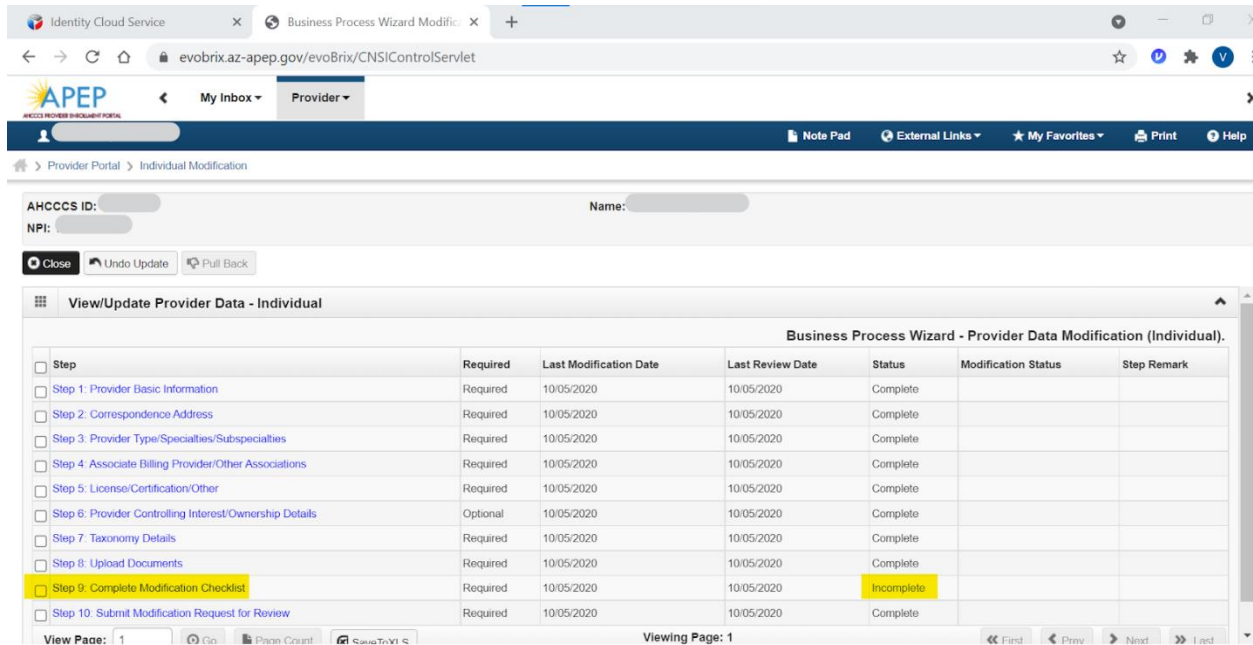
# Modification Request

From within the “Provider” drop-down option located along the top of the APEP landing page.

1. Select “Manage Provider Information” option



**Note:** Immediately after initial approval (or modification approval) APEP will reset the ‘Complete Modification Checklist’ step to incomplete.



# Modification Request

No action is needed when the 'Complete Modification Checklist' step is incomplete after initial approval (or modification approval).

## Enrollment Overview

The process will demonstrate the steps to follow for submitting a "Modification Request "

- Blue font: indicates a hyperlink.
- All steps display in blue font indicating the step is ready for data entry.
- "Modification Status" column: This column will display blank. As modifications are made, this column will reflect the current status.
- Step Remark column: This column will alert you to any problems in completing the step.
- \* An asterisk indicates required fields. Required fields must be completed to advance forward.

**Note:** It's important to note multiple application steps can be modified and submitted at once. Once a "Modification Request" has been submitted, it is in review and has been assigned to a state worker for processing, another "Modification Request" cannot be submitted until the State has completed the submitted request. Modification requests not assigned, use the 'Pull Back' button. The 'pull back' button allows a user to pull the request back, apply corrections, and submit again. Contact Provider Enrollment if additional assistance is needed. The following examples will demonstrate two examples of how to modify (1.) the Correspondence Address and (2.) adding a Billing Association.

## Example 1: Modification Request "Updating Correspondence Address"

### Part I: BPW Steps

1. Select Step 3: Correspondence Address.

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Provider Basic Information	Required	06/03/2020	06/03/2020	Complete		
Step 2: Locations	Required	06/03/2020	06/03/2020	Complete		
Step 3: Correspondence Address	Required	06/03/2020	06/03/2020	Complete		
Step 4: Provider Type/Specialties/Subspecialties	Required	06/03/2020	06/03/2020	Complete		
Step 5: Associate Billing Provider/Other Associations	Optional	06/03/2020	06/03/2020	Complete		
Step 6: Licenses/Certification/Other	Required	06/03/2020	06/03/2020	Complete		
Step 7: Provider Controlling Interest/Ownership Details	Required	06/03/2020	06/03/2020	Complete		
Step 8: Taxonomy Details	Required	06/03/2020	06/03/2020	Complete		
Step 9: Ware Servicing Provider Details	Optional	06/03/2020	06/03/2020	Complete		
Step 10: Upload Documents	Required	06/03/2020	06/03/2020	Complete		
Step 11: Complete Modification Checklist	Required	06/03/2020	06/03/2020	Incomplete		
Step 12: Submit Modification Request for Review	Required	06/03/2020	06/03/2020	Complete		

2. Select "Correspondence" in blue font on the Correspondence Address List.

# Modification Request

**Note:** On the Correspondence Address List, the status will display as “Approved”. This means that you can make modifications. If the status was “In review”, changes aren’t accepted until the changes are submitted to state and the state completes its review.

The screenshot shows the AHCCCS Provider Portal interface. At the top, the user is logged in as valentzuola,veronica. The main content area displays the provider details for ELISCO, ALVIN B. Below this is the "Correspondence Address List" section. It includes a filter bar and a table with the following data:

Address Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Correspondence	1313 S Harbor Blvd, PAYER CREDENTIALING, Anaheim, CALIFORNIA 92802	07/05/1983	12/31/2999	Approved	Active	
<input type="checkbox"/> Correspondence	701 E Jefferson St, PAYER CREDENTIALING, Phoenix, ARIZONA 85034	06/23/2020	12/31/2999	In Review	Active	

Page ID: pgCorrespondenceList(Provider) Environment: AZ\_UAT R10c-1.1 Server Time: 06/22/2020 11:52:56 MST

3. On the “Manage Provider Correspondence Address” page, complete modifications to the address displayed.
4. Select the “Validate Address” option.

The screenshot shows the "Manage Provider Correspondence Address" page. The address type is "Correspondence" and the status is "Approved". The address details are as follows:

Type of Address: Correspondence Status: Approved  
End Date: 12/31/2999

Address Line 1: 701 E Jefferson St  
Address Line 2: (Empty)  
Address Line 3: PAYER CREDENTIALING  
City/Town: Phoenix  
State/Province: ARIZONA  
County: Maricopa  
Country: UNITED STATES  
Zip Code: 85034

Page ID: pgCorrespondenceAddress(Provider) Environment: AZ\_UAT R10c-1.1 Server Time: 06/22/2020 11:52:21 MST

5. On the “Correspondence Address Page” the status will display “In Review”

# Modification Request

## 6. Select "Close."

The screenshot shows the 'Correspondence Address List' table with the following data:

Address Type	Address	Start Date	End Date	Status	Operational Status	Inactivation Date
<input type="checkbox"/> Correspondence	1313 S Harbor Blvd, PAYER CREDENTIALING, Anaheim, CALIFORNIA 92802	07/09/1983	12/31/2999	Approved	Active	
<input type="checkbox"/> Correspondence	701 E Jefferson St, PAYER CREDENTIALING, Phoenix, ARIZONA 85034	06/22/2020	12/31/2999	In Review	Active	

Page ID: pgCorrespondenceList(Provider) Environment: AZ\_UAT R19c-1.1 Server Time: 06/22/2020 11:52:56 MST

## 7. Review the "BPW Steps" page for the current modification:

- Step 3: Correspondence Address: "Modification Status" column will reflect as "Updated"
- Step 11: Submit Modification Request for Review: "Step Remark" column reflects "Modification Request has not been submitted"

**Note:** Step 10: Complete Modification Checklist must be completed prior to submission on all modification requests.

The screenshot shows the 'Business Process Wizard - Provider Data Modification (Individual)' table with the following data:

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 2: Locations	Required	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 3: Correspondence Address	Required	06/22/2020	06/03/2020	Complete	Updated	
<input type="checkbox"/> Step 4: Provider Type/Specialties/Subspecialties	Required	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 5: Associate Billing Provider/Other Associations	Optional	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 6: License/Certification/Other	Required	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 9: View Servicing Provider Details	Optional	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 10: Upload Documents	Required	06/03/2020	06/03/2020	Complete		
<input type="checkbox"/> Step 11: Complete Modification Checklist	Required	06/03/2020	06/03/2020	Incomplete		
<input type="checkbox"/> Step 12: Submit Modification Request for Review	Required	06/22/2020	06/03/2020	Incomplete		Modification Request has not been Submitted.

Page ID: pgBPWIndividualUpdate(Provider) Environment: AZ\_UAT R19c-1.1 Server Time: 06/22/2020 11:49:27 MST

# Modification Request

## Part II

### Step 11: Complete Modification Checklist

1. Select “Step 11: Complete Modification Checklist.”

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Provider Basic Information	Required	06/03/2020	06/03/2020	Complete		
Step 2: Locations	Required	06/03/2020	06/03/2020	Complete		
Step 3: Correspondence Address	Required	06/03/2020	06/03/2020	Complete	Updated	
Step 4: Provider Type/Specialties/Subspecialties	Required	06/03/2020	06/03/2020	Complete		
Step 5: Associate Billing Provider/Other Associations	Optional	06/03/2020	06/03/2020	Complete		
Step 6: License/Certification/Other	Required	06/03/2020	06/03/2020	Complete		
Step 7: Provider Controlling Interest/Ownership Details	Required	06/03/2020	06/03/2020	Complete		
Step 8: Taxonomy Details	Required	06/03/2020	06/03/2020	Complete		
Step 9: View Servicing Provider Details	Optional	06/03/2020	06/03/2020	Complete		
Step 10: Upload Documents	Required	06/03/2020	06/03/2020	Complete		
Step 11: Complete Modification Checklist	Required	06/03/2020	06/03/2020	Incomplete		
Step 12: Submit Modification Request for Review	Required	06/22/2020	06/03/2020	Incomplete		Modification Request has not been Submitted.

2. Answer each question and provide any additional information in the Comments field.
3. After reviewing the information, select “Save” and then “Close.”

Question	Answer	Comments
Do you need to request a Retroactive or Future Enrollment Date? If yes, enter the requested date in the comment field to be considered.	Not Completed	
Do you wish to end date your enrollment? If yes, enter date in comment field.	Not Completed	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	Not Completed	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	Not Completed	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	Not Completed	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	Not Completed	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	Not Completed	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	Not Completed	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	Not Completed	
Are you trying to reactivate a provider previously active with AHCCCS whose status became inactive or lapsed for any reason? If yes, please add the previous AHCCCS ID in the comments field again.	Not Completed	

4. Review the “Status” column. If any steps in the “Status” column display as “Incomplete” select the “incomplete” link to return and complete required information.

# Modification Request

## Part III

### Step 12: Submit Modification Request for Review

1. Select "Step 12: Submit Modification Request for Review"

Identity Cloud Service | Business Process Wizard Modifi- | +

az-uat-evo.cns-inc.com/evobris/CNSControlServlet

APEP | My Inbox | Provider

valenzuela,veronica

Provider Portal | Individual Modification

AHCCCS ID: 248741 | Name: ELISCO, ALVIN B.  
NPI: 1346241189

Close | Undo Update | Pull Back

### View/Update Provider Data - Individual

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Provider Basic Information	Required	06/03/2020	06/05/2020	Complete		
Step 2: Locations	Required	06/03/2020	06/03/2020	Complete		
Step 3: Correspondence Address	Required	06/03/2020	06/03/2020	Complete		
Step 4: Provider Type/Specialties/Subspecialties	Required	06/03/2020	06/03/2020	Complete		
Step 5: Associate Billing Provider/Other Associations	Optional	06/03/2020	06/03/2020	Complete		
Step 6: License/Certification/Other	Required	06/03/2020	06/03/2020	Complete		
Step 7: Provider Controlling Interest/Ownership Details	Required	06/03/2020	06/03/2020	Complete		
Step 8: Taxonomy Details	Required	06/03/2020	06/03/2020	Complete		
Step 9: View Servicing Provider Details	Optional	06/03/2020	06/03/2020	Complete		
Step 10: Upload Documents	Required	06/03/2020	06/03/2020	Complete		
Step 11: Complete Modification Checklist	Required	06/03/2020	06/03/2020	Incomplete		
Step 12: Submit Modification Request for Review	Required	06/03/2020	06/03/2020	Complete		

Page ID: ppEPWIndividualUpdate(Provider) | Environment: AZ\_UAT R10c-1.1 | Server Time: 06/22/2020 11:49:27 MST

2. Select "Next" to advance forward.

Identity Cloud Service | Welcome to MMIS | +

az-uat-evo.cns-inc.com/evobris/CNSControlServlet

APEP | My Inbox | Provider

valenzuela,veronica

Provider Portal | Individual Modification

AHCCCS ID: 248741 | Name: ELISCO, ALVIN B.  
NPI: 1346241189

Close | Next

NPI: 1346241189 | EnrollmentType: Individual/Sole Proprietor

The information submitted shall be verified and reviewed by the State.  
During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct. (Private and Confidential)

### Application Document Checklist

Forms/Documents	Special Instructions	Source	Required
No Records Found!			

Page ID: ppSubmitModification(Provider) | Environment: AZ\_UAT R10c-1.1 | Server Time: 06/22/2020 11:57:44 MST



# Modification Request

## 3. Carefully review the Provider Participation Agreement.

The screenshot shows a web browser window with the URL `az-uat-evo.crs-inc.com/evobriv/CNS/ControlServlet`. The page title is "Provider Part 3 - Individual Modification". The provider information is: AHCCCS ID: 248741, NPI: 1346241189, Name: ELISCO, ALVIN B. There are buttons for "Close" and "Submit for Modification". The "Final Submission" section is expanded to show the "Provider Participation Agreement".

**A. PURPOSE:**  
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Provider, as identified above, pursuant to Title XXX and Title XXXI of the Social Security Act and A.R.S. §36-2901 et seq. to govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only, (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a Contractor; and (3) the registration of the Provider who wishes to participate and qualify under the one-time only waiver option.  
Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Provider do hereby acknowledge and expressly agree as follows.

**B. GENERAL TERMS AND CONDITIONS:**

1. Pursuant to 42 C.F.R. §431.107, the Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clauses, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.

Page ID: pgSubmitModification(Provider) Environment: AZ\_UAT R10c-1.1 Server Time: 06/22/2020 11:57:56 MST

## 4. Select the "Check box" indicating agreement with the Provider Participating Agreement. The signor's full name and Date will automatically display.

## 5. Select "Submit Application"

The screenshot shows the same web browser window as above, but scrolled down to the signature section. The provider information remains the same. The "Submit for Modification" button is now highlighted.

33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

**ELECTRONIC SIGNATURE:** This Acknowledgement is to let you know that by submitting an electronic signature, you are providing an electronic mark, that is held to the same standard as a legally binding equivalent of a handwritten signature provided by you on behalf of your organization. For purposes of the acknowledgement, a digital mark is considered a typed legal First and Last name (legal name may include middle name, initial or suffix) followed by the typed date. Any document requiring an electronic signature may contain a signature acknowledgment statement provided in the same area requiring the electronic signature.

**AGREEMENT & ACKNOWLEDGEMENT:** I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding. Likewise, I, on behalf of the organization that I am authorized to represent, consent to do business electronically. This electronic signature will function as acknowledgement that I am authorized to represent and bind the organization for which this documentation is submitted. An electronic record will be kept of the documentation with which the electronic signature is associated. This electronic record will be retained and capable of being reproduced for future use. It is also acknowledged that this electronic signature meets the standard identified in A.R.S. § 44-7031 for uniqueness, verification, sole control, and record linkage applicable for Arizona.

The undersigned attest that they have entered into an agreement effective on the date indicated below. Both parties agree an authorized representative of the enrolling entity has the authority to sign and submit this electronic agreement and to maintain enrollment information through AHCCCS Provider Registration.

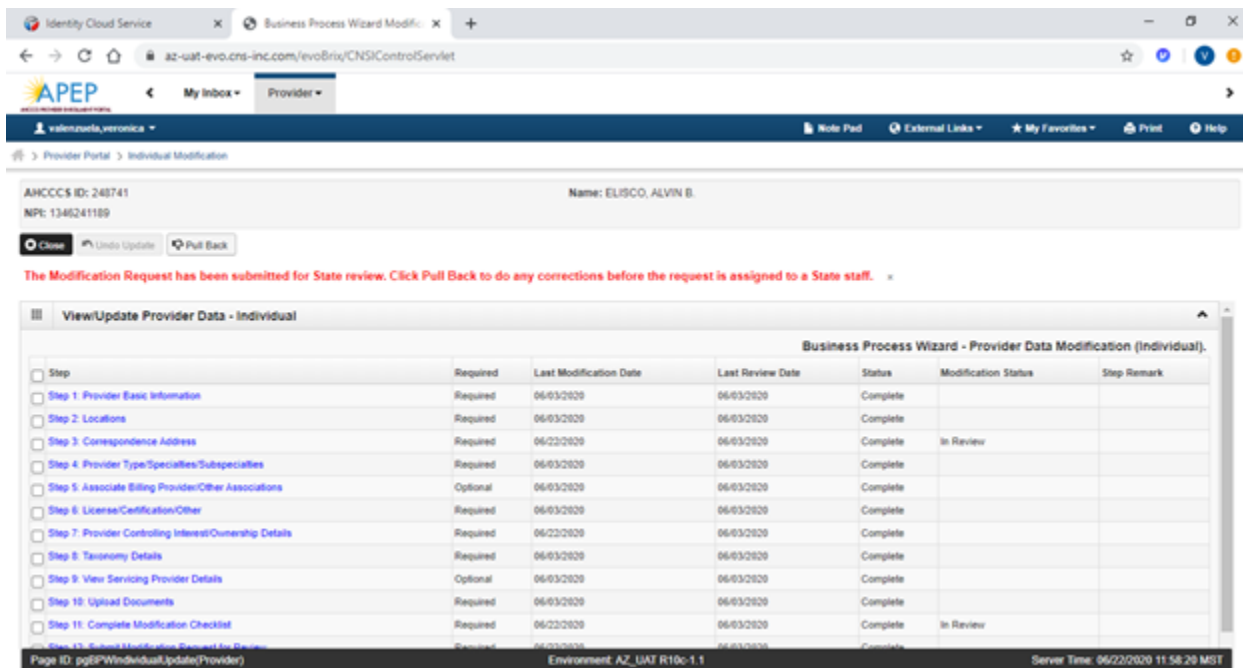
I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

First Name: veronica Last Name: valenzuela Date: 06/22/2020

Page ID: pgSubmitModification(Provider) Environment: AZ\_UAT R10c-1.1 Server Time: 06/22/2020 11:57:56 MST

# Modification Request

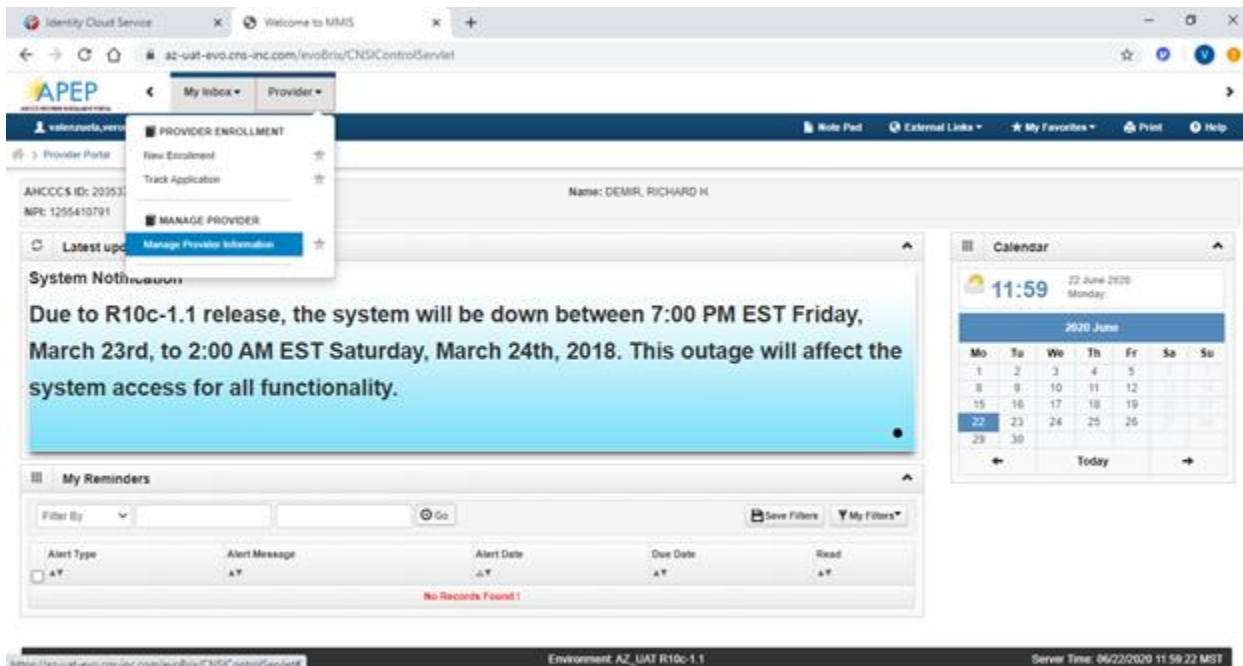
6. If you have successfully submitted the modification, you will see the message in red at the top of the page.
7. Select "Close" to exit from the application.



## Example 2: Modification Request "Add an Additional Billing Provider" Part I

To begin a modification, select the "Provider" drop-down option located along the top of the APEP landing page.

1. Select "Manage Provider Information" option



# Modification Request

## Part II

### Step 1: BPW Steps

1. Select “Step 5: Associate Billing Provider/Other Associations”

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Provider Basic Information	Required	05/22/2020	05/22/2020	Complete		
Step 2: Locations	Required	05/22/2020	05/22/2020	Complete		
Step 3: Correspondence Address	Required	05/22/2020	05/22/2020	Complete		
Step 4: Provider Type/Specialties/Subspecialties	Required	05/22/2020	05/22/2020	Complete		
Step 5: Associate Billing Provider/Other Associations	Optional	05/22/2020	05/22/2020	Complete		
Step 6: License/Certification/Other	Required	05/22/2020	05/22/2020	Complete		
Step 7: Provider Controlling Interest/Owning Details	Required	05/22/2020	05/22/2020	Complete		
Step 8: Taxonomy Details	Required	05/22/2020	05/22/2020	Complete		
Step 9: View Servicing Provider Details	Optional	05/22/2020	05/22/2020	Complete		
Step 10: Upload Documents	Required	05/22/2020	05/22/2020	Complete		
Step 11: Complete Modification Checklist	Required	05/22/2020	05/22/2020	Incomplete		
Step 12: Submit Modification Request for Review	Required	05/22/2020	05/22/2020	Complete		

2. Select “Add” on the Billing Provider/Other Associations List.

**Note:** On the Associate Billing Provider/Other Associations List, the status will display as “Approved”. This means that you can make modifications. If the status is “In review”, no changes could be made until the state completes its review.

NPI/AHCCCS ID	Provider Name	Start Date	End Date	Status	Operational Status	Inactivation Date
189189637	PHOENICIAN MEDICAL CENTER INC.	02/03/2008	12/31/2999	Approved	Active	

# Modification Request

3. On the “Associate Billing Provider/Other Associations” page, complete required fields to add the billing provider.
4. Select “Confirm Provider” option.
5. Select “OK”

Welcome to MMS - Google Chrome  
az-uat-evo.cns-inc.com/evobrix/CNSControlServlet

Print Help

AHCCCS ID: 203537 Name: DEMIR, RICHARD H.  
NPI: 1255410791

**Associate Billing Provider/Other Associations**

Enter NPI/AHCCCS ID of Billing Provider/Other Associations and click "Confirm Provider."

Type: NPI \*  
ID: 1568663250 \*  
Start Date: 06/22/2020 \*  
Provider Name: P3 VNS OF PHOENIX INC  
End Date: \*

Confirm Provider OK Cancel

Page ID: dgAssocBillingPrvdt(Provider)

6. The “Billing Provider/Other Association” list, “the status will display “In Review”
7. Select “Close”

Identity Cloud Service Billing Provider/Other Associati...  
az-uat-evo.cns-inc.com/evobrix/CNSControlServlet

APEP  
My Inbox Provider  
valenzuela,veronica  
Note Pad External Links My Favorites Print Help

Provider Portal Individual Modification

AHCCCS ID: 203537 Name: DEMIR, RICHARD H.  
NPI: 1255410791

Close Add

**Billing Provider/Other Associations List**

Filter By And Filter By And Operational Status  
Active Go Save Filters My Filters

NPI/AHCCCS ID	Provider Name	Start Date	End Date	Status	Operational Status	Inactivation Date
1568663250	P3 VNS OF PHOENIX INC	06/22/2020	12/31/2999	In Review	Active	
1891895637	PHOENIXIAN MEDICAL CENTER INC.	02/03/2008	12/31/2999	Approved	Active	

View Page: 1 Page Count Save To XLS Viewing Page: 1 First Prev Next Last

Page ID: pgBillingPrvdt.lst(Provider) Environment: AZ\_UAT R10c-1.1 Server Time: 06/22/2020 12:01:03 MST

# Modification Request

- On the “Billing Provider/Other Association” list, “the status will display “In Review”
- Select “Close”

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Provider Basic Information	Required	05/22/2020	05/22/2020	Complete		
Step 2: Locations	Required	05/22/2020	05/22/2020	Complete		
Step 3: Correspondence Address	Required	05/22/2020	05/22/2020	Complete		
Step 4: Provider Type/Specialties/Subspecialties	Required	05/22/2020	05/22/2020	Complete		
Step 5: Associate Billing Provider/Other Associations	Optional	06/22/2020	05/22/2020	Complete	Updated	
Step 6: License/Certification/Other	Required	05/22/2020	05/22/2020	Complete		
Step 7: Provider Controlling Interest/Owning Details	Required	05/22/2020	05/22/2020	Complete		
Step 8: Taxonomy Details	Required	05/22/2020	05/22/2020	Complete		
Step 9: View Servicing Provider Details	Optional	05/22/2020	05/22/2020	Complete		
Step 10: Upload Documents	Required	05/22/2020	05/22/2020	Complete		
Step 11: Complete Modification Checklist	Required	05/22/2020	05/22/2020	Incomplete		
Step 12: Submit Modification Request for Review	Required	06/22/2020	05/22/2020	Incomplete		Modification Request has not been Submitted.

- Review the “BPW Steps” page for the current modification:
  - Step 5: Associate Billing Provider/Other Associations: “Modification Status” column will reflect as “Updated”

**Note:** Step 12: Complete Modification Checklist must be completed prior to submission on all modification requests.

# Modification Request

## Part III

### Step 11: Complete Enrollment Checklist

1. Select "Step 11: Complete Enrollment Checklist."

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
Step 1: Provider Basic Information	Required	05/22/2020	05/22/2020	Complete		
Step 2: Locations	Required	05/22/2020	05/22/2020	Complete		
Step 3: Correspondence Address	Required	05/22/2020	05/22/2020	Complete		
Step 4: Provider Type/Specialties/Subspecialties	Required	05/22/2020	05/22/2020	Complete		
Step 5: Associate Billing Provider/Other Associations	Optional	06/22/2020	05/22/2020	Complete	Updated	
Step 6: License/Certification/Other	Required	05/22/2020	05/22/2020	Complete		
Step 7: Provider Controlling Interest/Ownership Details	Required	06/22/2020	05/22/2020	Complete		
Step 8: Taxonomy Details	Required	05/22/2020	05/22/2020	Complete		
Step 9: View Servicing Provider Details	Optional	05/22/2020	05/22/2020	Complete		
Step 10: Upload Documents	Required	05/22/2020	05/22/2020	Complete		
Step 11: Complete Modification Checklist	Required	05/22/2020	05/22/2020	Incomplete		Please Answer all the Questions. Modification Request has not been Submitted.
Step 12: Submit Modification Request for Review	Required	06/22/2020	05/22/2020	Incomplete		

2. Answer each question and provide any additional information in the Comments field.
3. After reviewing the information, select "Save" and then "Close"

Question	Answer	Comments
Do you need to request a Retroactive or Future Enrollment Date? If yes, enter the requested date in the comment field to be considered.	No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	No	
Are you trying to reactivate a provider previously active with AHCCCS whose status became inactive or lapsed for any reason? If yes, please add the previous AHCCCS ID in the comments field again.	No	

# Modification Request

4. Carefully review the "Status" column. If any steps show "Incomplete" select the "incomplete" link to return and complete required information.

Business Process Wizard - Provider Data Modification (Individual)

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 2: Locations	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 3: Correspondence Address	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 4: Provider Type/Specialties/Subspecialties	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 5: Associate Billing Provider/Other Associations	Optional	06/22/2020	05/22/2020	Complete	Updated	
<input type="checkbox"/> Step 6: License/Certification/Other	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 7: Provider Controlling Interest/Owning Details	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 9: View Servicing Provider Details	Optional	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 10: Upload Documents	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 11: Complete Modification Checklist	Required	06/22/2020	05/22/2020	Complete	Updated	
<input type="checkbox"/> Step 12: Submit Modification Request for Review	Required	06/22/2020	05/22/2020	Incomplete		Modification Request has not been Submitted.

## Part IV

### Step 12: Submit Modification Request for Review

1. Select "Step 12: Submit Modification Request for Review"

Business Process Wizard - Provider Data Modification (Individual)

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 2: Locations	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 3: Correspondence Address	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 4: Provider Type/Specialties/Subspecialties	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 5: Associate Billing Provider/Other Associations	Optional	06/22/2020	05/22/2020	Complete	Updated	
<input type="checkbox"/> Step 6: License/Certification/Other	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 7: Provider Controlling Interest/Owning Details	Required	06/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 9: View Servicing Provider Details	Optional	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 10: Upload Documents	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 11: Complete Modification Checklist	Required	06/22/2020	05/22/2020	Complete	Updated	
<input type="checkbox"/> Step 12: Submit Modification Request for Review	Required	06/22/2020	05/22/2020	Incomplete		Modification Request has not been Submitted.

# Modification Request

2. Select "Next" to proceed forward.

The screenshot shows a web browser window with the URL `az-uat-evo.cna-inc.com/evobris/CNS/ControlServlet`. The page title is "Provider Part 1 Individual Modification". The user is logged in as `valenzuela.veronica`. The form displays the following information:

- AHCCCS ID: 203537
- NPI: 1255410791
- Name: DEMIR, RICHARD H.

Navigation buttons: **Close** and **Next**.

**Final Submission**

NPI: 1255410791      EnrollmentType: Individual Sole Proprietor

The information submitted shall be verified and reviewed by the State.  
During this time, any changes to the information shall not be accepted.

I agree that the information submitted as a part of the application is correct. (Private and Confidential)

**Application Document Checklist**

Forms/Documents	Special Instructions	Source	Required
No Records Found!			

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3. Review the Provider Participation Agreement.

The screenshot shows the same web browser window as above, but the "Next" button is now selected. The form displays the following information:

- AHCCCS ID: 203537
- NPI: 1255410791
- Name: DEMIR, RICHARD H.

Navigation buttons: **Close** and **Submit for Modification**.

**Final Submission**

**Provider Participation Agreement**

**A.PURPOSE:**

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Provider, as identified above, pursuant to Title XXV and Title XXI of the Social Security Act and A.R.S. §39-2901 et seq. to govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a Contractor; and (3) the registration of the Provider who wishes to participate and qualify under the one-time only waiver option.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Provider do hereby acknowledge and expressly agree as follows:

**B.GENERAL TERMS AND CONDITIONS:**

- 1.Pursuant to 42 C.F.R. §431.107, the Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
- 2.All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.

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# Modification Request

4. Select the “Check box” indicating agreement with the Provider Participating Agreement. The signor’s First and Last name, and Date will automatically display.
5. Select “Submit Application”

AHCCCS ID: 203537  
NPI: 1255410791  
Name: DEMIR, RICHARD H.

Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

**ELECTRONIC SIGNATURE:** This Acknowledgement is to let you know that by submitting an electronic signature, you are providing an electronic mark, that is held to the same standard as a legally binding equivalent of a handwritten signature provided by you on behalf of your organization. For purposes of the acknowledgement, a digital mark is considered a typed legal First and Last name (legal name may include middle name, initial or suffix) followed by the typed date. Any document requiring an electronic signature may contain a signature acknowledgment statement provided in the same area requiring the electronic signature.

**AGREEMENT & ACKNOWLEDGEMENT:** I agree that my electronic signature is the legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding. Likewise, I, on behalf of the organization that I am authorized to represent, consent to do business electronically. This electronic signature will function as acknowledgement that I am authorized to represent and bind the organization for which this documentation is submitted. An electronic record will be kept of the documentation with which the electronic signature is associated. This electronic record will be retained and capable of being reproduced for future use. It is also acknowledged that this electronic signature meets the standard identified in A.R.S. § 44-7031 for uniqueness, verification, sole control, and record linkage applicable for Arizona.

The undersigned attest that they have entered into an agreement effective on the date indicated below. Both parties agree an authorized representative of the enrolling entity has the authority to sign and submit this electronic agreement and to maintain enrollment information through AHCCCS Provider Registration.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

First Name: vrb99ca      Last Name: valier2ulla      Date: 06/22/2020

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6. If you have successfully submitted the modification, you will see the message in red at the top of the page.
7. Select “Close” to exit from the application.

AHCCCS ID: 203537  
NPI: 1255410791  
Name: DEMIR, RICHARD H.

The Modification Request has been submitted for State review. Click Pull Back to do any corrections before the request is assigned to a State staff.

View/Update Provider Data - Individual

Step	Required	Last Modification Date	Last Review Date	Status	Modification Status	Step Remark
<input type="checkbox"/> Step 1: Provider Basic Information	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 2: Locations	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 3: Correspondence Address	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 4: Provider Type/Specialties/Subspecialties	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 5: Associate Billing Provider/Other Associations	Optional	06/22/2020	05/22/2020	Complete	In Review	
<input type="checkbox"/> Step 6: License/Certification/Other	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 7: Provider Controlling Interest/Ownership Details	Required	06/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 8: Taxonomy Details	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 9: View Servicing Provider Details	Optional	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 10: Upload Documents	Required	05/22/2020	05/22/2020	Complete		
<input type="checkbox"/> Step 11: Complete Modification Checklist	Required	06/22/2020	05/22/2020	Complete	In Review	

Page ID: pgEPWIndividualUpdate(Provider)      Environment: AZ\_UAT R10c-1.1      Server Time: 06/22/2020 12:37:56 MST

# Modification Request

**Note:** Once the modification has been submitted to the state for review, it can be cancelled for a short period of time using the “Pull Back” option. The “Pull Back” option becomes unavailable once the state has assigned the submitted document to complete the review. If you continue to need the document to be cancelled, Contact Provider Assistance at 602-417-7670 option 5 for assistance.