Contents

Atypical Agency Enrollment

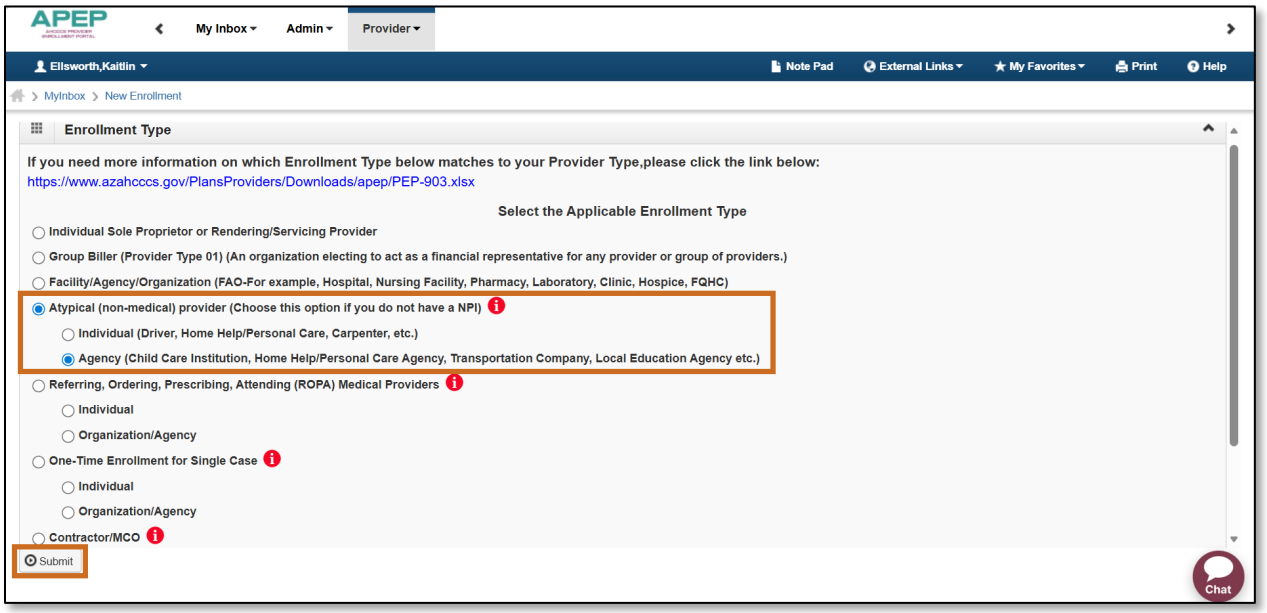
This guide explains how to complete the enrollment process for providers when the provider being enrolled:

- Is a Facility/Agency/Organization (FAO), providing health care or support services;
- Does not have a National Provider Identifier (NPI)

For a comprehensive list of Atypical Agencies see the **Screening Glossary**. Common examples include NEMT, Habilitation Providers, or Group Home.

Beginning an Application

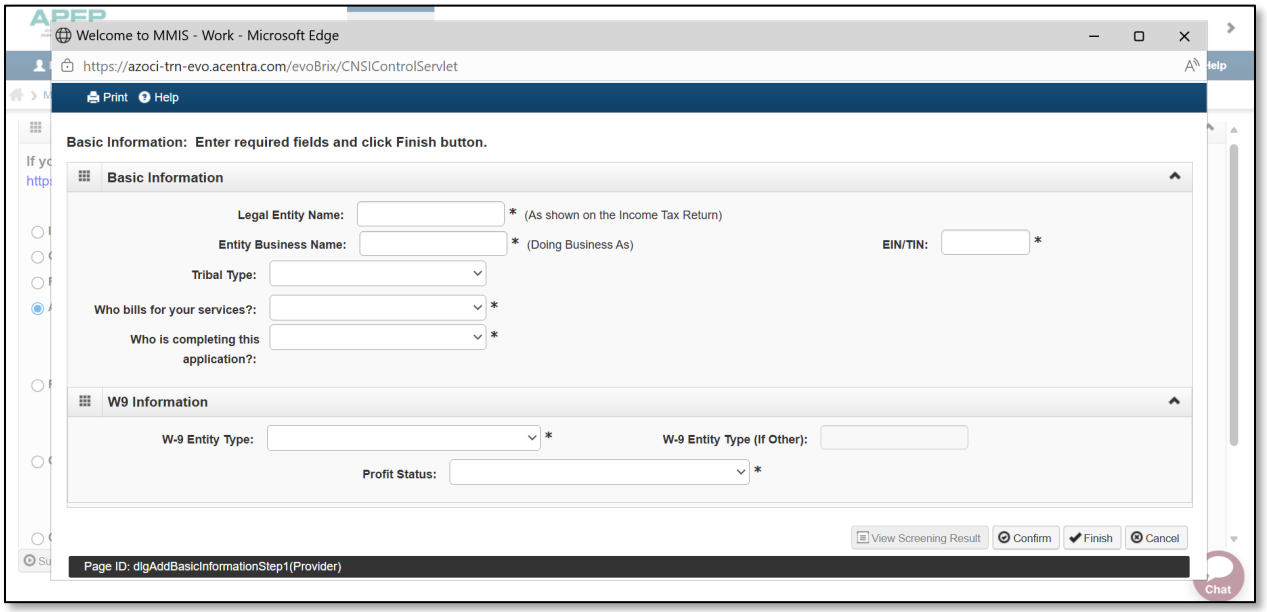
To begin an application, select the “Atypical (non-medical)” option, then select “Submit.”



Step 1: Provider Basic Information

- Select Step 1: “Provider Basic Information.”

Note: * An asterisk indicates required response prior to selecting “Finish.”

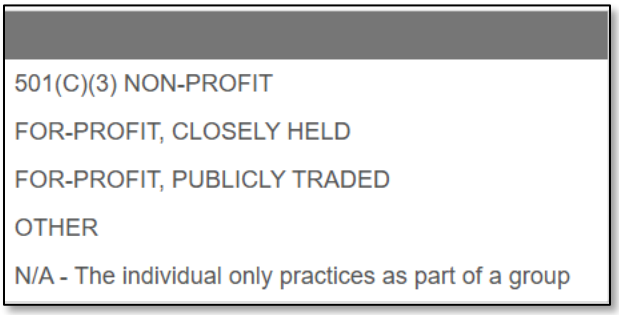


Enter the provider’s basic information.

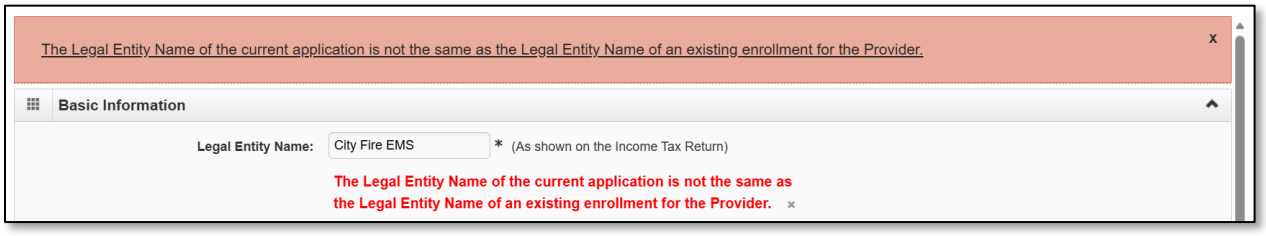
- Legal Entity Name: As shown on the organization’s IRS 147C letter and the Request for Taxpayer Identification Number and Certification (IRS W9)
- Entity Business Name: The Provider’s “Doing Business As” (DBA) name shown on the organization’s license.
- EIN/TIN: Enter the organization’s Tax Identification Number (TIN) as shown on the organization’s 147C.
    - Tribal Type: Select the applicable dropdown option. Leave blank when not applicable.
        - IHS-Indian Health Service
        - Privately owned on tribal land
        - Tribally owned on tribal land
- Who bills for your services: In-house, or outside biller
- Who is completing this application: Employee of this provider, or outside credentialing agent

- W-9 Entity Type: The information selected should most closely match the details reported to the IRS on your W-9. If you are unsure refer to your tax advisor. Select from the following:

- Profit Status: If you are unsure refer to your tax advisor. Select from the following:



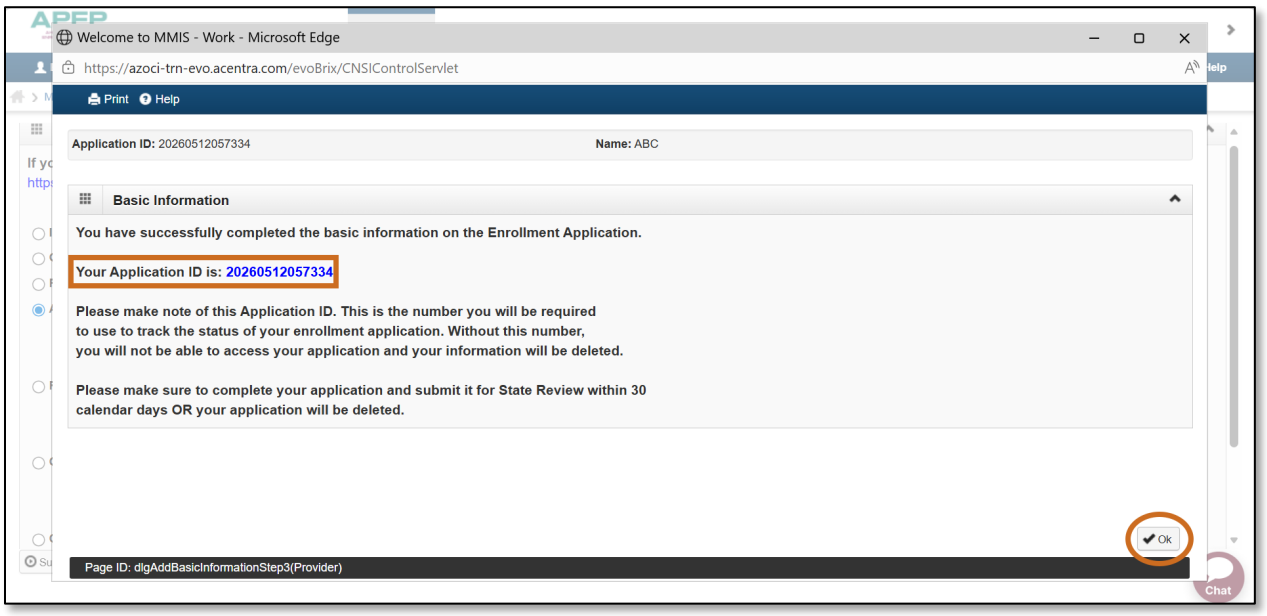
- Once complete select, “Confirm”



- Once the Basic Information is complete, an Application ID will be provided. You will need this Application ID if you choose to complete the application at a later time. Once an application has been started, you will have 30 calendar days to complete and submit the application.

Take note of the Application ID. If the Application ID is misplaced, check the email account used during the User Registration process to retrieve the email containing the Application ID.

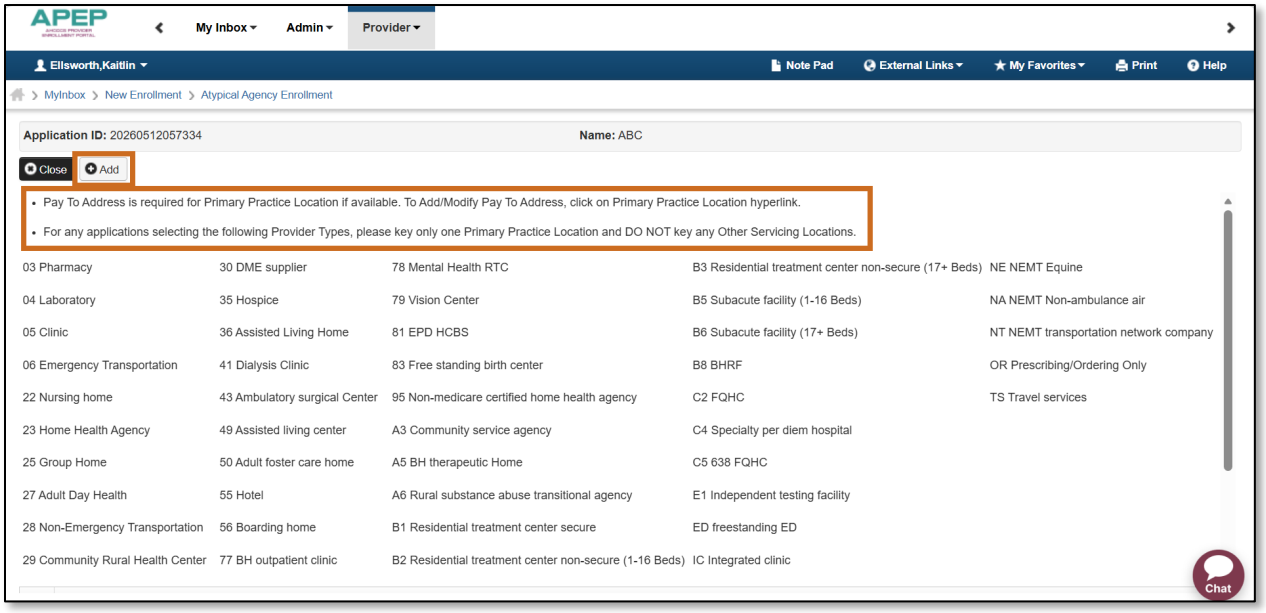
- To continue with the application, select “OK”.



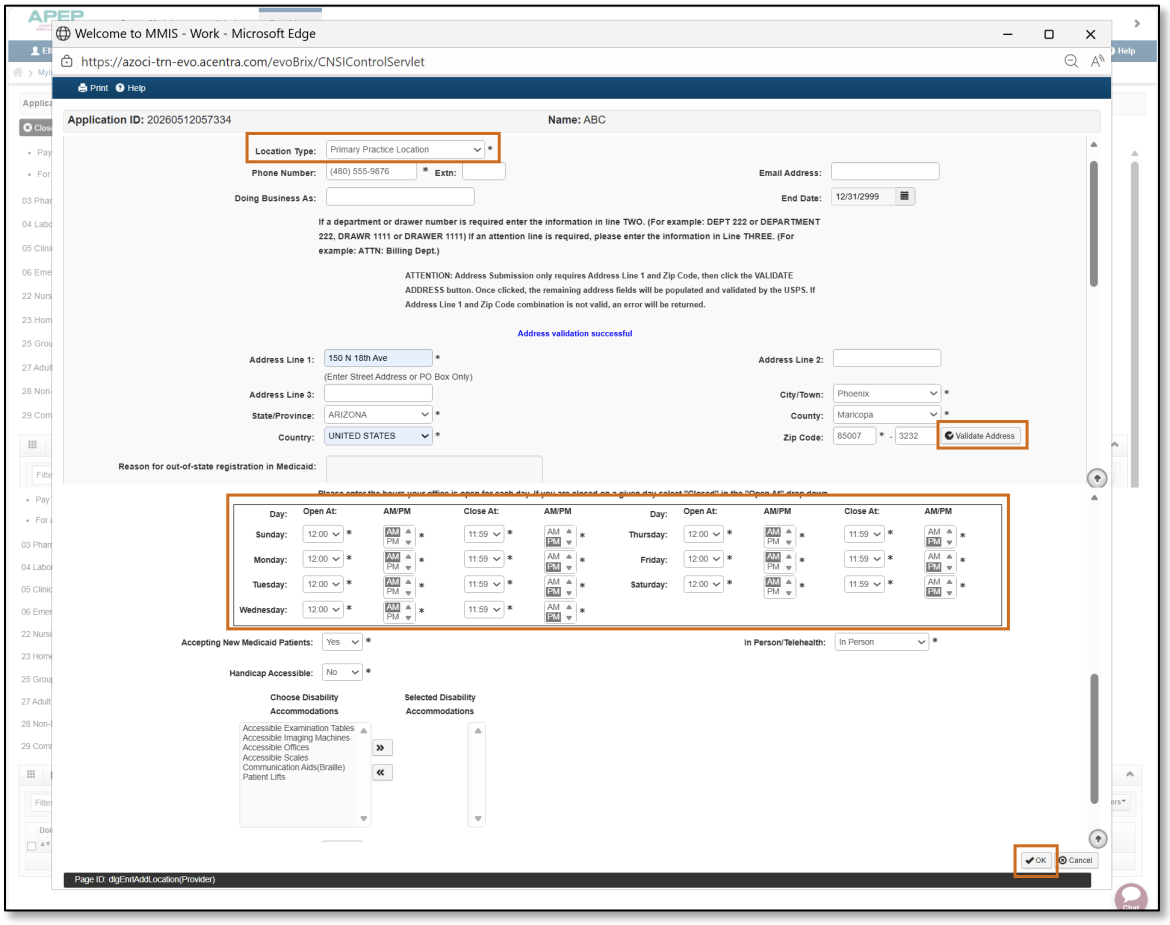
Step 2: Add Locations

Fields with an asterisk are required fields and must be completed to move to the next step.

- Select “Step 2: Add Locations.”
- Select “Add” to open up the details page to add a Primary Practice Location and Pay To Address for the location(s). Adding additional servicing locations is optional.



- Select: “Primary Practice Location” in the drop down menu. Complete all required fields, then select “Validate Address” and “OK” to proceed forward.



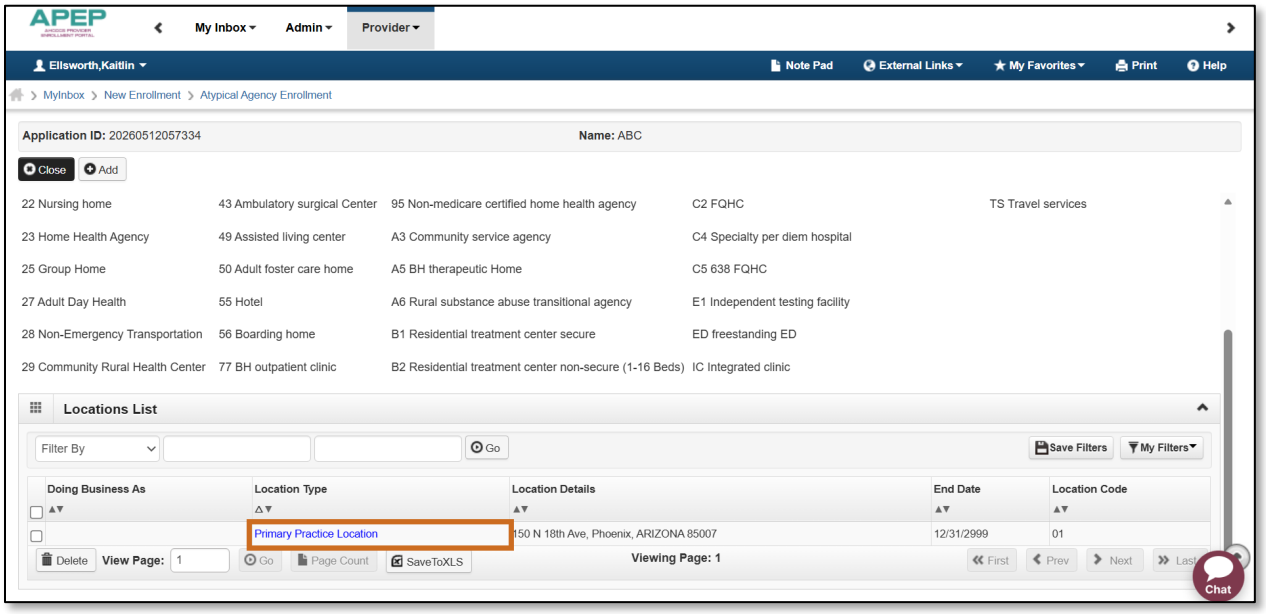
Enter the street address on Address line 1 and the five-digit Zip Code, then click “Validate Address.” The remainder of the address fields will automatically populate and be validated by the information from the U.S. Postal Service.

If the address is not found with Address Line 1 and Zip Code entered, validate your address using the USPS link:

- Proceed to Enter State, City and County
- Select “Validate Address”
- Select “OK”
- A pop up will generate stating “Please confirm Address Line 1 and Zip Code are correct. Address cannot be validated with the US Postal Service. Please press OK to continue OR press Cancel and revalidate the address.”
- Select “OK”

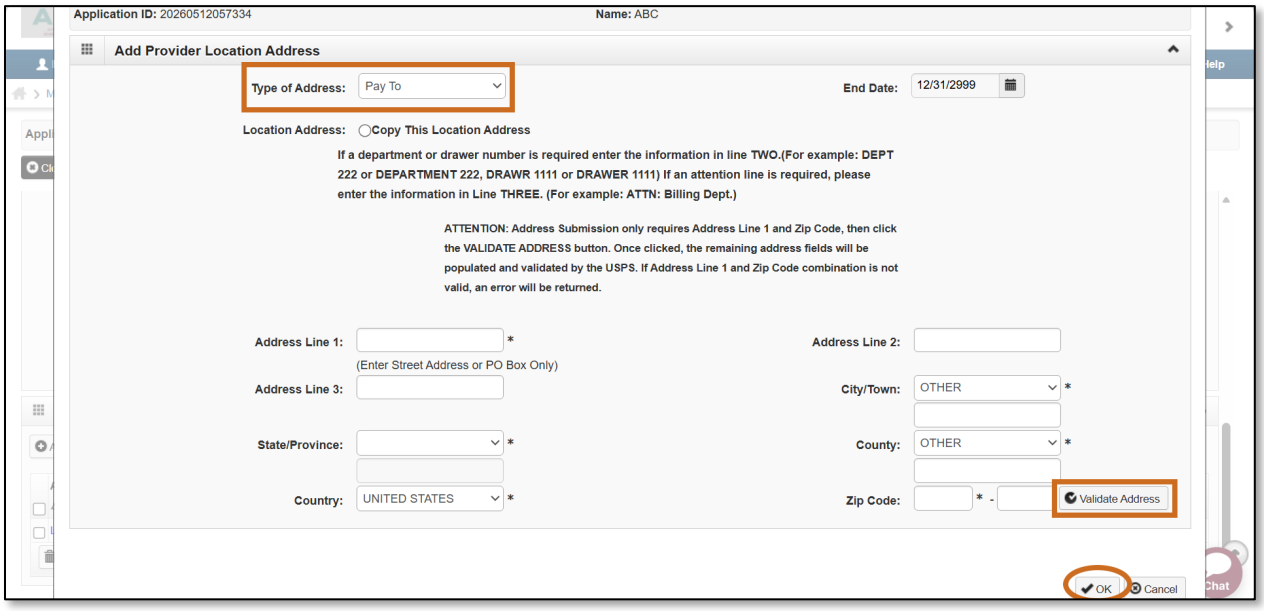
Every “Primary Practice Location” requires hours of operation.

- Select “OK” when complete.
- Select the “Primary Practice location” link to add a Pay To Address. The link will display in Blue font under the “Location Type” field.

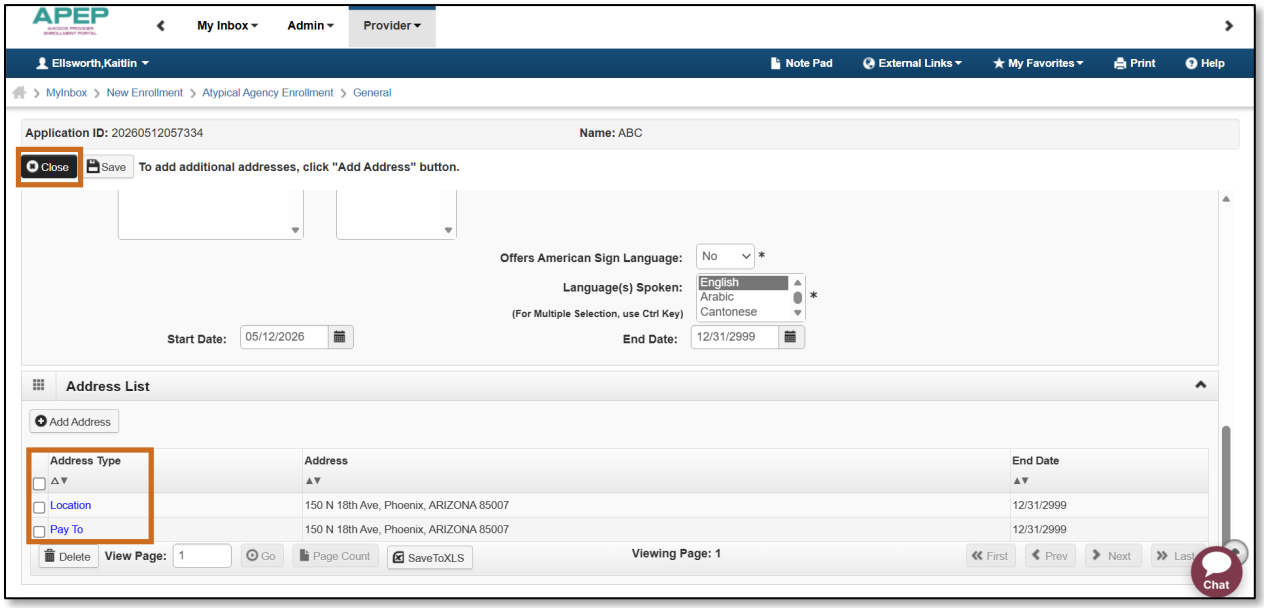


- Select “Add Address.”
- Type of Address: Select “Pay To Address” in the drop-down menu. Enter, review and “Validate Address” the address.
- When complete, select “OK” to proceed forward.

Note: If the “Pay to Address” is the same as the Primary Practice Location, Click the Location Address radio button “Copy this Location Address” to copy the address. Then click “OK.”

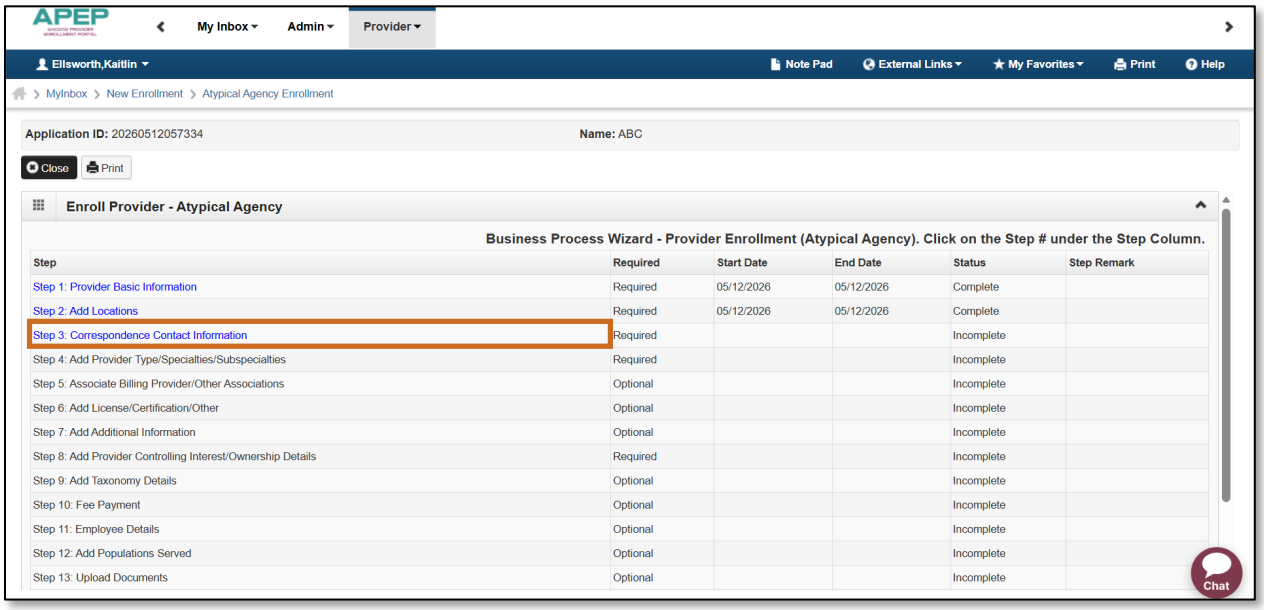


- The Provider Practice Location(s) will now display in the Address list.

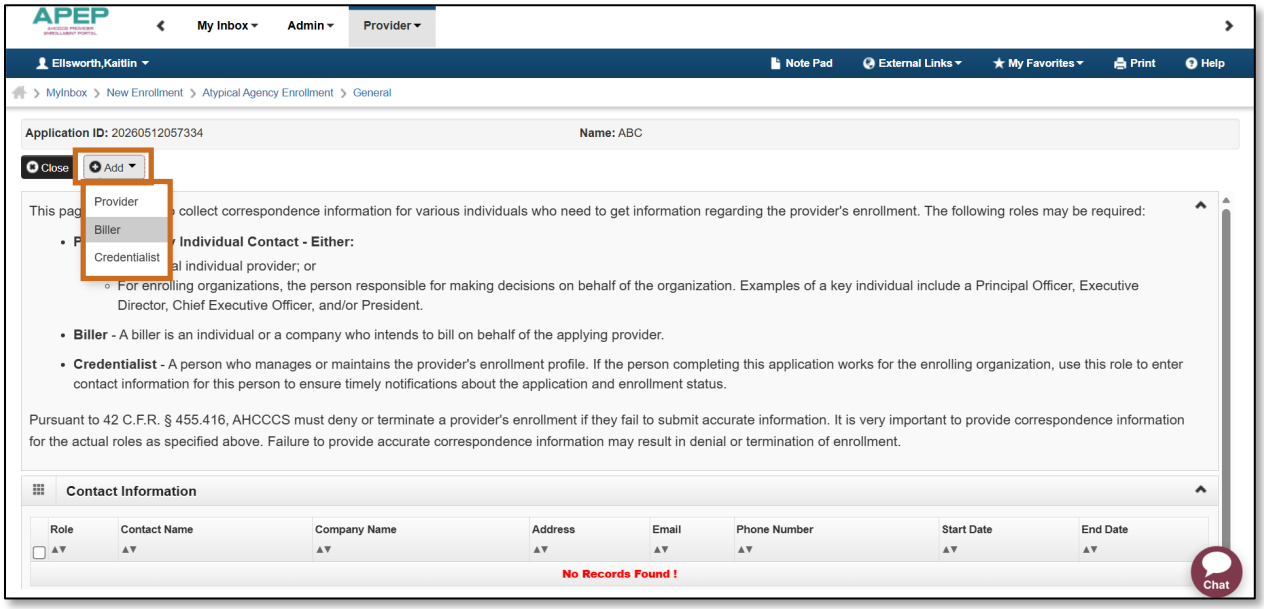


Step 3: Add Correspondence Address

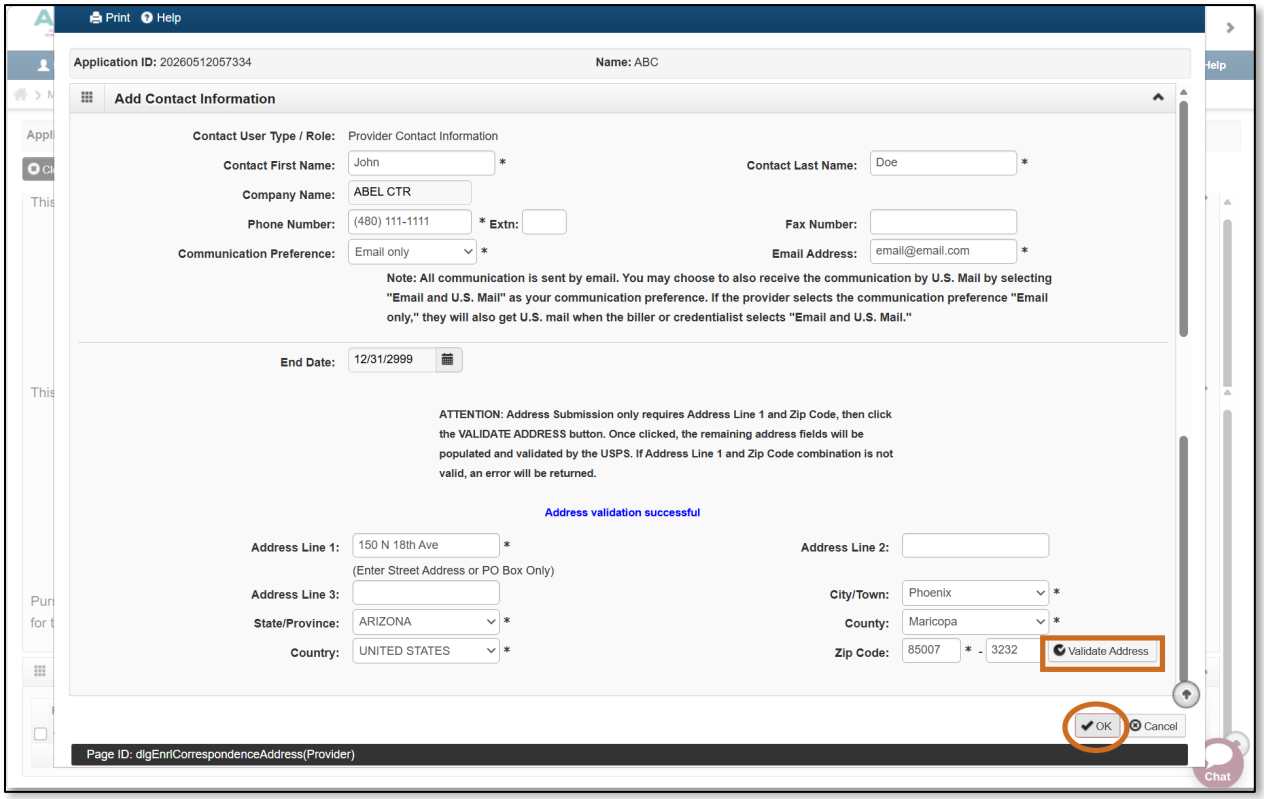
- Select “Step 3: Add Correspondence Address”



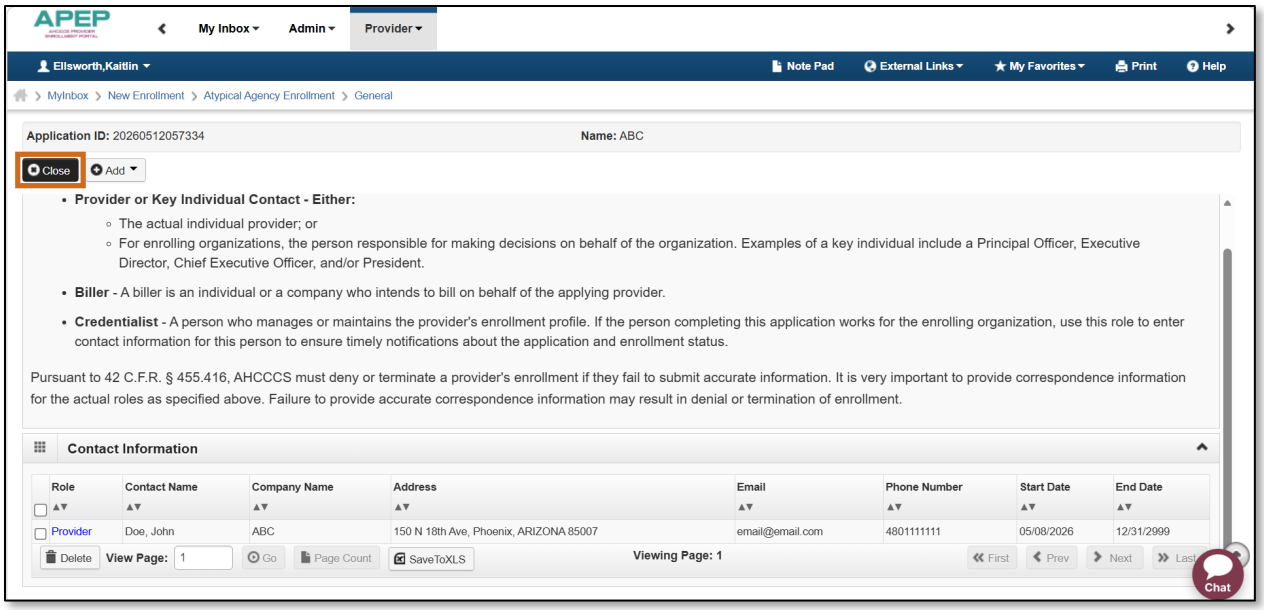
- Select “Add”



- In the “Communication Preference” field, select “Email and US Mail” or “Email Only.”
  - Only one option may be selected. All notices will go to the mailing address or email address entered on this screen.
- Review and click “Validate Address” option. When complete, select “OK.”

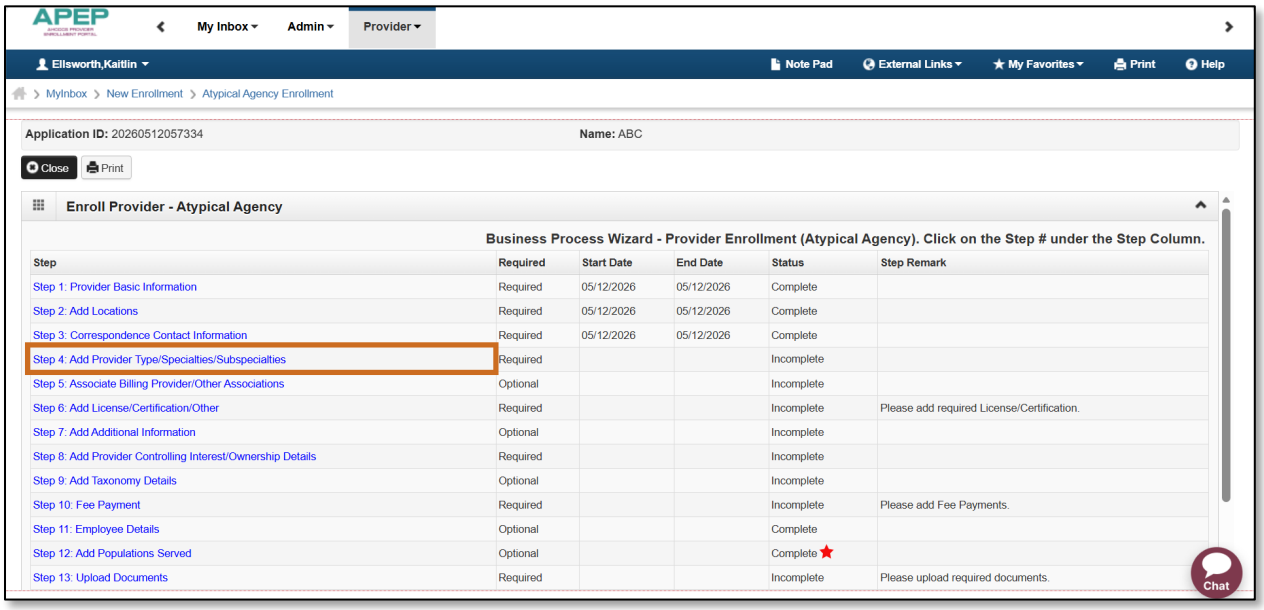


- Select “Close” to proceed forward.

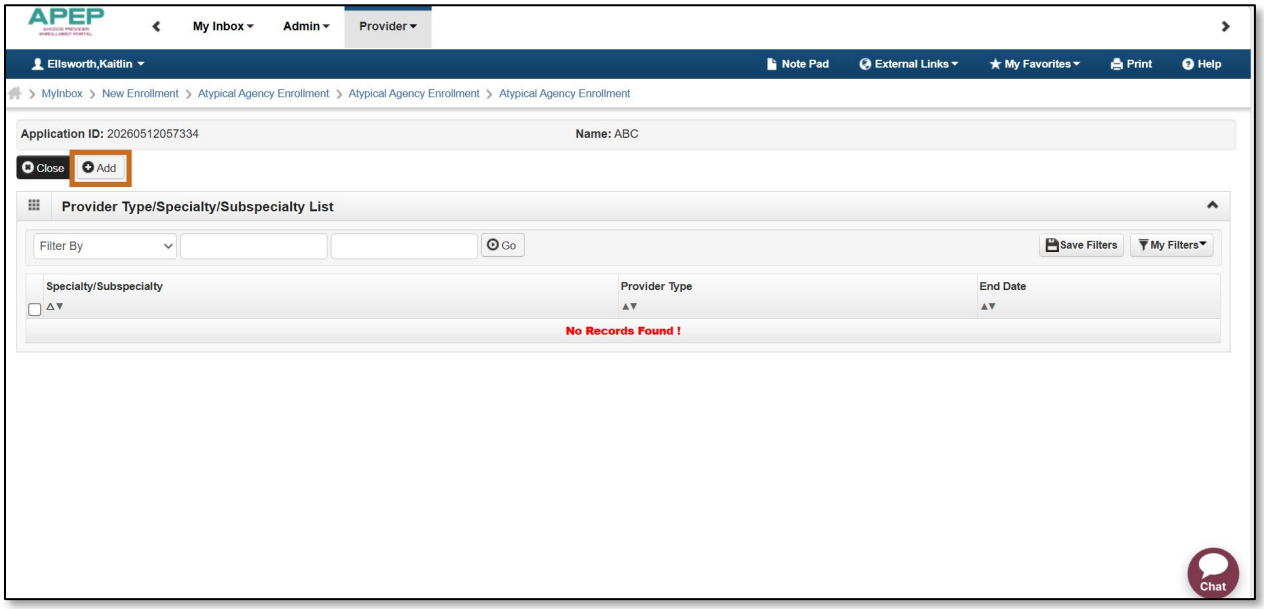


Step 4: Add Provider Type Specialties/Subspecialties

- Select “Step 4: Add Provider Type Specialties/Subspecialties”



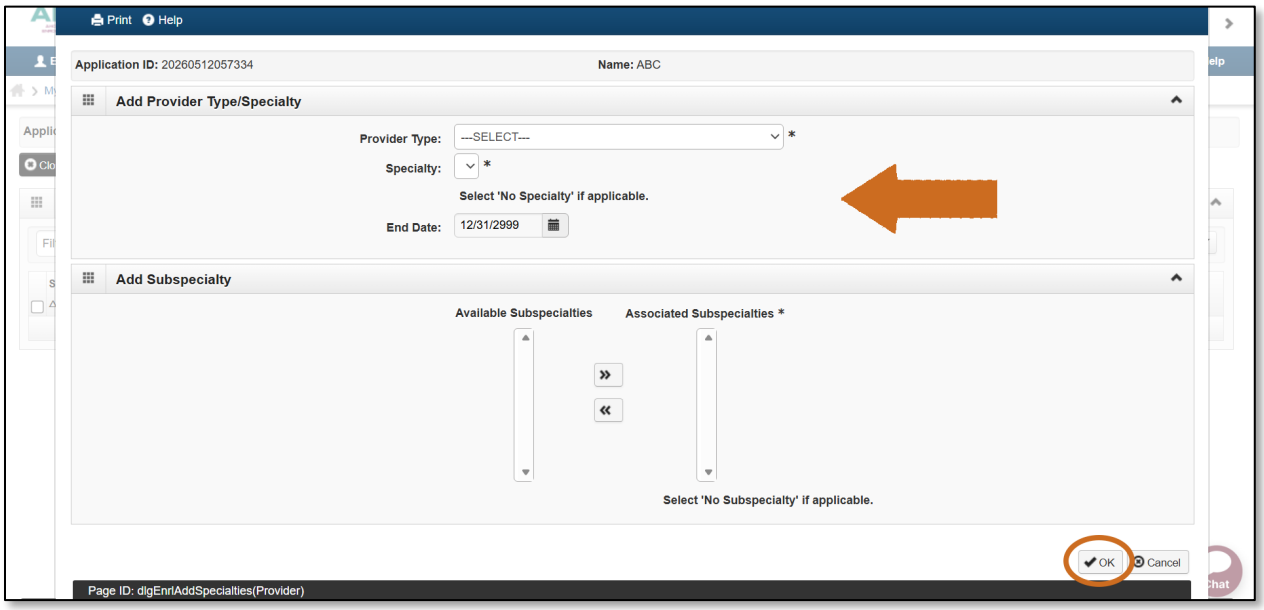
- Select “Add”



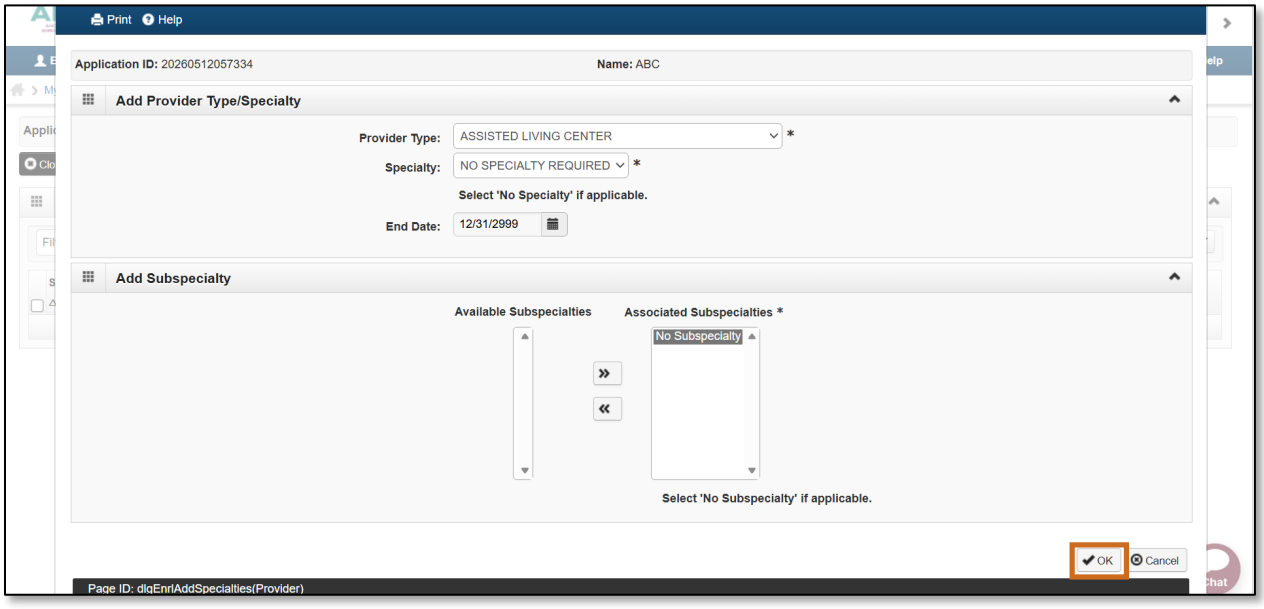
- Select the “Provider Type” in the drop-down option.
- Select the “Specialty” in the drop-down option, or “No Specialty” if applicable. Subspeciality will default to “No Subspeciality”

For new enrollments, the “Add Provider Type/Specialty & Add Subspecialty” fields will display empty.

- When complete, select “OK” to proceed forward.



The image below is an example of a completed provider type.



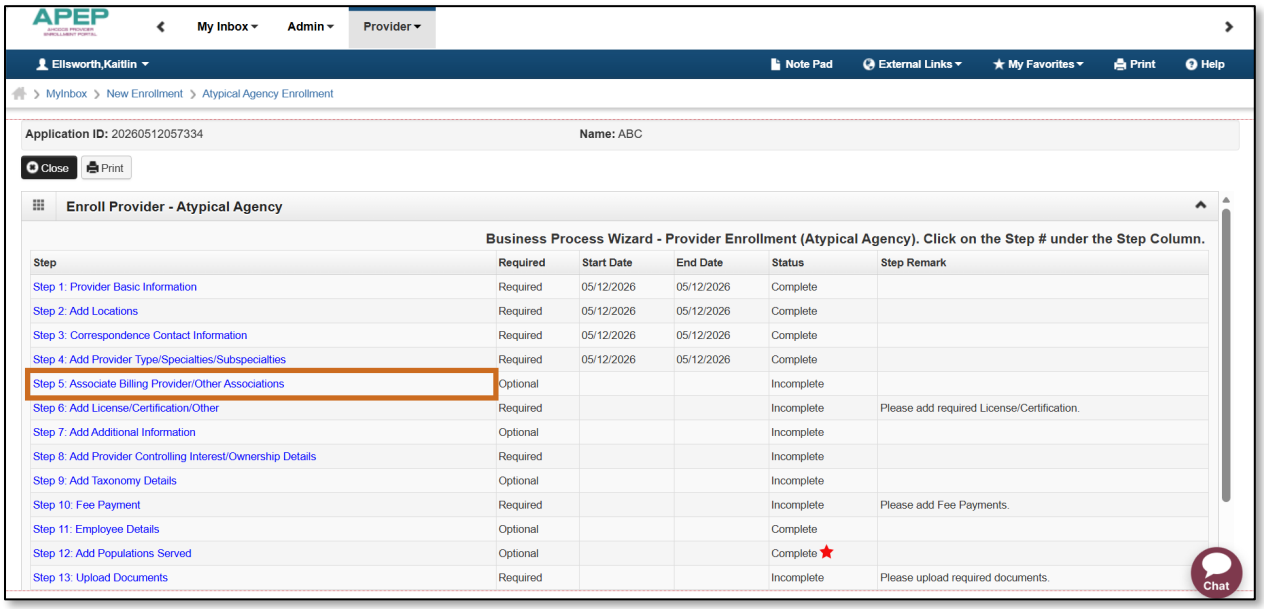
Once Step 4 is completed, the rest of the enrollment steps become available and may be completed in any order.

Step 5: Associate Billing Provider/Other Associations

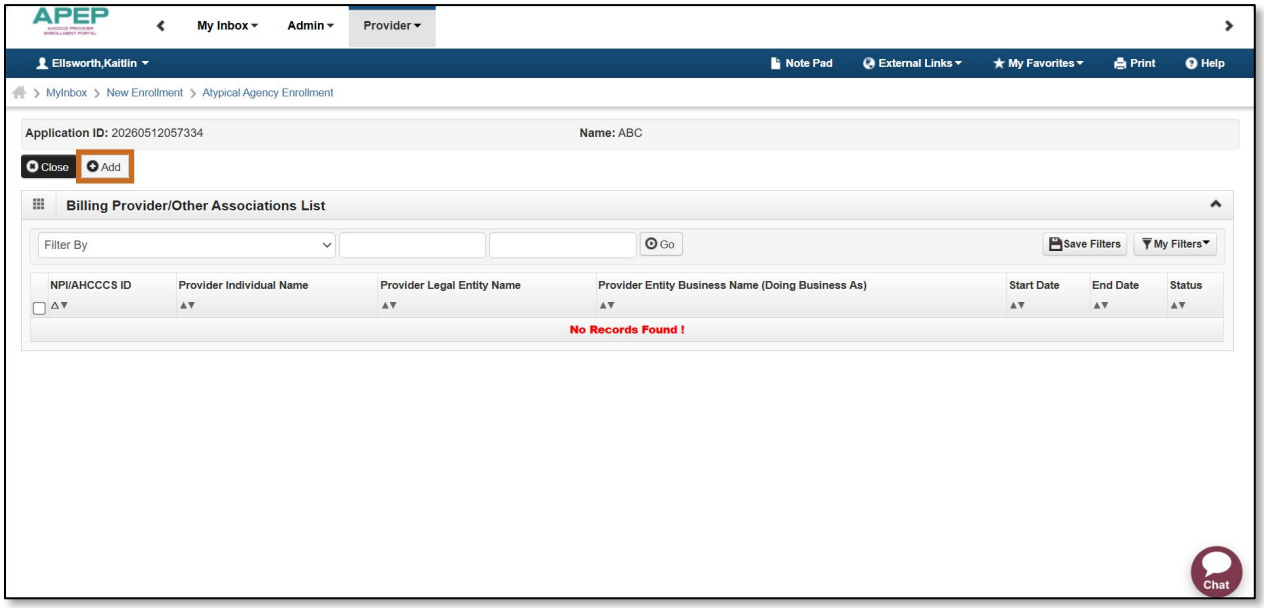
The next step is Step 5, which is marked as “Optional.” This step is for an Associate Billing Provider, in other words, an employee of the facility, agency, or organization that has already started an application with AHCCCS. If this does not apply to you skip, to Step 6.

To complete Step 5:

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

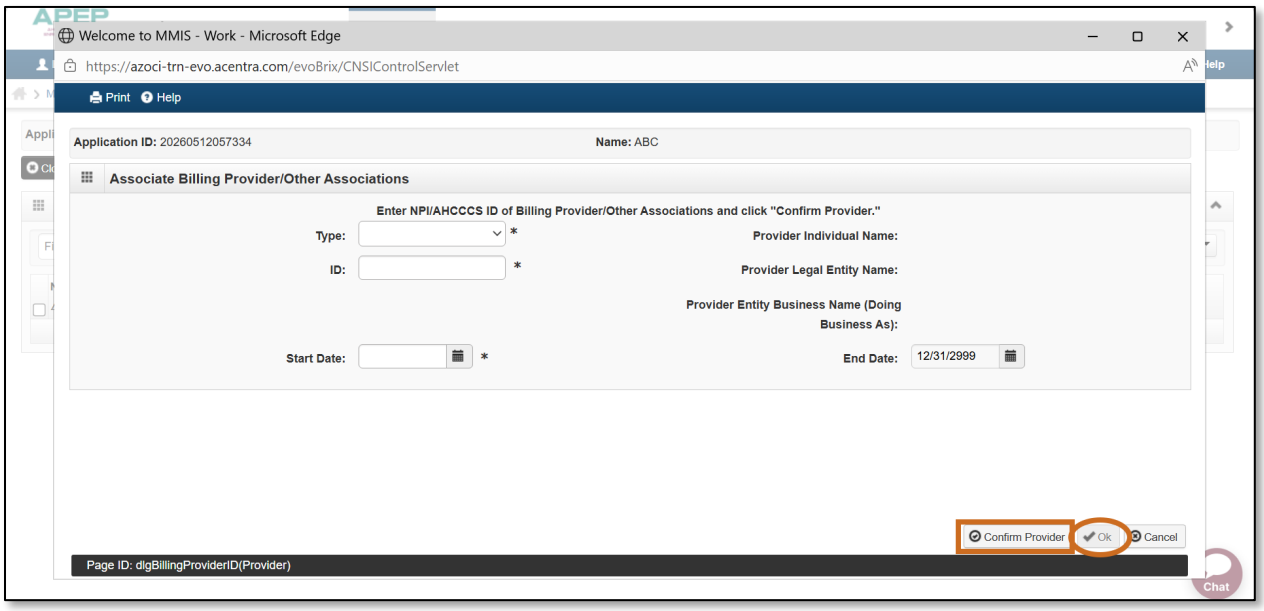


- Select “Add”

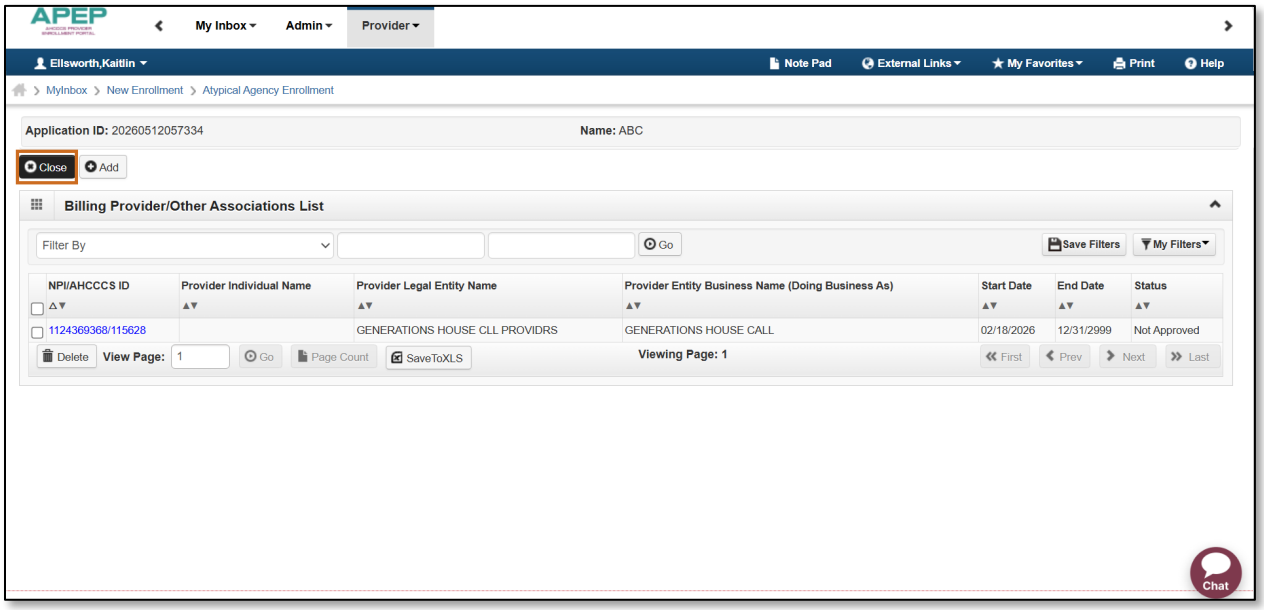


- Enter the six-digit AHCCCS ID or 10-digit NPI of the billing provider. Select “Confirm Provider.” Once the provider is confirmed, select “OK” to complete the association.

Note: If your provider is known to AHCCCS, the Provider Name field is auto-populated.

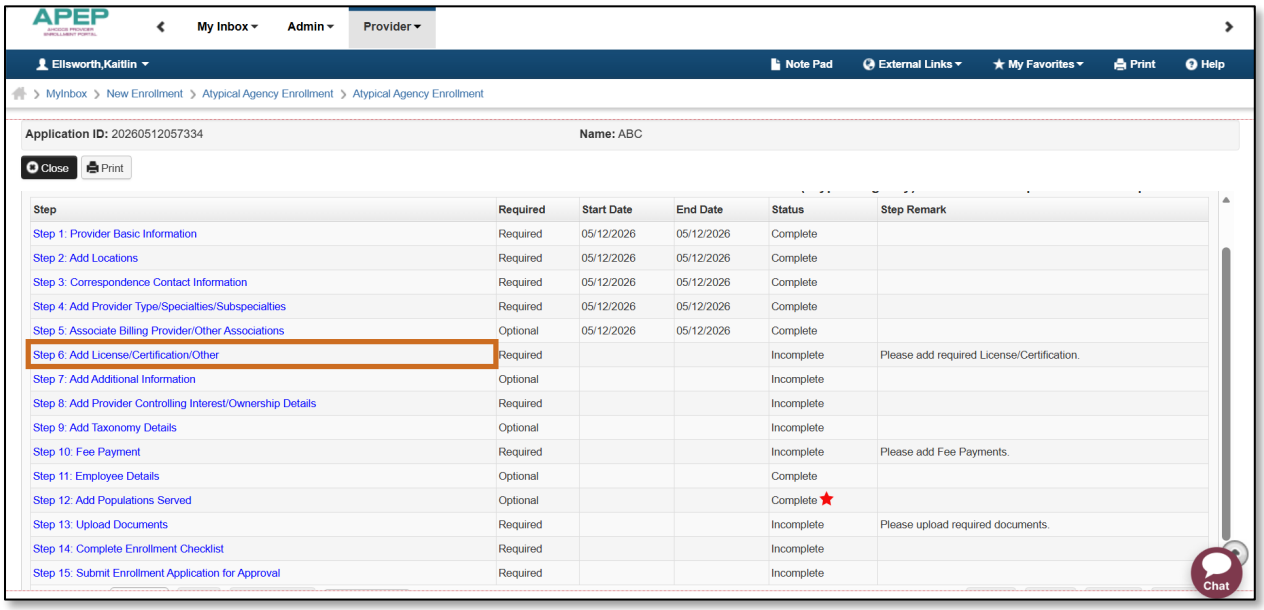


- Select “Close” to advance forward

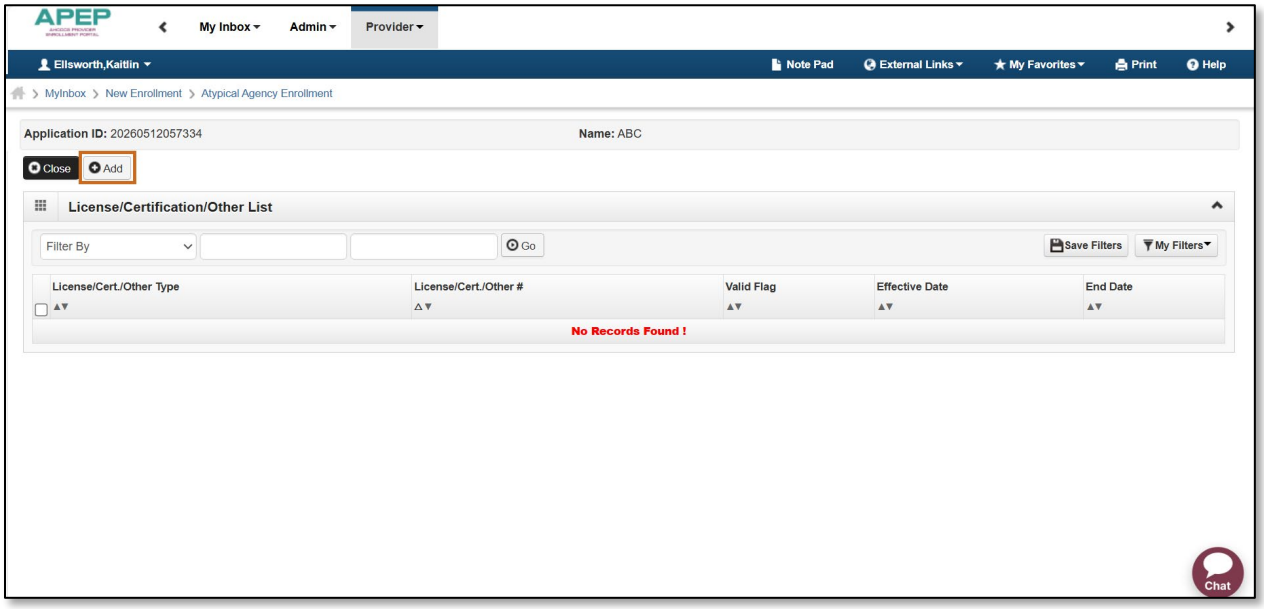


Step 6: Add License/Certification/Other

- Select “Step 6: Add License/Certification/Other”



- Select “Add”

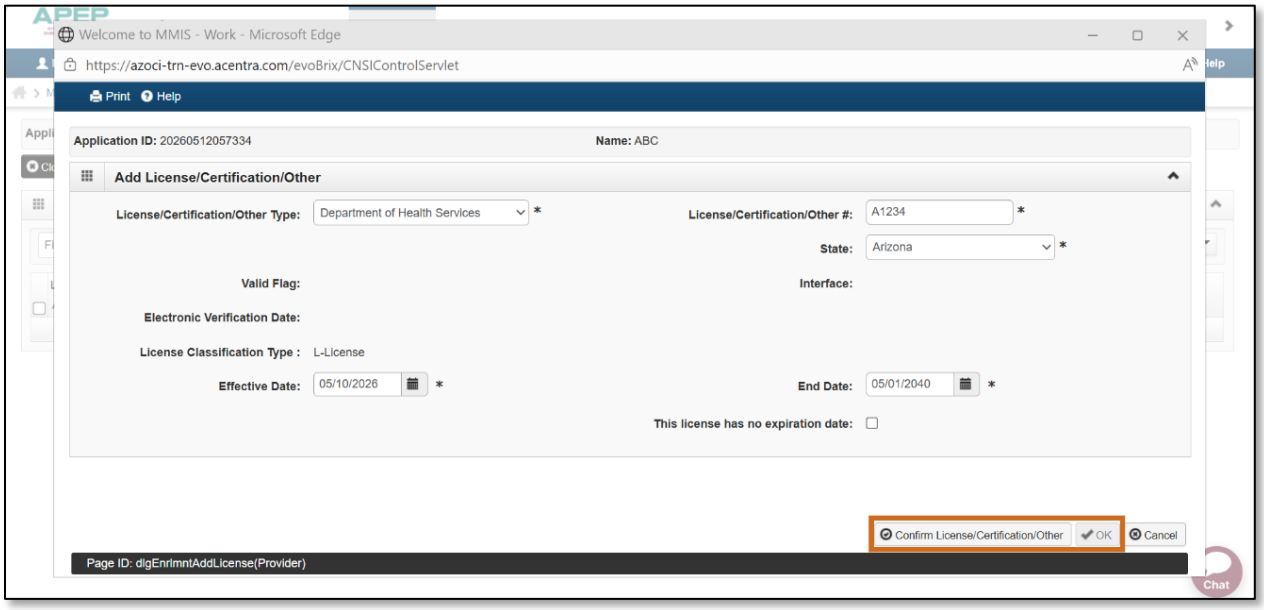


Note: Licensing/documents entered here will need to be uploaded in Step 13.

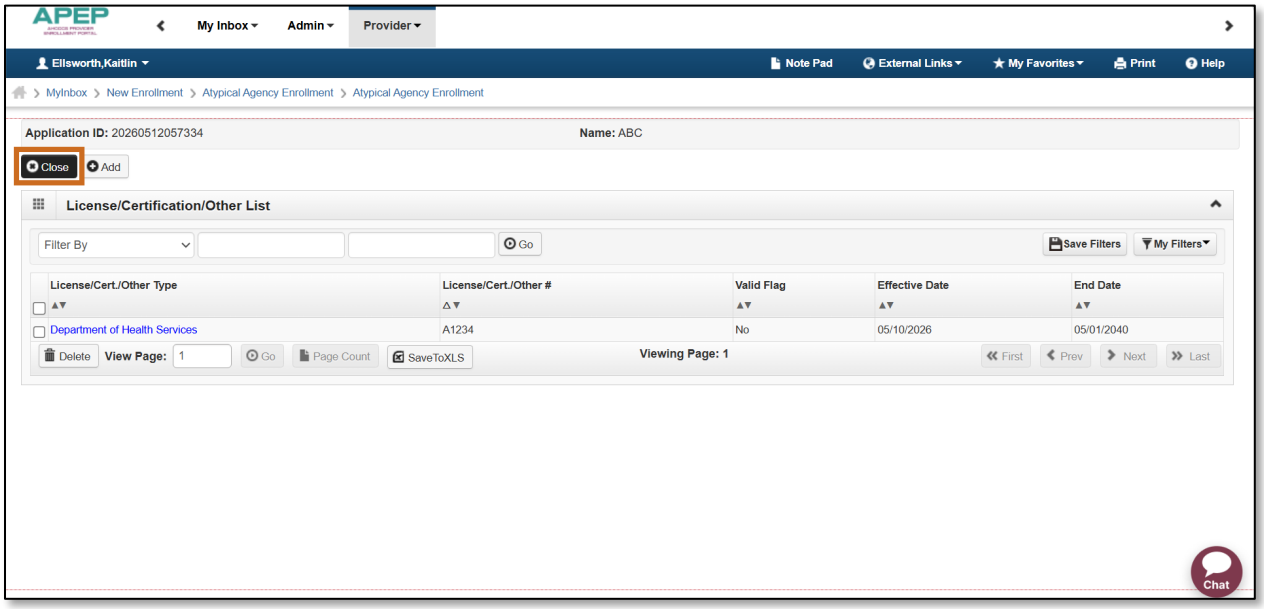
- Enter the License/Certification/Other List Information. Once complete, select “Confirm License/Certification”, and Select “OK.” Repeat for each available License/Certification.

The licenses and certifications listed in the drop-down menu are based on the specialty indicated in Step 4: Add Provider Type Specialty/Sub-Specialties.

- Enter the License/Certification/Other List Information. Once complete, select “Confirm License/Certification”, and Select “OK.” Repeat for each available License/Certification.



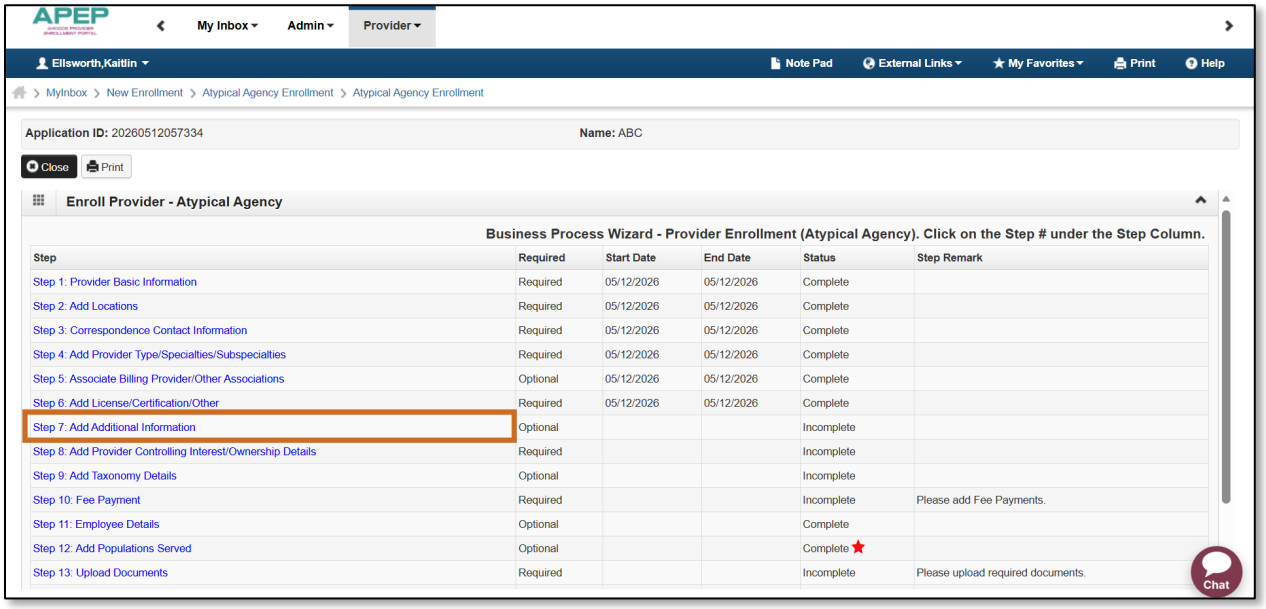
- Select “Close” to proceed forward.



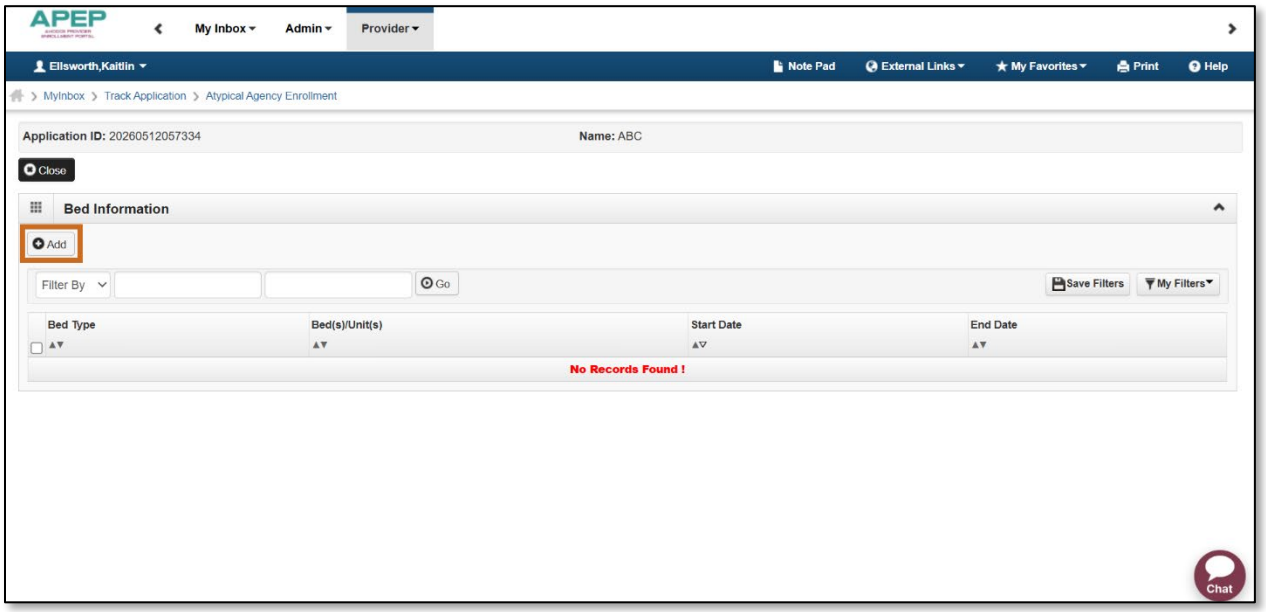
Step 7: Add Additional Information

This step is optional for most providers for Atypical Agencies and allows information about bed types to be added.

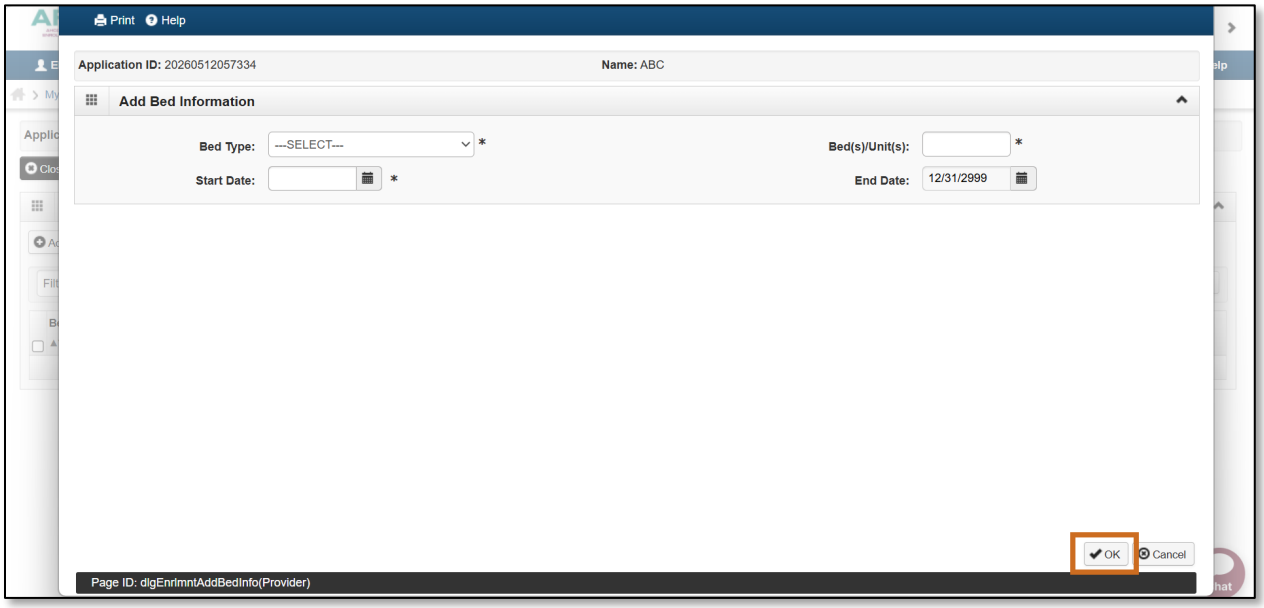
- Select “Step 7: Add Additional Information”



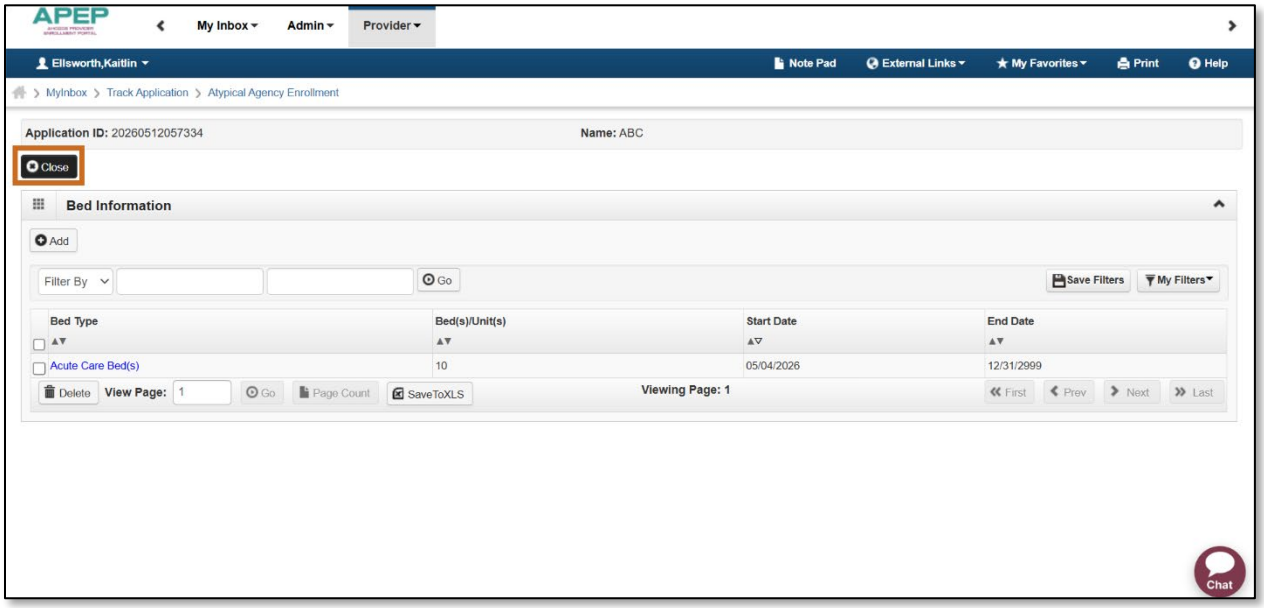
- Select “Add” under Bed Information to bring up details window for bed information.



- Select “Bed Type” drop-down option.
- Select “Bed Unit(s): insert the number of beds.
- Select “Calendar” option and add “Start Date” for bed type.
- Click “OK.”

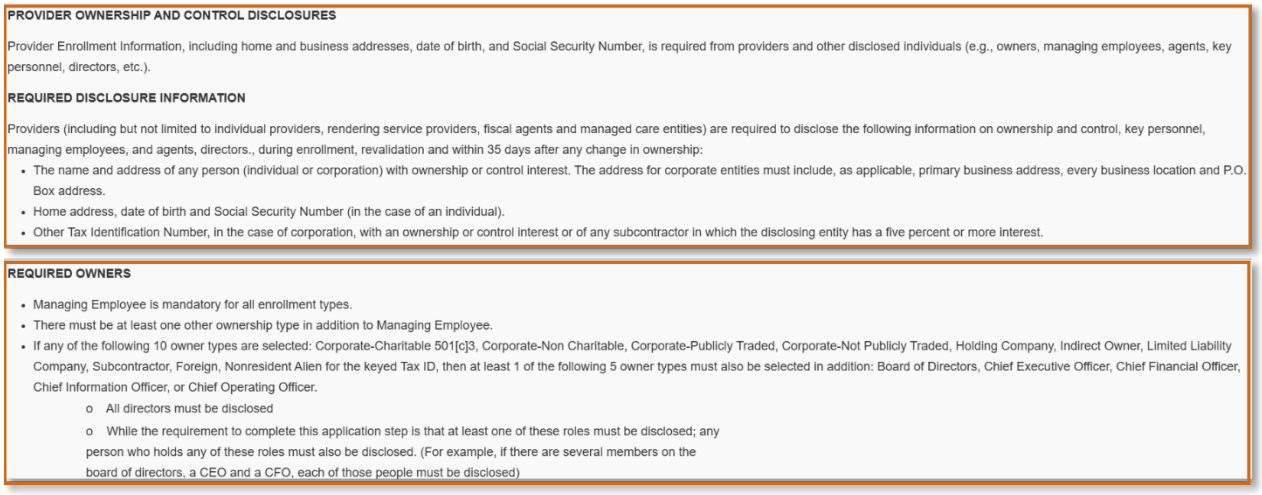


- Select “Close” to proceed forward.



Step 8: Add Provider Controlling Interest/Ownership Details

It's important that all information notated on this page is read.



PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider Enrollment Information, including home and business addresses, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, key personnel, directors, etc.).

REQUIRED DISCLOSURE INFORMATION

Providers (including but not limited to individual providers, rendering service providers, fiscal agents and managed care entities) are required to disclose the following information on ownership and control, key personnel, managing employees, and agents, directors., during enrollment, revalidation and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Home address, date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.

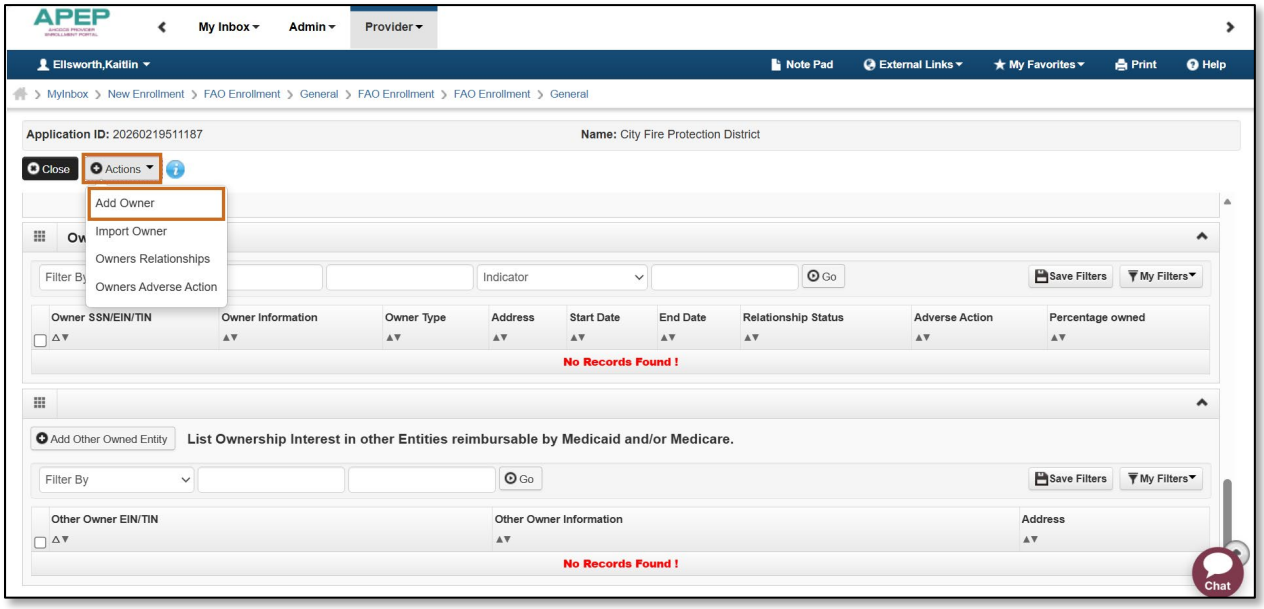
REQUIRED OWNERS

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 10 owner types are selected: Corporate-Charitable 501[c]3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
    - All directors must be disclosed
    - While the requirement to complete this application step is that at least one of these roles must be disclosed; any person who holds any of these roles must also be disclosed. (For example, if there are several members on the board of directors, a CEO and a CFO, each of those people must be disclosed)

- Select "Actions" then select "Add Owner" to add ownership information. Repeat this step if there are multiple owners.

Note: The "Actions" drop-down menu offers you the option to Add an Owner, Import Owner, specify Owner Relationships, and provide details about Owners Adverse Action.

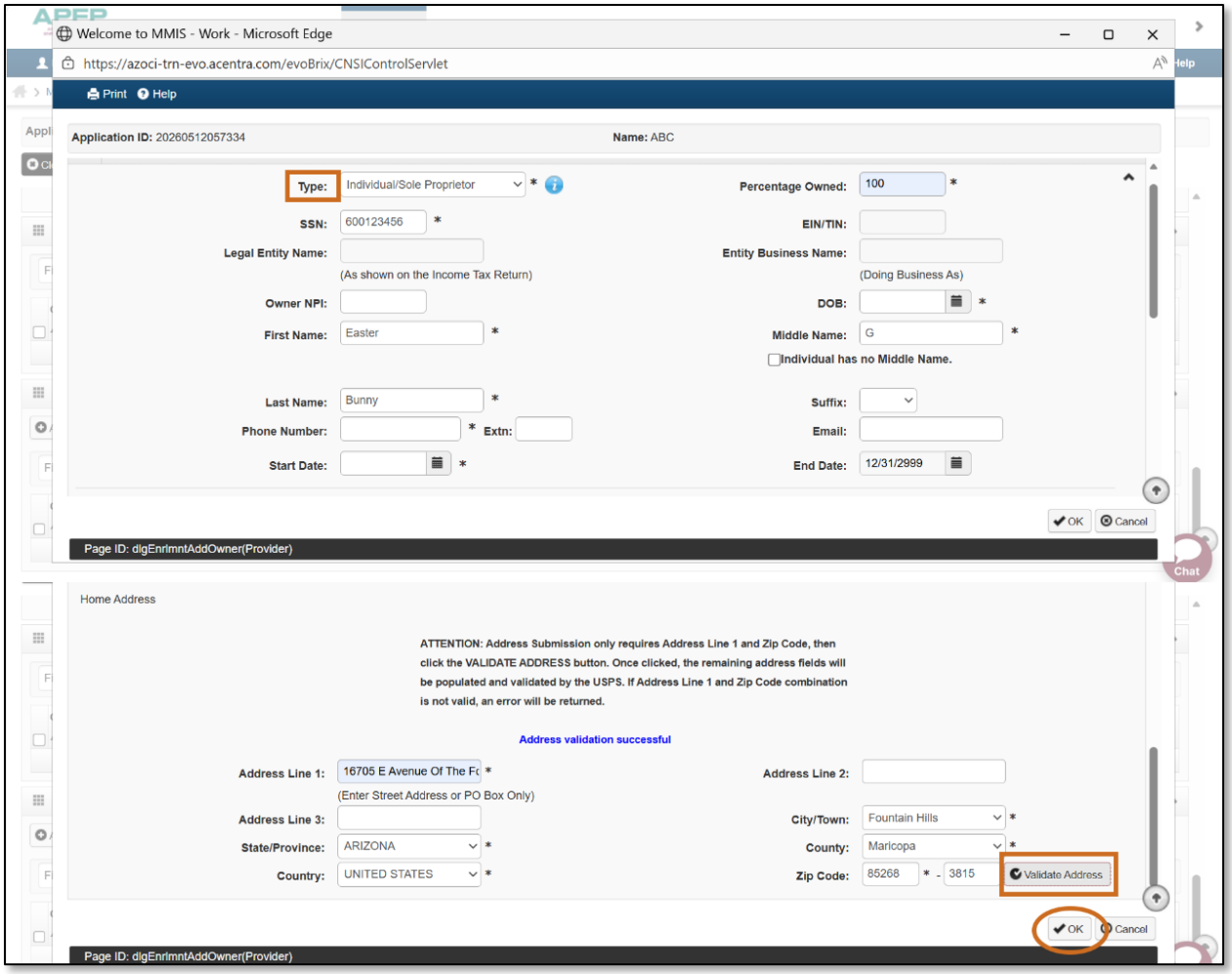
- Select "Add Owner" in the drop-down menu.

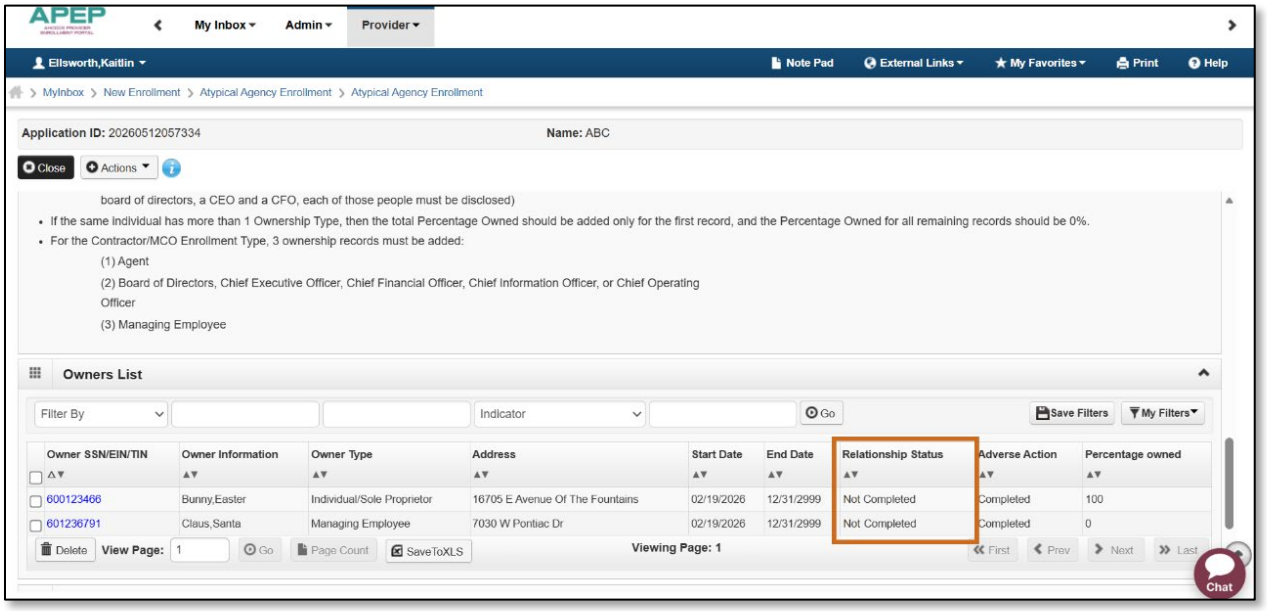


- Select "Type"
- Complete all required fields.
- Select "OK"

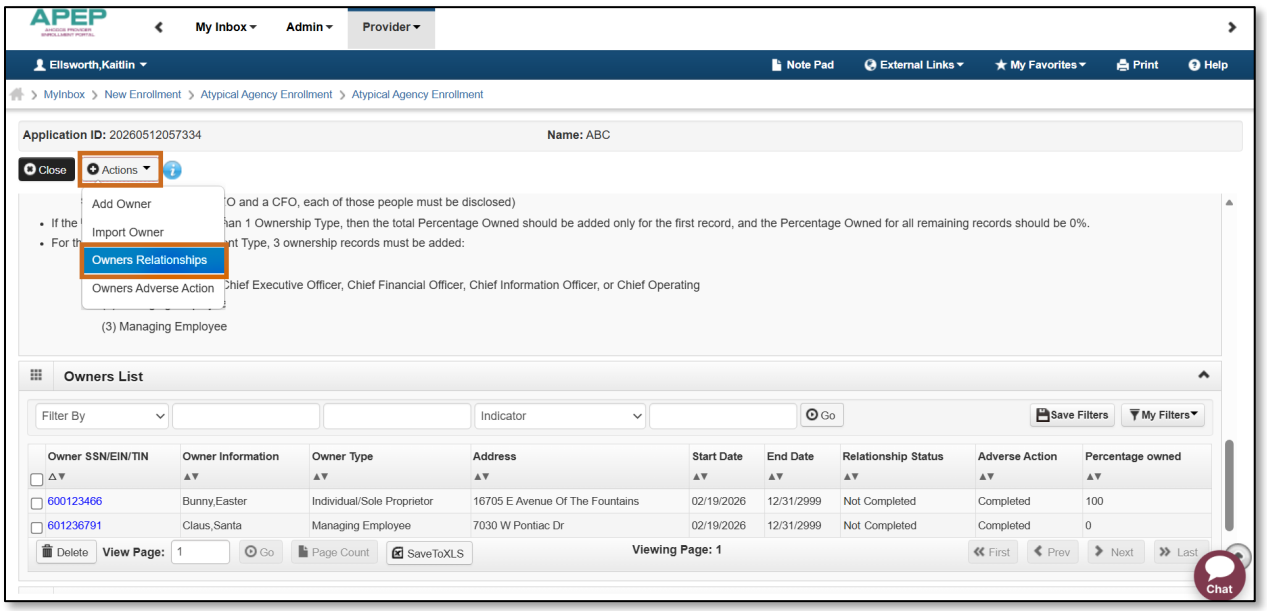
Atypical Agency Enrollment

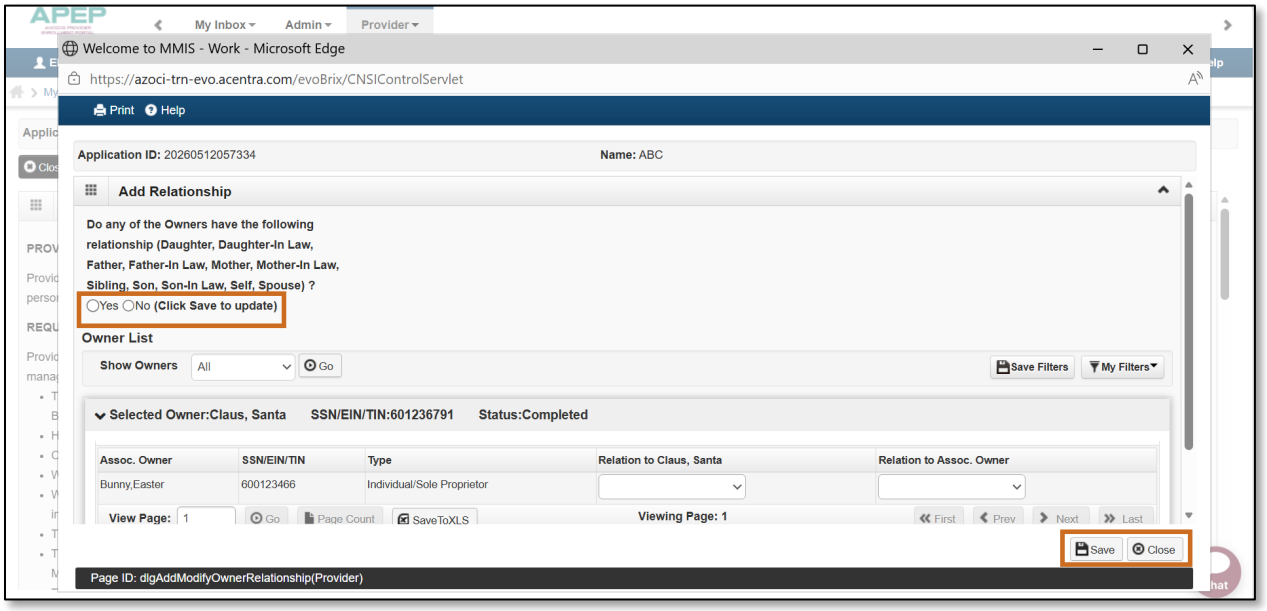
You must disclose all Directors, Chief Executive Officers, and Presidents listed publicly on the Arizona Corporation Commission Entity Information page under the Principal Information Section. Disclosure Provider Enrollment Information, including home and business addresses, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, key personnel, directors, etc.). There are no exceptions for voluntary board status or non-profit status.





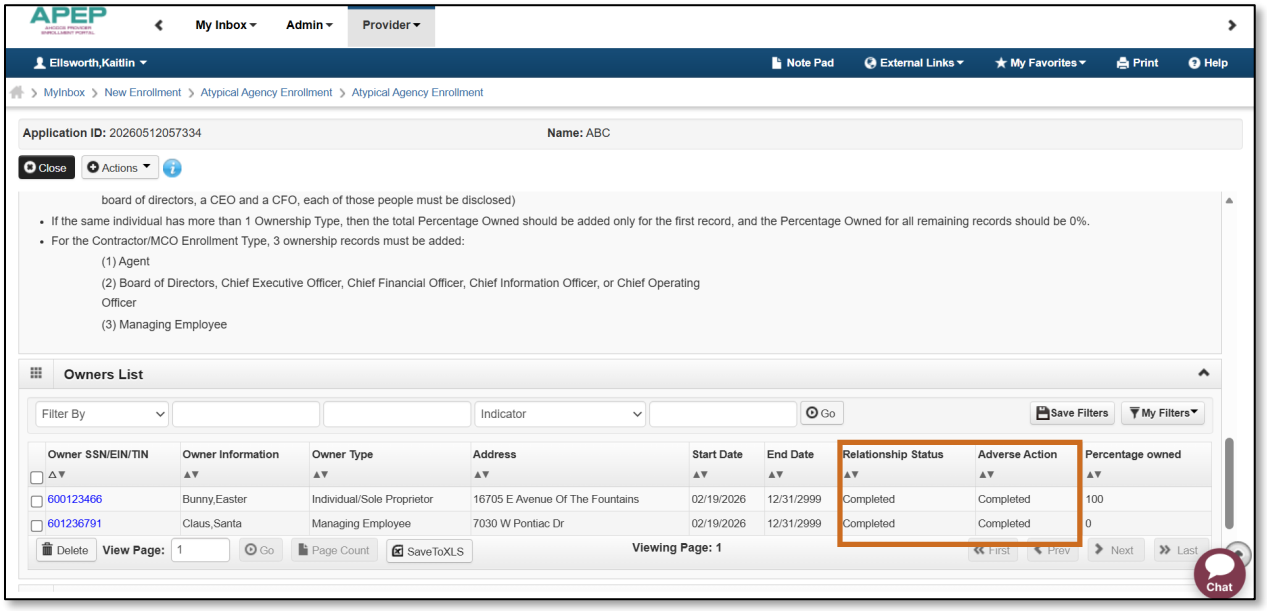
- Select “Owner’s Relationships.” This option requires an action to proceed forward. Select “Actions” then select “Owners Relationship” to disclose and establish Owner’s Relationships.





- Complete the drop-down fields to describe the relationship between provider owners.
- If owners have no familial relationship, clicking the “No” option to the questions at the top will eliminate the drop-down menu.

When all information has been entered, select “Save” then “Close.”



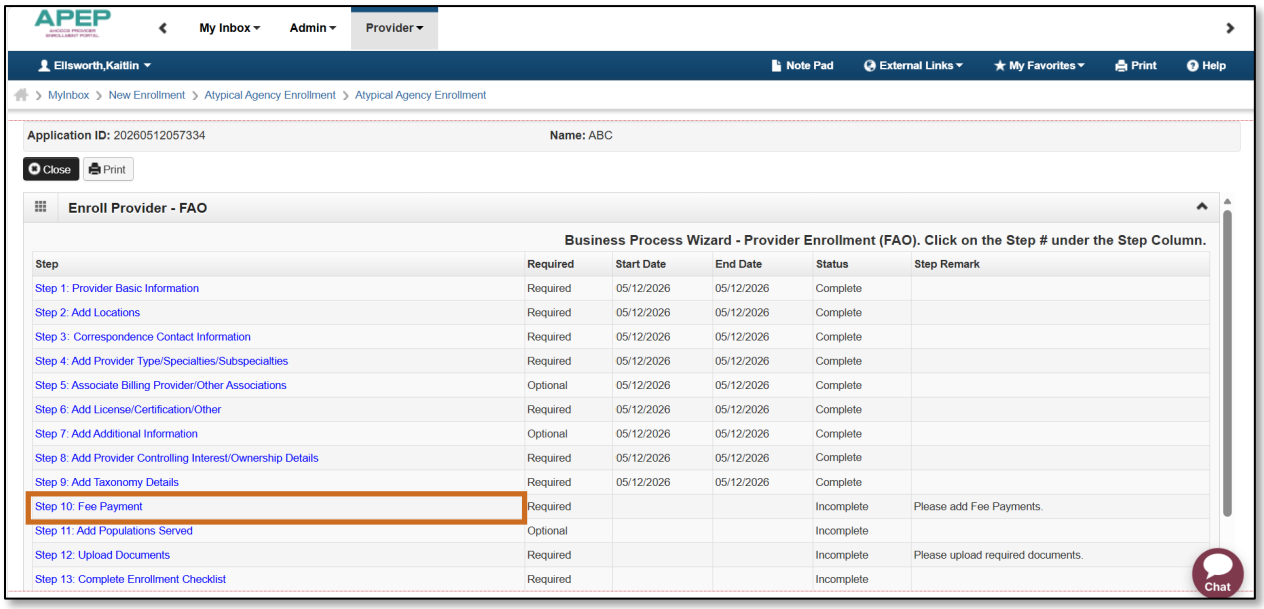
Step 9: Add Taxonomy Details

This step does not apply to the Atypical Agency enrollment type because it relates to the provider's National Provider Identifier (NPI) number.

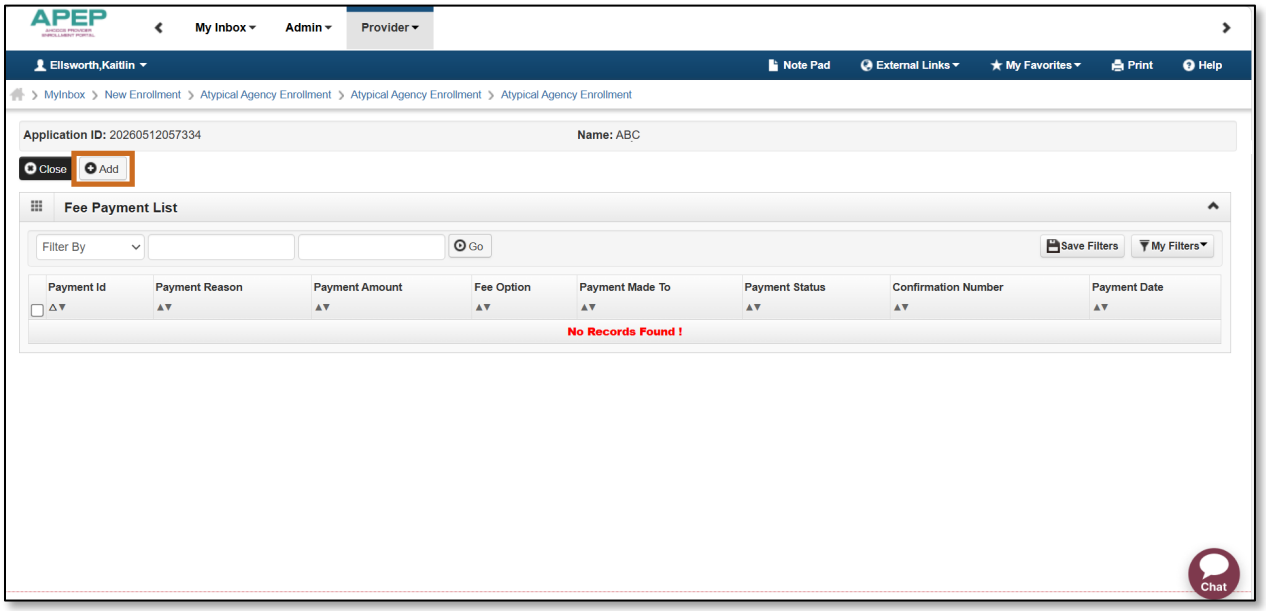
Step 10: Fee Payment

States are required to collect a "Fee Payment" on Institutional providers prior to execution of the Provider Participation Agreement.

- Select "Step 10: Fee Payment"



- Select "Add"

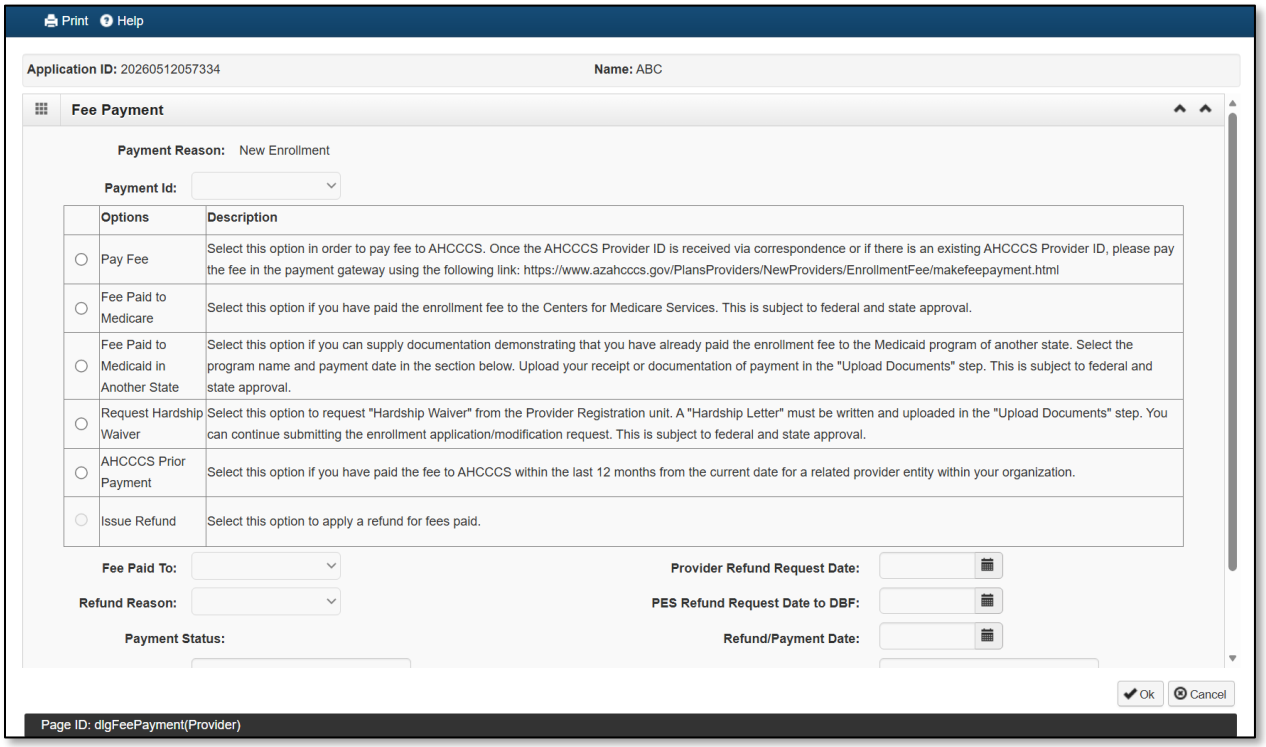


- Select applicable “Fee Payment” option.
    - Note: Fee payment can be made 72 hours after the application is submitted.

With the exception of “Pay Fee,” all other options selected are subject to federal and state approval and could require additional information.

Note: Do not select “AHCCCS Prior Payment”

- Select “OK” to proceed forward.

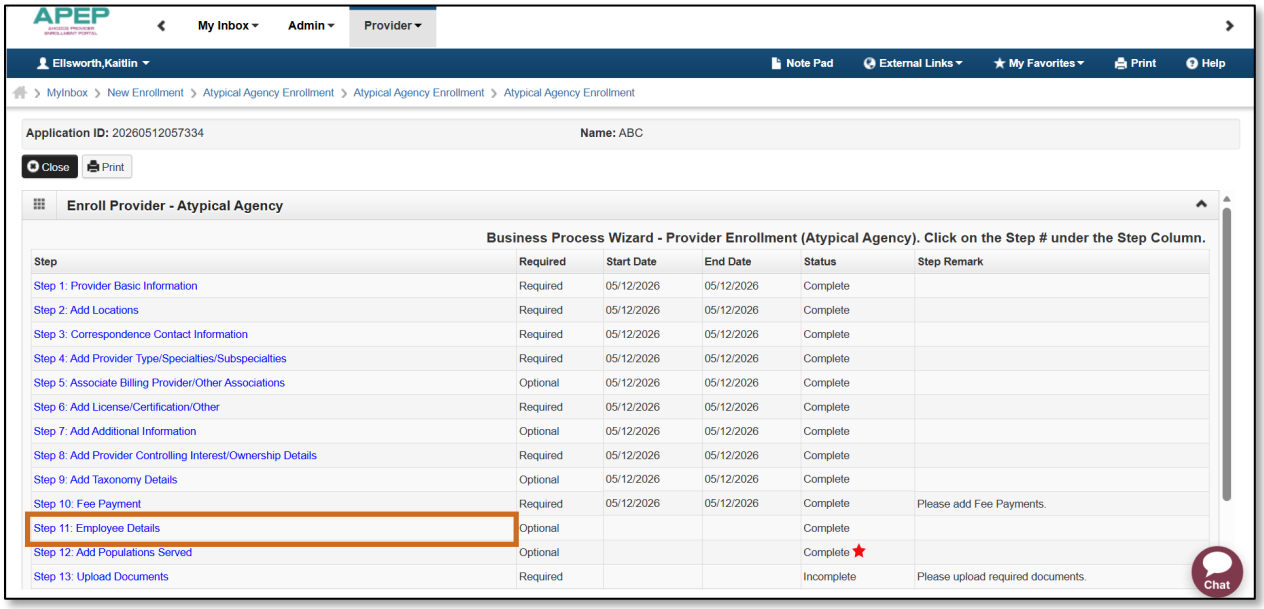

Print
Help
Application ID: 20260512057334
Name: ABC
Fee Payment
Payment Reason: New Enrollment
Payment Id:
Options
Description
Pay Fee
Select this option in order to pay fee to AHCCCS. Once the AHCCCS Provider ID is received via correspondence or if there is an existing AHCCCS Provider ID, please pay the fee in the payment gateway using the following link: https://www.azahcccs.gov/PlansProviders/NewProviders/EnrollmentFee/makefeepayment.html
Fee Paid to Medicare
Select this option if you have paid the enrollment fee to the Centers for Medicare Services. This is subject to federal and state approval.
Fee Paid to Medicaid in Another State
Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below. Upload your receipt or documentation of payment in the "Upload Documents" step. This is subject to federal and state approval.
Request Hardship Waiver
Select this option to request "Hardship Waiver" from the Provider Registration unit. A "Hardship Letter" must be written and uploaded in the "Upload Documents" step. You can continue submitting the enrollment application/modification request. This is subject to federal and state approval.
AHCCCS Prior Payment
Select this option if you have paid the fee to AHCCCS within the last 12 months from the current date for a related provider entity within your organization.
Issue Refund
Select this option to apply a refund for fees paid.
Fee Paid To:
Refund Reason:
Payment Status:
Provider Refund Request Date:
PES Refund Request Date to DBF:
Refund/Payment Date:
Ok
Cancel
Page ID: dlgFeePayment(Provider)

Step 11: Employee Details

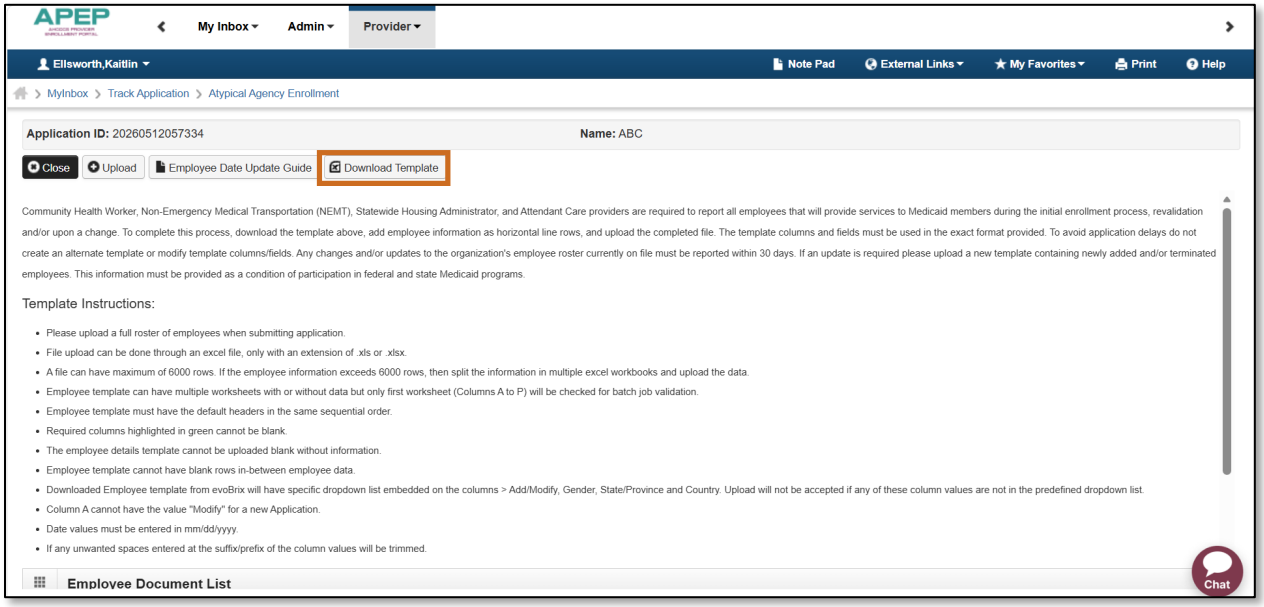
Depending on the Provider Type selected in Step 4, the Employee Details Step will be required.

These provider types are Community Health Worker, Non-Emergency Medical Transportation (NEMT), Statewide Housing Administrator, and Attendant Care.

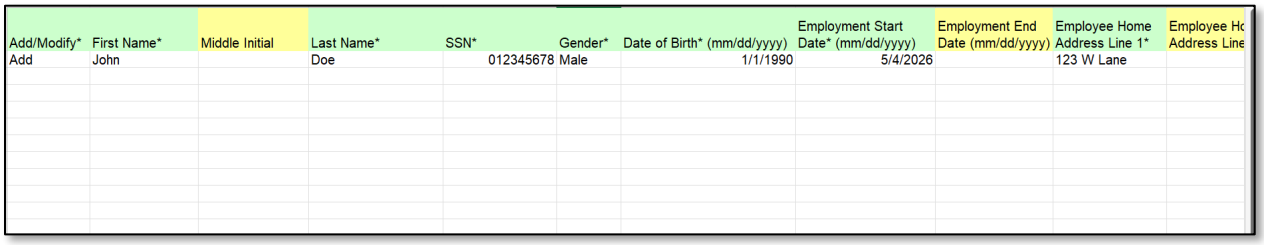
- Select “Step 11: Employee Details”



- Download the template

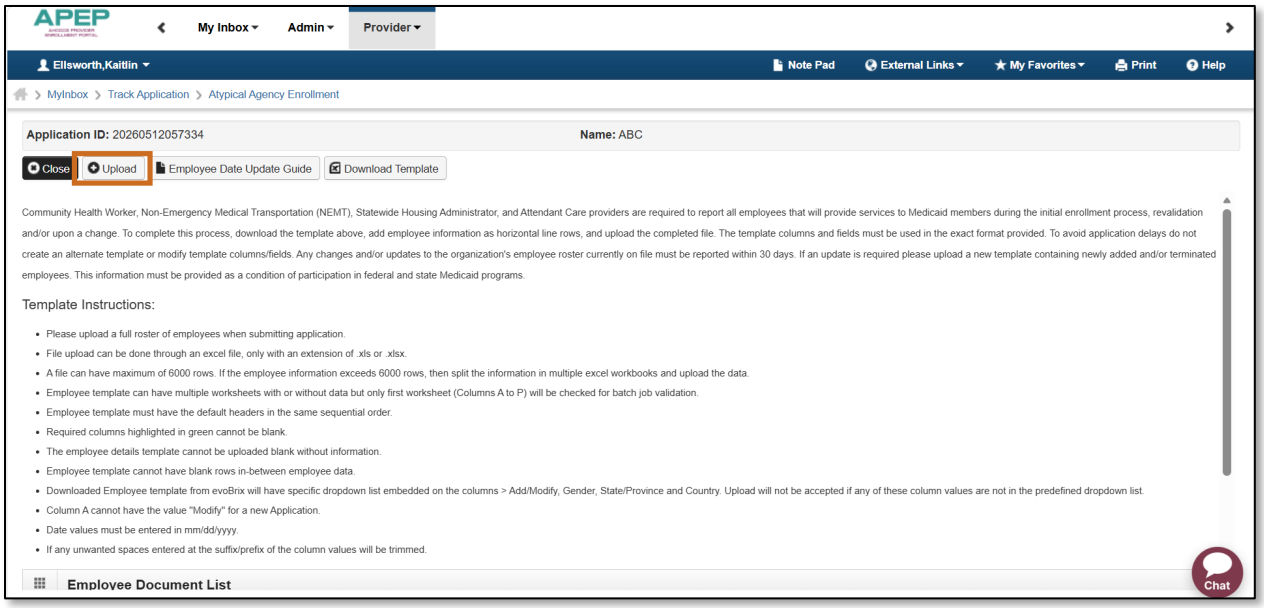


- Fill out the template spreadsheet with the employee details.

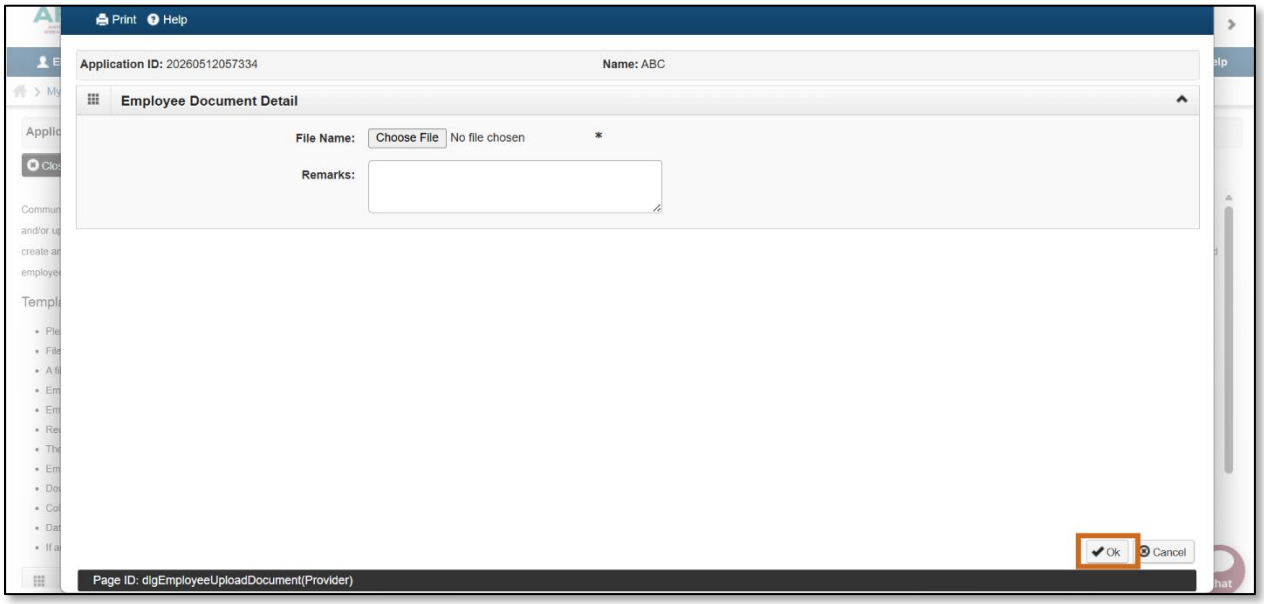


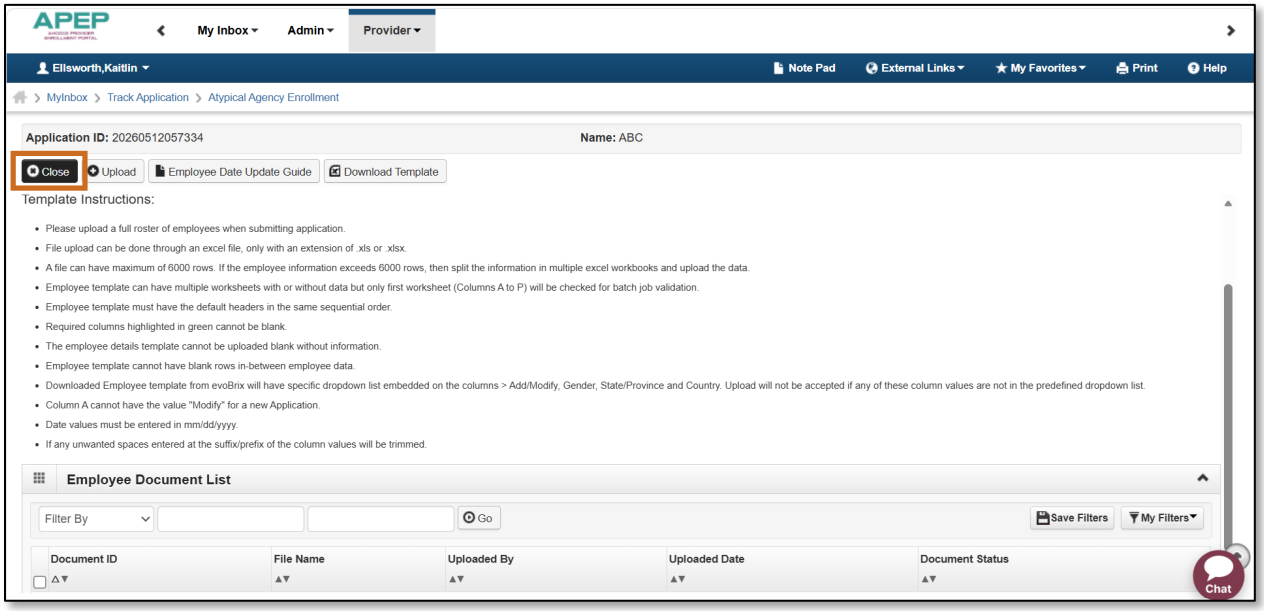
Add/Modify*	First Name*	Middle Initial	Last Name*	SSN*	Gender*	Date of Birth* (mm/dd/yyyy)	Employment Start Date* (mm/dd/yyyy)	Employment End Date (mm/dd/yyyy)	Employee Home Address Line 1*	Employee Ho Address Line
Add	John		Doe	012345678	Male	1/1/1990	5/4/2026		123 W Lane	

- Upload the template.



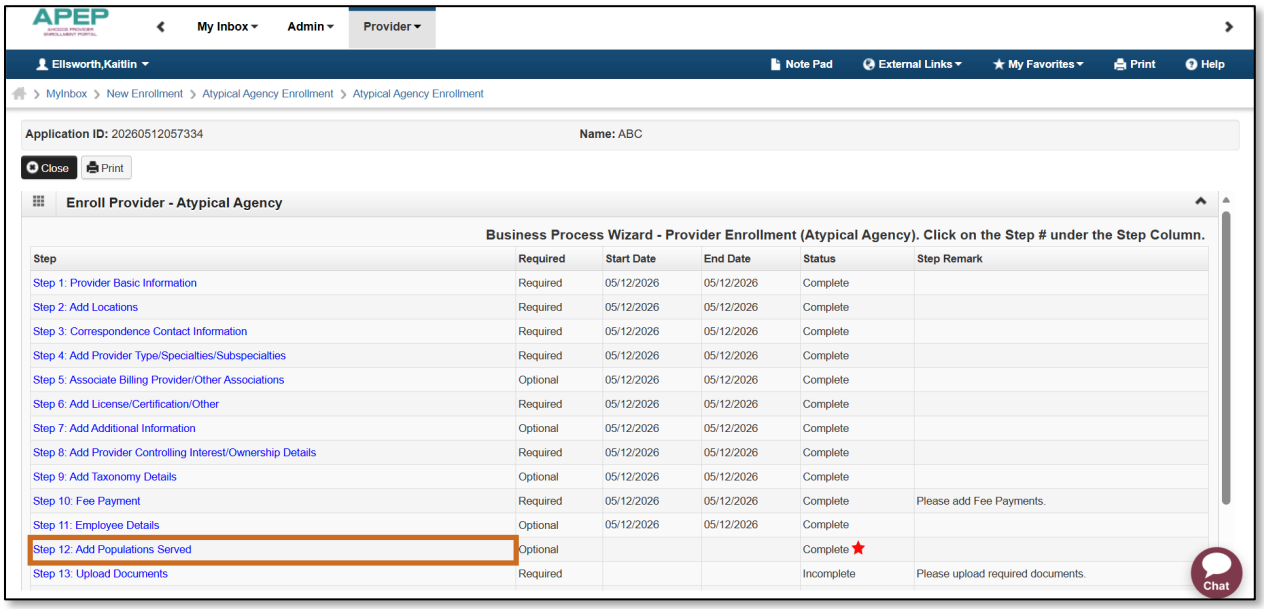
- Select “OK”, then “Close”

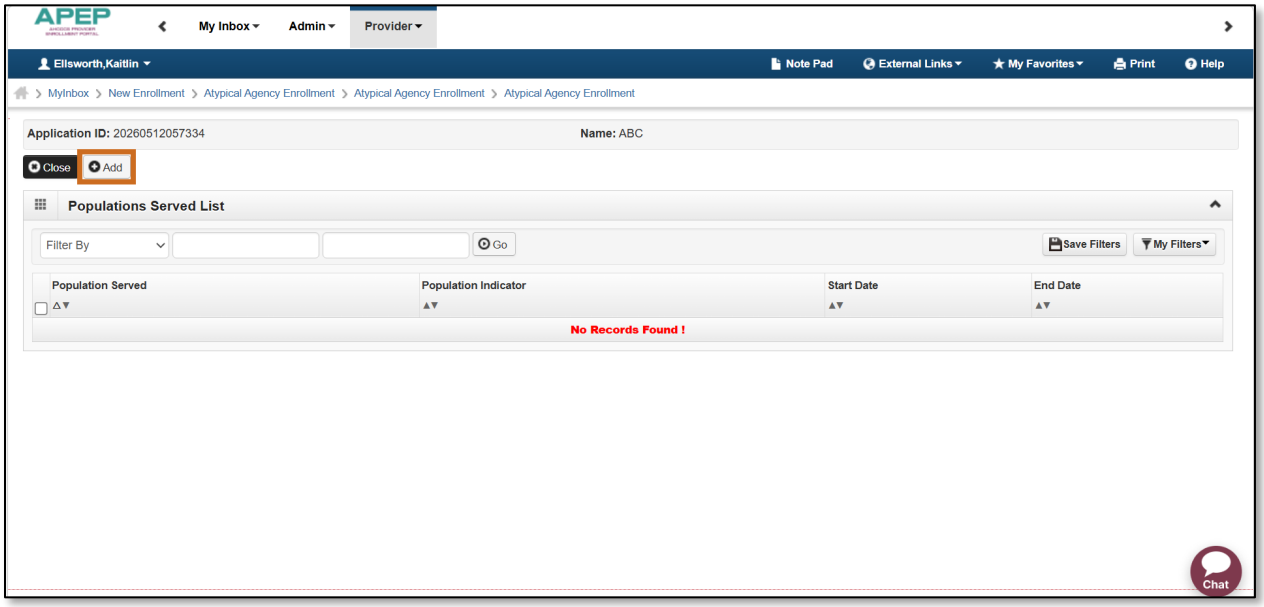


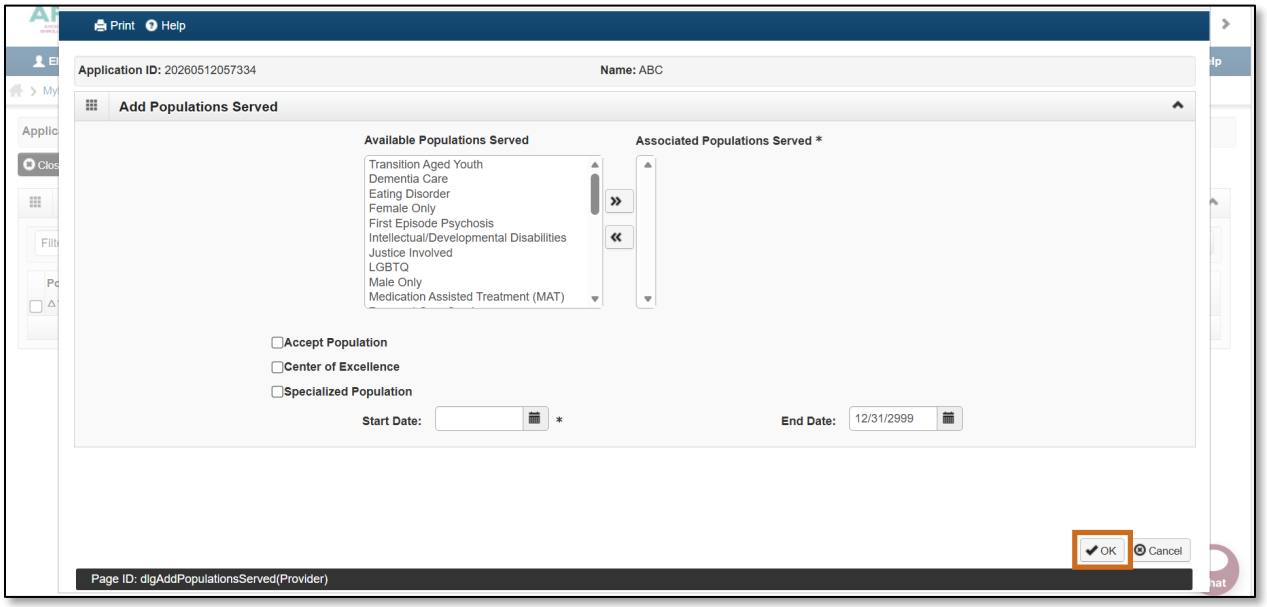


Step 12: Add Populations Served

This step is optional.



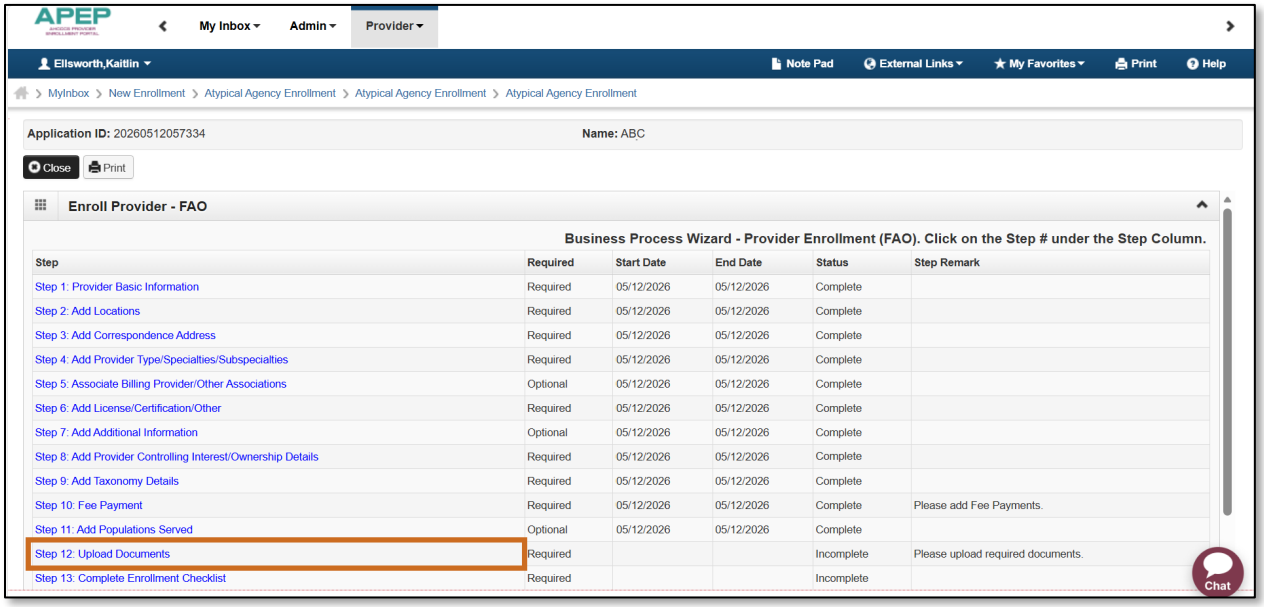



Print
Help
Application ID: 20260512057334
Name: ABC
Add Populations Served
Available Populations Served
Associated Populations Served *
Transition Aged Youth
Dementia Care
Eating Disorder
Female Only
First Episode Psychosis
Intellectual/Developmental Disabilities
Justice Involved
LGBTQ
Male Only
Medication Assisted Treatment (MAT)
Accept Population
Center of Excellence
Specialized Population
Start Date:
*
End Date:
12/31/2999
OK
Cancel
Page ID: dlgAddPopulationsServed(Provider)

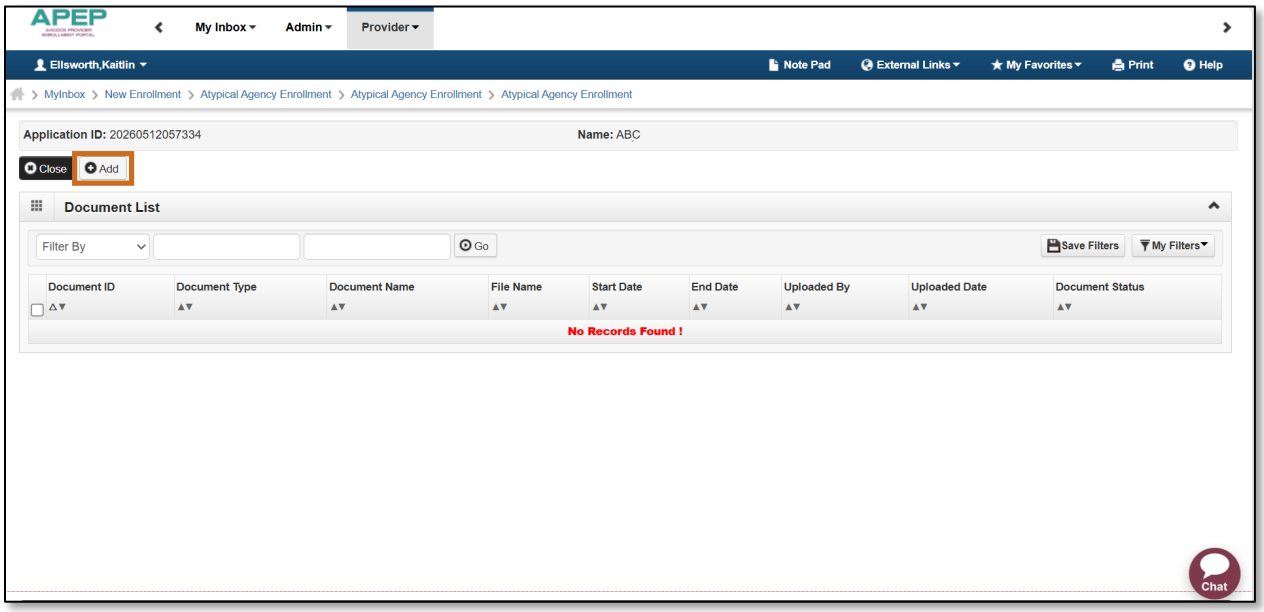
Step 13: Upload Documents

Providers must upload an electronic copy of all applicable licenses, certifications, and W-9 forms in this step.

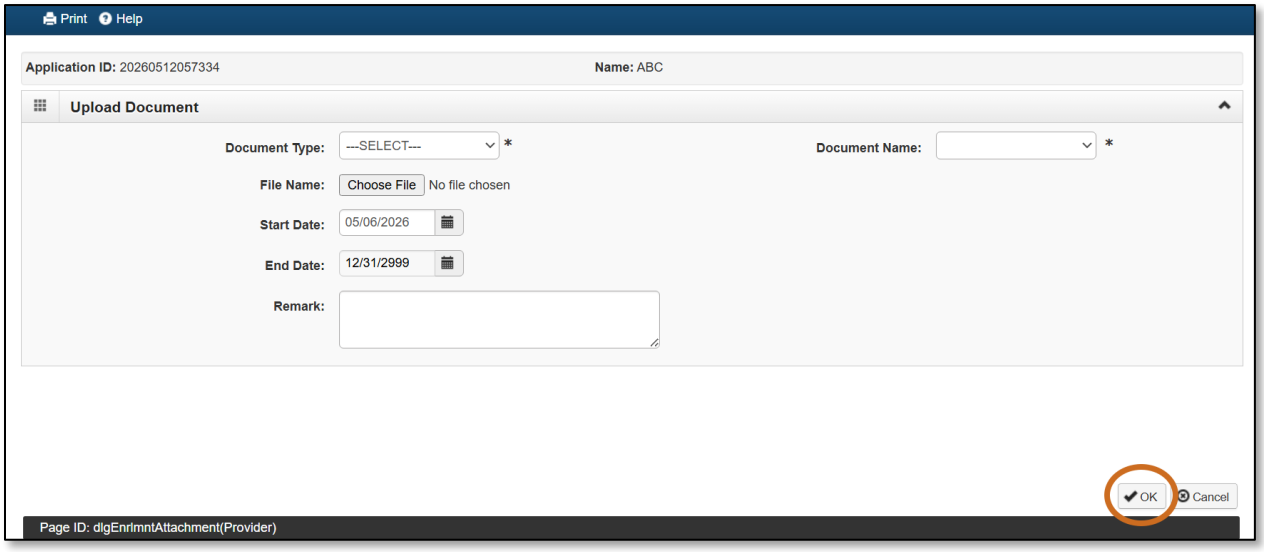
- Select “Step 13: Upload Documents”



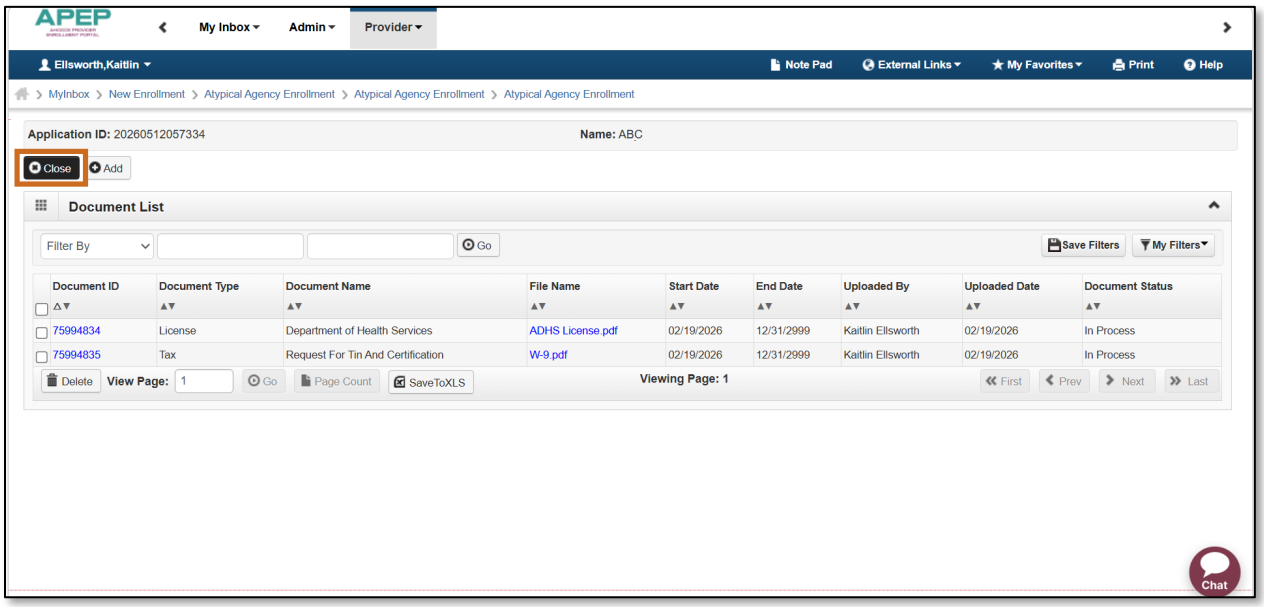
- Select “Add”



- Select the applicable Document Type and Document Name. Select “Browse” to find the document.
    - Document types that may be uploaded include PDF, Word, Excel, PNG, and JPEG.
- Select “OK”

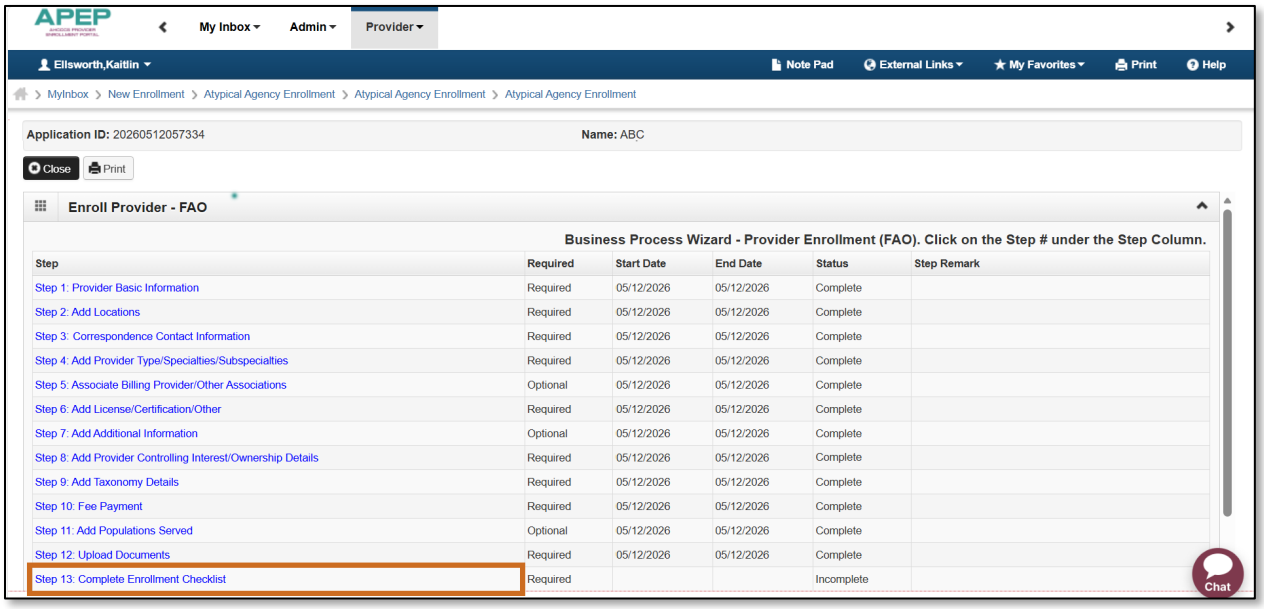


- Repeat these steps for each document to upload.
- Once “Upload Documents” has been completed, each Uploaded Document will display with document name and start/end dates.
- Select “Close”



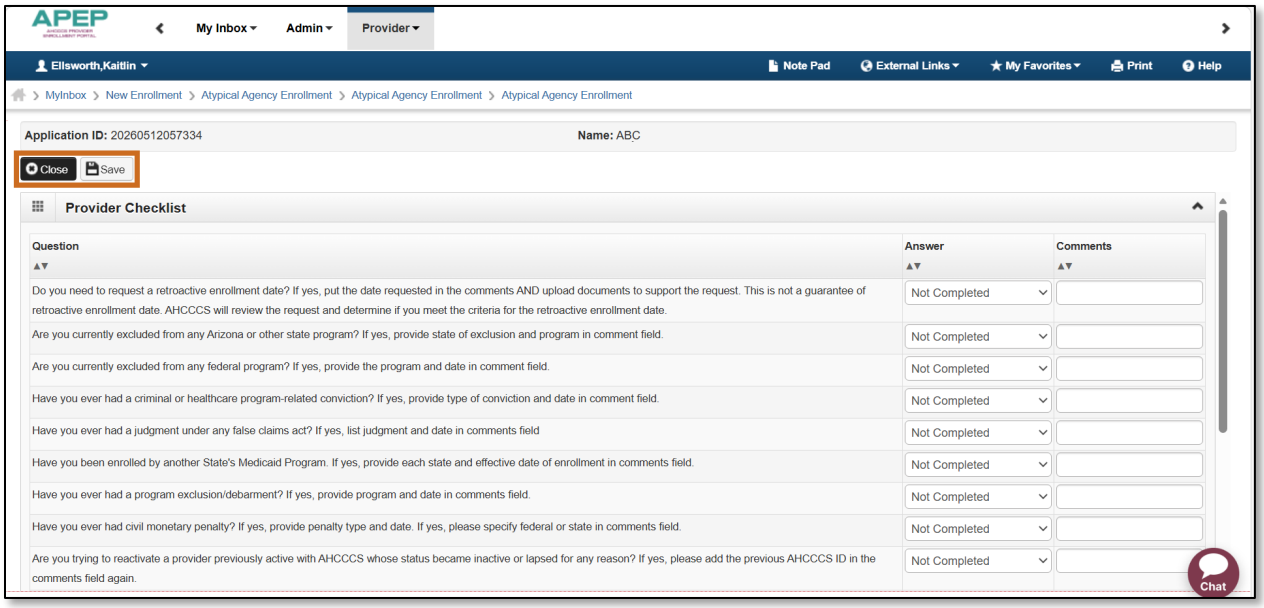
Step 14: Complete Enrollment Checklist

- Select “Step 14: Complete Enrollment Checklist”



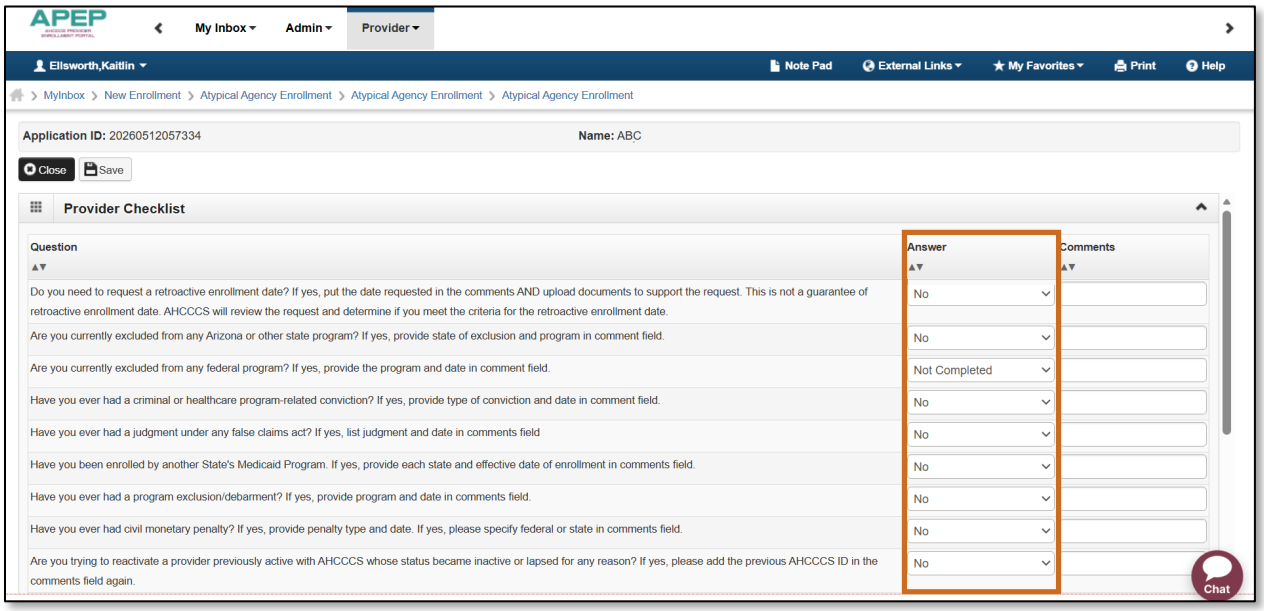
Step	Required	Start Date	End Date	Status	Step Remark
Step 1: Provider Basic Information	Required	05/12/2026	05/12/2026	Complete	
Step 2: Add Locations	Required	05/12/2026	05/12/2026	Complete	
Step 3: Correspondence Contact Information	Required	05/12/2026	05/12/2026	Complete	
Step 4: Add Provider Type/Specialties/Subspecialties	Required	05/12/2026	05/12/2026	Complete	
Step 5: Associate Billing Provider/Other Associations	Optional	05/12/2026	05/12/2026	Complete	
Step 6: Add License/Certification/Other	Required	05/12/2026	05/12/2026	Complete	
Step 7: Add Additional Information	Optional	05/12/2026	05/12/2026	Complete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required	05/12/2026	05/12/2026	Complete	
Step 9: Add Taxonomy Details	Required	05/12/2026	05/12/2026	Complete	
Step 10: Fee Payment	Required	05/12/2026	05/12/2026	Complete	
Step 11: Add Populations Served	Optional	05/12/2026	05/12/2026	Complete	
Step 12: Upload Documents	Required	05/12/2026	05/12/2026	Complete	
Step 13: Complete Enrollment Checklist	Required			Incomplete	

- Answer each question and provide any additional information in the comments field. After reviewing the information, select “Save” and then select “Close.”
- Any “Yes” answer will require additional documentation to be uploaded for review.

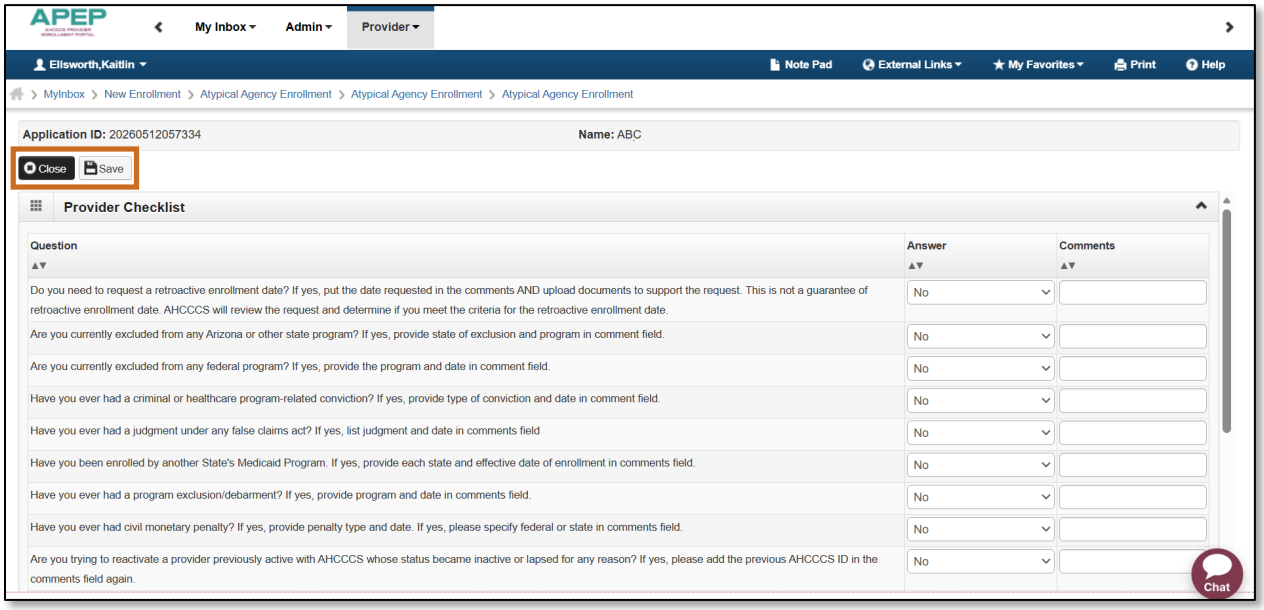


Question	Answer	Comments
Do you need to request a retroactive enrollment date? If yes, put the date requested in the comments AND upload documents to support the request. This is not a guarantee of retroactive enrollment date. AHCCCS will review the request and determine if you meet the criteria for the retroactive enrollment date.	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	

If any of the questions show "Not Completed", select the "Not Completed" dropdown to complete the required information.



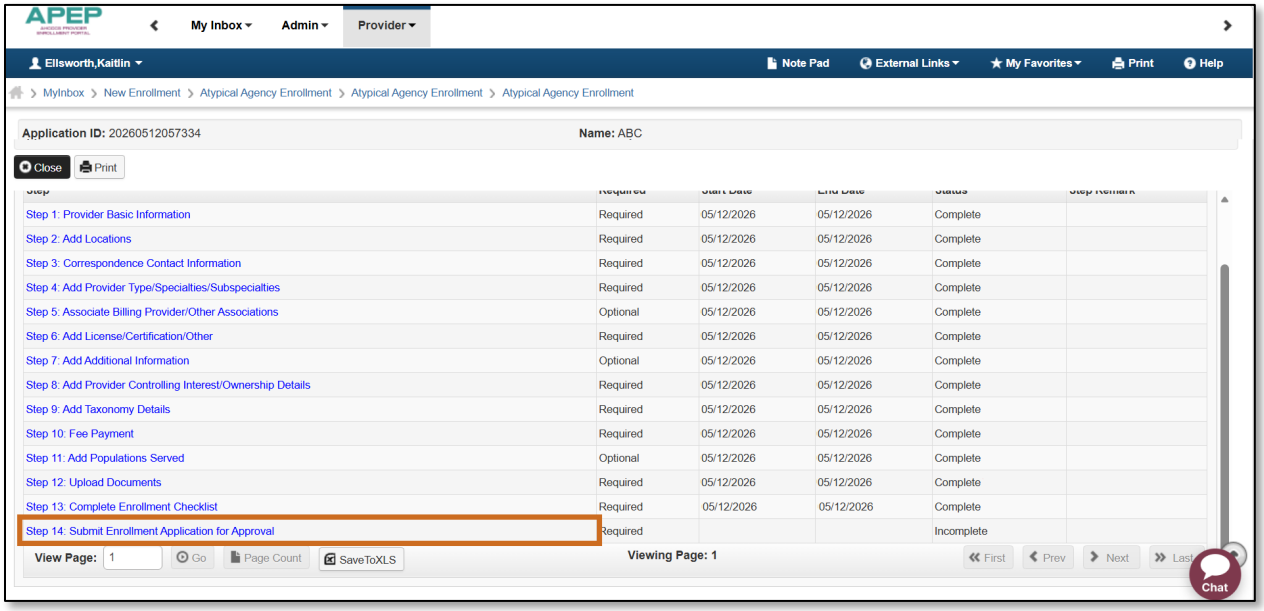
- After reviewing the information, select "Save" and then select "Close"



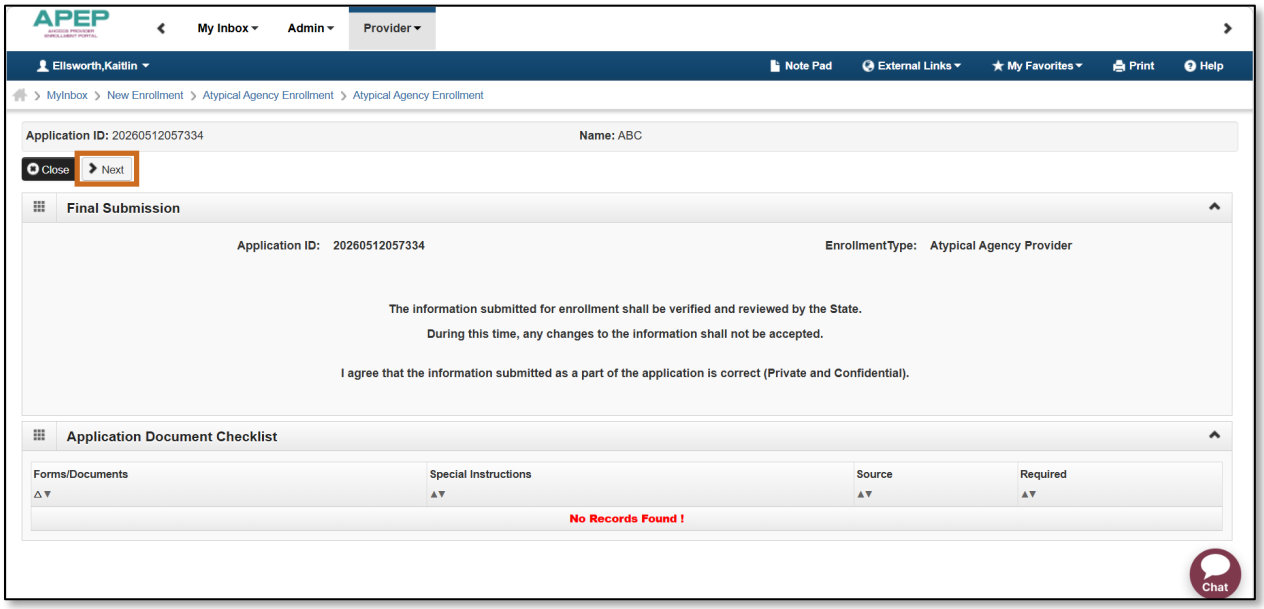
Step 15: Submit Enrollment Application for Approval

If a step is displaying “Incomplete” in the Status column, please return to that step and complete all required fields.

- Select “Step 15: Submit Enrollment Application for Approval.”

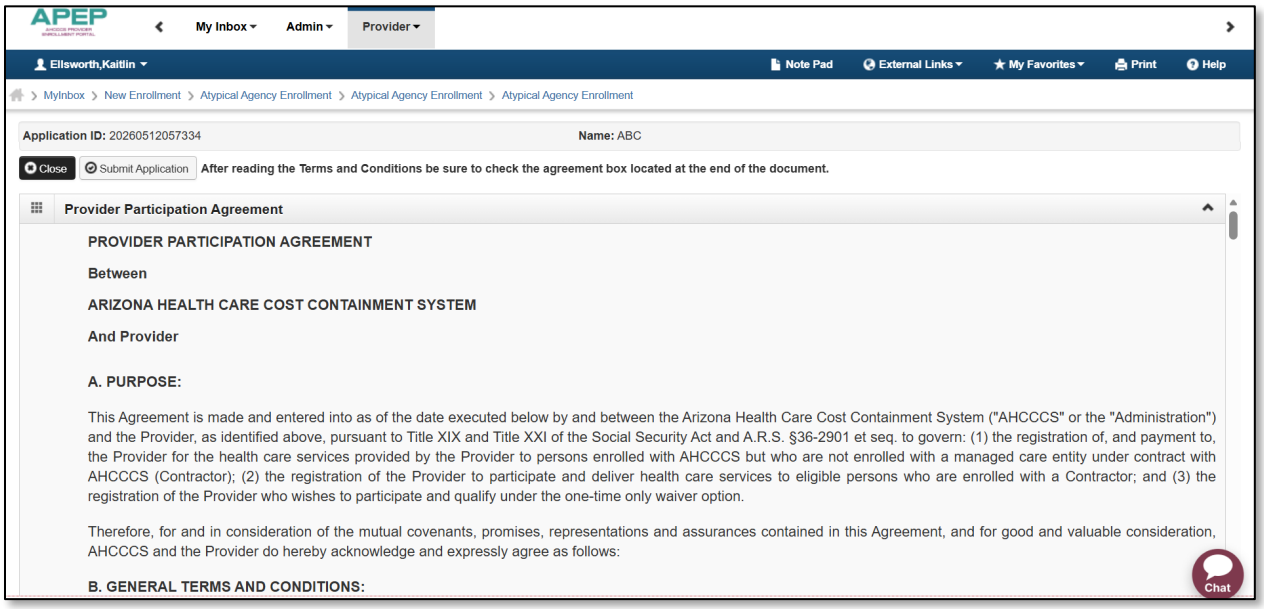


By selecting “Next” this indicates the information you are submitting is accurate.

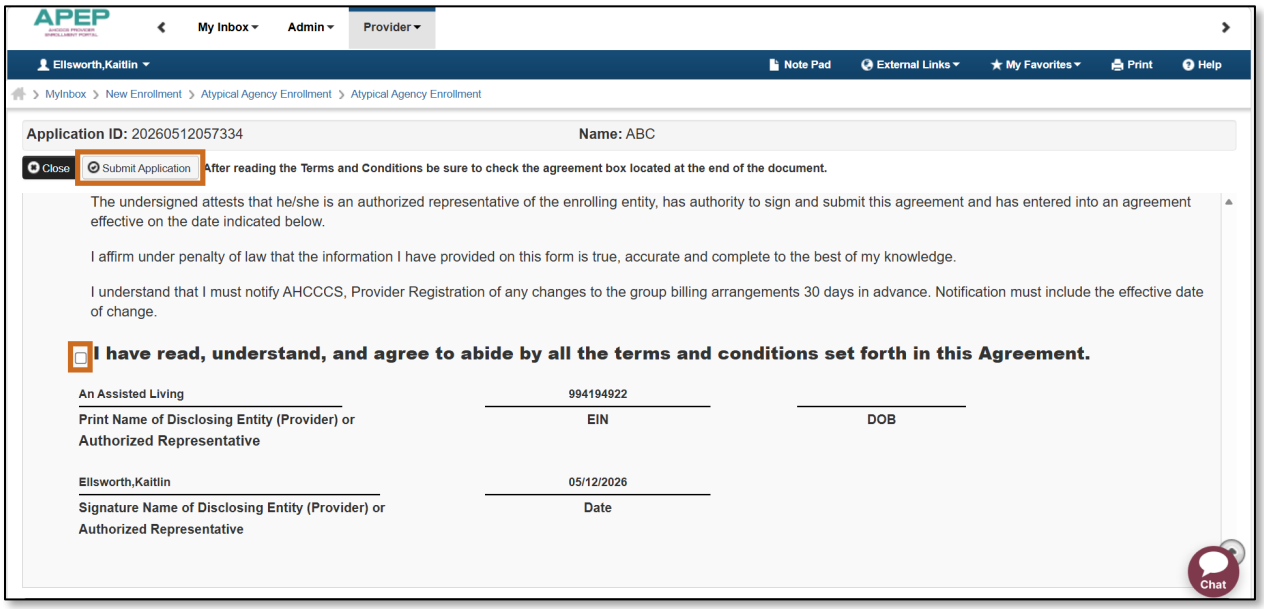


- Review the Provider Participation Agreement.

The image below is an example of a Provider Participation Agreement.



- Select the check box indicating agreement with the Provider Participation Agreement. The signor's full name and date will automatically display.
- Select "Submit Application"



A message should display stating the application has been successfully submitted. Return to APEP to track the status of the application with the Application ID number.

- Select “Close”