

Atypical Agency Enrollment





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)

These providers include:

- Adult Day Health Centers
- Adult Foster Care Providers
- Home and Community-Based Services Providers
- Home Help Agencies
- Residential Treatment Facilities
- Habilitation Providers
- Mental Health Providers
- Developmentally Disabled Day Care
- Personal Care Attendant Agencies
- Blood Banks
- Respite Care or Specialized Services

Beginning an Application

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



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Enrollment Type						^
	Select the Applicable Enrollment Type					
Individual/Sole Proprietor						
C Regular Individual/Sole Proprietor or Rendering/Servicing Provide	er					
Group Practice (Corporation, Partnership, LLC, etc.)						
Facility/Agency/Organization (FAO-Hospital, Nursing Facility, Various E	Entities)					
Contractor/MCO						
Managed Care Organization						
○ Correctional Facilities						
O Tribal Behavioral Health						
O Department Of Economic Security						
 Atypical (non-medical) provider (Choose this option if you do not have 	a NPI)					
 Individual (Driver, Home Help/Personal Care, Carpenter, etc.) 						
Agency (Child Care Institution, Home Help/Personal Care Agency,	, Transportation Company, Local Education Agency etc.)					

Enrollment Overview

Each provider must complete steps 1 through 13 to submit the application.

- Status column: This column will change from "Incomplete" to "Complete" as steps are completed.
- Step Remark column: This column will alert you to any problems in completing the step.
- Blue font: indicates a hyperlink.
- Steps display in blue font when the step is ready for data entry.
- In order to skip steps, you must first complete steps 1 through 4 in numerical order to make the remainder of steps available.
- * An asterisk indicates required fields. Required fields must be completed to proceed forward.

NOTE: It is important to ensure all data entered is accurate and valid.



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Step 1: Provider Basic Information

1. Select Step 1: "Provider Basic Information."

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

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ва	Basic Information: Enter required fields and click Finish button.	
	III Basic Information	^
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	Entity Business Name: X (Doing Business As)	EIN/TIN: *
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	Profit Status: 🗸 🗸 🗸	

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2	Basic Information. Enter the provider's basic information
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- Legal Entity Name: As shown on the provider's Income Tax Return
- Entity Business Name: Provider's "Doing Business Name"

Note: If you are an employee of a facility, agency, or organization and you do not have an EIN, the FAO for which you work must have an application registered with AHCCCS before you can continue to register yourself as a provider. You will not be able to submit your application until your employer does so first.

✓ Finish S Cancel



- 3. Tribal Type: Select the drop-down option if you provide services for tribal members. Leave the questions blank if not applicable.
 - IHS-Indian Health Service
 - Privately owned on tribal land
 - Tribally owned on tribal land

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Basic Inf	formation: Enter required fields and click F	inish button.						
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	Entity Business Name:	(ABC * (Doing Business As) EIN/TIN: 891122334 *					
	Tribal Type:		<u> </u>					
	9 Information				•			
	amoniation	IHS - Indian Health Service						
	W-9 Entity Type:	Privately owned on tribal land	* W-9 Entity Type (If Other):					
	Profit Status:	Tribally owned on tribal land	✓ *					

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- 4. W-9 Entity Type: IRS W-9 information provided must match IRS reports.
 - Corporate-Charitable applies for non-profits
 - Corporate-Non-Charitable applies for many private companies.
 - Profit Status: Non-Profit, For-Profit and Closely Held are the most common Profit Status Codes that apply for non-profits and private companies.
- 5. Once complete select, "Finish" to proceed forward.



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	W9 Information		*
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6. Once the Basic Information is complete, an Application ID will be provided. You will need this Application ID later 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.

Note: Write down your Application ID and keep it in a safe place. If you misplace the Application ID, check your email account used during the User Registration process to retrieve the email containing the Application ID. If you are unable to locate the email containing the Application ID, please contact the AHCCCS Provider Enrollment team.

7. To continue with the application, select "OK". By selecting "OK", this will take you to "Step 2: Add Locations". This step is required prior to submission of the application.



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	Application ID: 20200622985834	Name: ABC		
	III Basic Information			^
	You have successfully completed the basic information on the Enrollment Application. Your Application ID is: 20200622985834			
	Please make note of this Application ID. This is the number you will be required to use to track the status of your enrollment application. Without this number, you will not be able to access your application and your information will be deleted.			
	Please make sure to complete your application and submit it for State Review within 30 calendar days OR your application will be deleted.			

✔ Ok

Note: To complete the next step, "Click" the blue hyperlink. Currently, only Step 2 has a hyper link. However, once you complete Step 4, every step will display a hyper link allowing you to complete the

Step2: Add Locations

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steps in any order.

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Step 1: Provider Basic Information	Require	d 06/22/2020	06/22/2020	Complete			
Step 2: Add Locations	Require	d		Incomplete			
Step 3: Add Correspondence Address	Require	d		Incomplete			
Step 4: Add Provider Type/Specialties/Subspecialties	Require	d		Incomplete			
Step 5: Associate Billing Provider/Other Associations	Optiona	I		Incomplete			
Step 6: Add License/Certification/Other	Optiona	I		Incomplete			
Step 7: Add Additional Information	Optiona	I		Incomplete			
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Step 8: Add Provider Controlling Interest/Ownership Details Step 9: Add Taxonomy Details Step 10: Fee Payment Step 11: Upload Documents Step 12: Complete Enrollment Checklist	Optiona Optiona Optiona Require	l d		Incomplete Incomplete			



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2. 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 are optional.

Note: If you are already registered with AHCCCS, you will see a list of your locations under the "Locations List." For a new enrollment, this list will be empty.

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

Note: Enter your street address on Address line 1 and your 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.

- 4. Every "Primary Practice Location," requires hours of operation. Fill in these fields as appropriate.
- 5. Select, "OK," when complete.



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6. Select the "Primary Practice location" link to add Pay-To Address. The link will display in Blue font under the "Location Type" field.

Note: A message at the top will indicate a "Pay to Address is required for the Primary Practice Location. To Add/Modify Pay to Address, click on the Primary Practice Location hyperlink."

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 Type of Address: Select "Pay-To-Address" in the drop-down menu. Carefully enter, review and "Validate Address" the address. When complete, select "OK" to proceed forward.
 Note: If the "Pay to Address" is the same is the Primary Practice Location, Click the "Location Address: radio button Copy this Location Address" to copy the address. Then click "OK."

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	AITN:	Billing Dept.)					
		ATTENTION: Address Su	Ibmission only requires Address Line 1 and Zip Code, then click the VALIDATE				
		ADDRESS button. Once USPS. If Address Line 1	clicked, the remaining address fields will be populated and validated by the and Zip Code combination is not valid, an error will be returned.				
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	Count	ry: UNITED STATES 🗸 *	Zip Code:	85034 * - 2215	Validate Address		





9. The provider address will now display in the Address list.

Note: To add additional practice locations and pay to addresses, select "Add Address" and repeat steps 1 through 9. To continue without adding another service location, select "Save" and then select "Close" to proceed forward.

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Step 3: Add Correspondence Ad	ddress				
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Step 3: Add Correspondence Address	Required			Incomplete	
Step 4: Add Provider Type/Speciaties/Subspeciaties	Required			Incomplete	•
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete	
Step 6: Add License/Certification/Other	Optional			Incomplete	
Step 7: Add Additional Information	Optional			Incomplete	
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete	
Step 9: Add Taxonomy Details	Optional			Incomplete	
Step 10: Fee Payment	Optional			Incomplete	
Step 11: Upload Documents	Optional			Incomplete	
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□ [△] ♥			
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3. In the "Communication Preference" field, select "Standard Mail" or "Email." Note: Only one option may be selected. All notices will go to the mailing address or email address entered on this screen.

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Carefully enter, review and "Validate Address" the address. When complete, select "OK."
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Country:	UNITED STATES V	Zip Co	ode: 85034 * - 2215 Validate Address	
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5. Select "close" to proceed forward.

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Step 4: Add Provider Type Specialties/Subspecialties

1. Select "Step 4: Add Provider Type Specialties/Subspecialties."

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Step 1: Provider Basic Information	Required	06/22/2020	06/22/2020	Complete			
Step 2: Add Locations	Required	06/22/2020	06/22/2020	Complete			
Step 3: Add Correspondence Address	Required	06/22/2020	06/22/2020	Complete			
Step 4: Add Provider Type/Specialties/Subspecialties	Required			Incomplete			
Step 5: Associate Billing Provider/Other Associations	Optional			Incomplete			
Step 6: Add License/Certification/Other	Optional			Incomplete			
Step 7: Add Additional Information	Optional			Incomplete			
Step 8: Add Provider Controlling Interest/Ownership Details	Required			Incomplete			
Step 9: Add Taxonomy Details	Optional			Incomplete			
Step 10: Fee Payment	Optional			Incomplete			
Step 11: Upload Documents	Optional			Incomplete			
Step 12: Complete Enrollment Checklist	Required			Incomplete			
Step 13: Submit Enrollment Application for Approval	Required			Incomplete			



2. Select "Add."

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3. Complete the "Add Provider Type/Specialty" and "Add Subspecialty" fields as appropriate.

Environment: AZ_UAT R10c-1.1

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- 4. Select, appropriate "Provider Type" in the drop-down option.
- 5. Select, the "Speciality" in the drop-down option, or "No Specialty" if applicable.
- Add "Subspecialty": Select, "Associated Subspecialty": "No Subspecialty." Note: For new enrollments, the "Add Provider Type/Specialty & Add Subspecialty" fields will display empty.
- 7. When complete, select "OK" to proceed forward.



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		Select 'No Subspecialty' if applicable.		

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

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



Step 5: Association 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:

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

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Step 2: Add Locations	Required	06/22/2020	06/22/2020	Complete				
Step 3: Add Correspondence Address	Required	06/22/2020	06/22/2020	Complete				
Step 4: Add Provider Type/Specialties/Subspecialties	Required	06/22/2020	06/22/2020	Complete				
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2. Select, "Add."				
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3. 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.

Environment: AZ_UAT R10c-1.1

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

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4. Select, "Close", to advance forward

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Step 6: Add License/Certification/Other

1. Select "Step 6: Add License/Certification/Other."

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Step 2: Add Locations	Required	06/22/2020	06/22/2020	Complete				
Step 3: Add Correspondence Address	Required	06/22/2020	06/22/2020	Complete				
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2. Select "Add."

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License/Cert./Other Type	License/Cert./Other #	Valid Flag ▲▼	Effective Date	Er	nd Date

3. Carefully enter the License/Certification/Other List Information. Once complete, select "Confirm License/Certification", and Select "OK." Repeat for each available License/Certification.

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Page ID: pgLicenseListForEnrImnt(Provider)

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

4. Select, "Close", to proceed forward.

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Step 7: Add Additional Information

Note: This step is optional for most providers For Atypical Agencies, this link allows you to add information about bed types.



1. Select, "Step 7: Add Additional Information" 🜍 Identity Cloud Service 🗙 🔇 Business Process Wizard Start 🗙 🕂 ð × _ ← → C ☆ 🏻 az-uat-evo.cns-inc.com/evoBrix/CNSIControlServlet ☆ Ø 0 V K My Inbox ▼ Provider ▼ APEP 👤 valenzuela,veronica 🔻 💾 Note Pad 🛛 🔇 External Links 🕶 ★ My Fa 🖨 Pr Atypical Agency Enrollment > Atypical Agency Enrollment Application ID: 20200622985834 Name: ABC Close III Enroll Provider - Atypical Agency ^ Business Process Wizard - Provider Enrollment (Atypical Agency), Click on the Step # under the Step Column. Step Required Start Date End Date Status Step Remark Step 1: Provider Basic Information Required 06/22/2020 06/22/2020 Complete Step 2: Add Locations 06/22/2020 06/22/2020 Complete Required Step 3: Add Correspondence Address Required 06/22/2020 06/22/2020 Complete 06/22/2020 Step 4: Add Provider Type/Specialties/Subspecialties Required 06/22/2020 Complete Step 5: Associate Billing Provider/Other Associations Optional 06/22/2020 06/22/2020 Complete 06/22/2020 ep 6: Add License/Certification/Other 06/22/2020 Required Complete Step 7: Add Additional Information Optional Incomplete Step 8: Add Provider Controlling Inte Required Incomplete Step 9: Add Taxonomy Details Optional Incomplete Step 10: Fee Payment Required Incomplete Please add Fee Payments. Step 11: Upload Documents Required Incomplete Please upload required documents Step 12: Complete Enrollment Checklist Required Incomplete Step 13: Submit Enrollment Application for Approv Required Incomplete Page ID: pgBPWAtypicalAgencyStart(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 06/22/2020 11:26:16 MST

2. Select, "Add," under Bed Information to bring up details window for bed information.

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Bed Type	Bed(s)/Unit(s)		Start Date		End	Date		
□ ▲ ▼	▲ ▼		₽					

3. Select "Bed Type," drop-down option.

- 4. Select "Bed Unit(s): insert the number of beds.
- 5. Select "Calendar" option and add "Start Date" for bed type.
- 6. Click "OK."

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7. Select, "Close," to proceed forward.

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Step 8: Add Provider Controlling Interest/Ownership Details

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

Environment: AZ_UAT R10c-1.1

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III Per Medicaid Provider Manual

PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

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

REQUIRED DISCLOSURE INFORMATION

- Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control 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.
 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.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an
- ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
 The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name of any other need agent of manage care of any minimum an other has an other sin.
 The name, address, date of birth and Social Security Number of any managing employee.

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.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- · For the Contractor/MCO Enrollment Type, 3 ownership records must be added:

(1) Agent

(2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer (3) Managing Employee

1. Select "Step 8: Add "Provider Controlling Interest/Ownership Details"

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tep 4: Add Provider Type/Specialties/Subspecialties	Required	06/22/2020	06/22/2020	Complete				
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 Clicking the link takes you to a page that describes who exactly should provide details of ownership or controlling 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.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, or Chief Financial Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
 - (1) Agent
 - (2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer

(3) Managing Employee

3. 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 (if applicable).



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





5. Select, "Type," In this example Individual Sole Proprietor is selected as owner type.

Note: The proprietor has 100% ownership and is the same individual as the Managing Employee.

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6. Select "Owner's Relationships." This option requires an action to proceed forward. Select

"Actions," then select "Owners Relationship" to disclose and establish if Owner's Relationships.

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7. Complete the drop-down fields to describe the relationship between provider owners.

Note: If owners have no familial relationship, clicking the "NO" option to the questions at the top will eliminate the drop-down menus. No relationship will need to be specified.

8. When all information has been entered, select "Save."

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9. For each provider owner, you must disclose any adverse actions taken. Select "Actions," then select "Owners Adverse Action."

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10. For each owner, indicate if any adverse actions have been taken by answering "Yes" or "No."

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11. If "YES," additional fields requiring a response to relevant details will populate. Click "OK," once completed.

Name: ABC
s defined in 42 C.F.R. ¿ 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or noio contendere plea) of any of the item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating let of a patient in connection with the delivery of a health care item or service, as further explained in 42 C.F.R. ¿ 1001.101(b); mbezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of s under any such program; ference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. ¿ 1001.101 or 1001.201; <i>nu</i> manufacture, distribution, prescription, or dispensing of a controlled substance; or
d, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or an
fication, permit, or the licensure of an entity in which they had an ownership interest of 5% or more ever been revoked, suspended, terminated, surrendered, placed
tment, pending plea, or investigation, that could result in any sanction, conviction (as defined in 42 C.F.R. ¿ 1001.2, and including convictions that are the result of n for any Responsive Entity?

12. Repeat this step for each disclosed Owner and Managing Employee.



This is an example of a completed Provider Controlling Interest/Owners Detail page. Note: The "Relationship Status" and Adverse Action" columns reflect as "Completed" for all disclosed Owner Types allowing you to proceed forward.

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Step 9: Add Taxonomy Details

This step does not apply to the Atypical Agency enrollment type and as it relates to the providers' National Provider Identifier (NPI) number.

Note: Taxonomy codes are reflective on the NPPES NPI Registry website; visit https://npiregistry.cms.hhs.gov/



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tep 4: Add Provider Type/Specialties/Subspecialties	Required	06/22/2020	06/22/2020	Complete						
tep 5: Associate Billing Provider/Other Associations	Optional	06/22/2020	06/22/2020	Complete						
tep 6: Add License/Certification/Other	Required	06/22/2020	06/22/2020	Complete						
tep /: Add Additional Information	Optional	06/22/2020	06/22/2020	Complete						
tep 8: Add Provider Controlling Interest/Ownership Details	Required	06/22/2020	06/22/2020	Complete						
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3. Enter your taxonomy code and start date. A Taxonomy list is available for reference by selecting, "Arrow" link next the Taxonomy Code field.

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5. Select "Close" to proceed forward.

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Step 10: Fee Payment

States are required to collect a "Fee Payment" on Institutional providers prior to execution of the Provider Participation Agreement. The "Fee Payment" is part of the screening process at Enrollment, Reactivation, Revalidation and some Modification requests adding an additional service address to provider's ID. The "Fee Payment" increases each calendar year mandated by federal government.

1. Select" Step 10: Fee Payment."

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2. Select "Add."

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3. Select, applicable "Fee Payment" option.

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

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4. Select "OK" to proceed forward.

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	۲	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		
	0	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.		
	0	Fee Paid to Medicaid in Another State	Select this option if you can supply documentation demonstrating that you have already paid the enroliment fee to the Medicaid program of another state. Select the program name and payment date in th section below. Upload your receipt or documentation of payment in the "Upload Documents" step. This is subject to federal and state approval.	Ð	
	0	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 errollment application/modification request. This is subject to federal and state approval.		
	0	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.		
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5. Select "Close" to proceed forward.

Note: The "Payment Status" column now indicates that the fee payment is pending.

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Step 11: Upload Documents

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

1. Select "Step 11: Upload Documents."

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ep 8: Add Provider Controlling Interest/Ownership Details	Required	06/22/2020	06/22/2020	Complete				
tep 9: Add Taxonomy Details	Optional	06/22/2020	06/22/2020	Complete				
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2. Select "Add."

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- 3. Select the applicable Document Type and Document Name. Select "Browse" to find the document on your machine.
- 4. Select, a "Start Date" and "End Date" for each uploaded document.

Note: The "Start Date" is the license/certificate date of issuance. If the license/certificate has a renewal date, this date will serve as the "End Date." If the license/certificate does not have a renewal date, the "End Date" can be left blank.

5. Select "OK."

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Note: Document types that may be uploaded include PDF, Word, Excel, and photo formats such as PNG and JPEG.

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- 6. Repeat steps 1 through 5 for each document to upload.
- 7. Once "Upload Documents" has been completed, each Uploaded Document will display with document name and start/end dates. Select "Close."



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Step 12: Complete Enrollment Checklist

1. Select "Step 12: Complete Enrollment Checklist."

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Step 3: Add Correspondence Address	Required	06/22/2020	06/22/2020	Complete			
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2. Answer each question and provide any additional information in the comments field. After reviewing the information, select "Save" and then select "Close."



Note: Specific questions could result in additional information needed, resulting in potential completed steps requiring review and an action taken by the provider prior to submission.

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Do you wish to end date your enrollment? If yes, enter date in comment field.	Not Completed	~		
re 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	~		
ave you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	Not Completed	~		
lave you ever had a judgment under any false claims act? If yes, list judgment and date in comments field	Not Completed	~		
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lave 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	~		
re 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 ag	Jain. Not Completed	~		-

3. Carefully review the "Answer" column. If any steps show "Not Completed," select the "Not Completed" link to return and complete required information.

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4. After reviewing the information, select "Save" and then select "Close."



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Step 13: Submit Enrollment Application for Approval

Note: If a step is displaying "Incomplete" in the Status column, Please return to that step and complete all required fields.

1. Select "Step 13: Submit Enrollment Application for Approval."

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tep 3: Add Correspondence Address	Required	06/22/2020	06/22/2020	Complete			
tep 4: Add Provider Type/Specialties/Subspecialties	Required	06/22/2020	06/22/2020	Complete			
tep 5: Associate Billing Provider/Other Associations	Optional	06/22/2020	06/22/2020	Complete			
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2. Select, "Next."



Note: By selecting "Next" this indicates the information you are submitting is correct.

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Close Next						
III Final Submission						
Applicatio	on ID: 20200622985834	Enrollm	entType: Atypical Age	ncy Provider		
	The information submitted for enrollment sh During this time, any changes to the i	all be verified and reviewed by the State. Iformation shall not be accepted.				
	I agree that the information submitted as a part of the	application is correct (Private and Confidenti	al).			
III Application Document Checklist						
Forms/Documents	Special Instructions	Sou	ce	Required		
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3. Carefully review the Provider Participation Agreement.

Note: The image below is an example of a Provider Participation Agreement. Prior to submitting, each provider must review the Medicaid Provider Participation Agreement in its entirety.

 C OC ON Contractory and a consideration of the Provider to feed on the Arizona Health Care Cost Contained in this Agreement is rade and entered into as of the date executed below by and between the Arizona Health Care Cost Contained in this Agreement Application ID: 20200622985834 Name: ABC C Core O Submit Application After reading the Terms and Conditions be sure to check the agreement box located at the end of the document. Frovider Participation Agreement Application ID: 20200622985834 Name: ABC C Core O Submit Application Agreement Application Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Contain Provider, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A R.S. §38-2901 et seq, to gover the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who (Contractor) or who receive emergency services only. (2) the registration of and for the Provider the participate and deliver health Care Cost Contain Therefore, for and in consideration of the Provider to participate and qualify under the one-time only waiver option. Therefore, for and in consideration of the Provider to participate and gualify under the one-time only waiver option. Therefore, for and no continue any contracts for the delivery of health care services to any AHCCCS eligible person, in terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the tis services rendered is submitted. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fies-FGuides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals, are available on the AHCCS All AHCCCS is using an amendment revision. Undate or oth			-	o ×
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Provider Partial > New Enrolment > Atypical Agency Enrolment Application ID: 20200622985834 Name: ABC O Closs O submit Application After reading the Terms and Conditions be sure to check the agreement box located at the end of the document. If 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 Contain Provider, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §38-2901 et seq. to gover the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who (Contractor) or who receive emergency services only. (2) the registration of and for the Provider to participate and deliver health 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 Agreer and the Provider do hereby acknowledge and expressly agree as follows: B.GENERAL TERMS AND CONDITONS: 1. Pursuant to 42 C.F.R. §431.107, the Provider is prohibited from participation in the AHCCCS system unless a provider participate and provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, in terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the tis services rendered is submitted. 2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fue-FGuides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS Subjeas an amendment revis	External Links •	★ My Favorites ▼	🖨 Print	😯 Help
Application ID: 20200622985834 Name: ABC © Closs © Submit Application After reading the Terms and Conditions be sure to check the agreement box located at the end of the document. III 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 Contain Provider, as identified above, pursuant to Tile XIX and Title XXI of the Social Security Act and A.R.S. §38-2901 et seq, to gover the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who (Contractor) or who receive emergency services only. (2) the registration of and for the Provider to participate and deliver health 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 Agreer and the Provider to barter packnowledge 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 participate provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, in terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the ti services rendered is submitted. 2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-FGuides are hereby incorporated by reference into this Agreement. Guidelines				
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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 Contain Provider, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 et seq, to gover the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who (Contractor) or who receive emergency services only, (2) the registration of and for the Provider to participate and deliver health Contractor, and (3) the registration of the mutual covenants, promises, representations and assurances contained in this Agreer 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 participate Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, in terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the ti services rendered is submitted. A.ILAHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-F Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCC 3.When AHCCCS is an amendment revision. Uadate or other change to modify this Agreement is incorrorated by				
 A.PURPOSE: This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Contain Provider, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 et seq. to gover the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who (Contractor) or who receive emergency services only, (2) the registration of and for the Provider to participate and deliver health 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 Agreer and the Provider do hereby acknowledge and expressly agree as follows: B.GENERAL TERMS AND CONDITONS: Pursuant to 42 C.F.R. §431.107, the Provider is prohibited from participation in the AHCCCS system unless a provider participate person, interminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the ti services rendered is public. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-FGuides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCC 3. When AHCCCS is an amendment revision. 				^
 Pursuant to 42 C.F.R. §43.10/r, the Provider is prohibited from participation in the ARCCCS system unless a provider participation in the ARCCCS system unless a provider participation or continue any contracts for the delivery of health care services to any ARCCCS eligible person, in terminated. Furthermore, ARCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the ti services rendered is submitted. All ARCCCS guidelines, policies and manuals, including but not limited to the ARCCCS Medical Policy Manual, ARCCS Fee-FGuides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the ARCCCS. When ARCCCS issues an amendment revision, update or other change to modify this Agreement or documents incorporated by 	n: (1) the registration is providing member s in care services to eligi ment, and for good an	of, and payment to, services under contr ible persons who are nd valuable consider	the Provide ract with AH0 e enrolled w ration, AHCC	r for CCCS ith a CCS
provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar d AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provide Dece Diversity devices the amendment, revision, update or other change has not been signed by the Provider. If the Provide	tion agreement with the cluding contracts with me the services were for-Service Manual, A CS website. Any reference that are a ays after the date AH r gives written notice	The Administration is any Contractor, if the rendered or at the te HCCCS Claims Clu a part of this Agreem CCCS publishes the to AHCCCS of Prov	in errect. This his Agreeme ime a claim les, and Rep hent, the e change to t vider's refusa	e nt is for worting the al to



4. Select the "Check box," indicating agreement with the Provider Participation Agreement. The signor's full name and date will automatically display.



Note: This returns you back to the BPW. A message should display letting you know your application has been successfully submitted. You can return back to APEP to track the status of your application with the Application ID number. FAOs will need their Application ID and AHCCCS ID to submit their enrollment fee.



6. Select, "Close."

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