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| **Provider Information** |
| **Check the purpose of the request:  Initial Application**   |  | | --- | |  | | *Date of Application* |   Initial Application Directions: Providers shall submit an application for each facility location providing services to members. Information on where to send the submission(s) is provided below. If applicable, Contractors will jointly determine a Lead Contractor to perform credentialing reviews and approvals on behalf of all the Contractors who intend to contract with the specific provider location. The provider will be notified, within 30 days of the initial application submission, by the Contractor about next steps in the credentialing process. Reference the “Application for Initial Approval and Initial Desk Audit” as specified in AMPM Policy 965. |
| **Check the purpose of the request:  Credentialing Amendment**   |  |  |  | | --- | --- | --- | |  |  |  | | *Date of Request* |  | *Effective Date of Change* |   **Credentialing Amendment Directions**  Providers shall submit a credentialing amendment and associated required documentation under any of the following specific circumstances:   1. Change in agency name, address or telephone number. 2. Change in the provider’s NPI and/or tax identification number. 3. Change in ownership, governing board, or Chief Executive of the program.   4. Adding or removing a Contractor that the providers contracts with or intends to contract with for the provision of services  **Only** update information in the “Provider Information” and “Provider Enclosures” sections that need to be updated.  **Do Not** update the “Services Provided” or “Program Description” sections. Information on where to send the submission is provided below. The provider will be notified, within 30 days of the credentialing amendment requestsubmission, by the Contractor about next steps in the credentialing process. Reference the “Credentialing Amendment” as specified in AMPM Policy 965. |

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| **National Provider Identification (NPI):** |  | |
|  |  | |
| *Provider Name* | *Provider Phone Number* | |
|  | | |
| *Provider E-Mail Address* | | |
| **Provider Administrative Address (if applicable)**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | | | | |  |  | | *Street* | | | | |  | *County* | |  |  |  |  |  | | | | *City* |  | *State* |  | *Zip Code* | | | | |
| **Provider Facility Address**   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | | | | |  |  | | *Street* | | | | |  | *County* | |  |  |  |  |  | | | | *City* |  | *State* |  | *Zip Code* | | | | |
| **Program Director**   |  |  |  | | --- | --- | --- | |  |  |  | | *Provider Name* |  | *Title* | |  |  |  | | *Provider Phone Number* |  | *Provider E-Mail Address* | |  |  |  | | *Tax Identification Number* | ***-OR-*** | *Social Security Number* | | |
| **Place an “X” next to one or more of the Contractors**  **for which the provider intends to contract**  **AHCCCS Contractors**  Arizona Complete Health  Banner University Family Care  Care1st of Arizona  Magellan Complete Care  Mercy Care  Health Choice Arizona  UnitedHealthcare Community Plan  Mark with an “X” if the applicant will be providing services to members enrolled with DCS/CMDP.  Mark with an “X” if the applicant will be providing services to American Indian members through Arizona Indian Health Program or Tribal ALTCS Fee-For-Service programs. | |
| **Provider Enclosures** | |
| **Enclose the following with the**  **initial application or credentialing amendment (as applicable)**  (*Check the box beside each document enclosed)*  Copy of provider incorporation documents  Copy of provider charter, if any  Occupancy Permit of Physical Facility Address  Copy of Passed Fire Inspection of Physical  Facility Address | |
| **Services Provided** | |
| **Check all services below that the provider intends to provide to AHCCCS members**   |  |  |  | | --- | --- | --- | |  | Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion) | | |  | Comprehensive Community Support (Supervised Day) | | |  | Home Care Training (Family Support) | | |  | Ongoing Support to Maintain Employment | | |  | Personal Care | | |  | Psychoeducational Service (pre-job training and development) | | |  | Psychosocial Rehabilitation Living Skills Training Services | | |  | Self-help/Peer Services (Peer Support) | | |  | Supervised Behavioral Health Day Treatment and Day Program | | |  | Transportation | | |  | Other |  |   A complete list of services that can be provided by Community Service Agencies may be found on the AHCCCS website under Medical Coding Resources.  **Check the following age groups for which your agency will be providing services:**  0-17 years  18 years and older | |

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| **Describe the purpose, goals and objectives of the program, including the populations that will be served** |
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| *Program Director, Printed Name* |
| *Program Director, Signature* | *Submission Date* |

Send completed forms to Credentialing@azahp.org. The Managed Care Organizations are using this central email inbox to coordinate the credentialing process through the Arizona Association of Health Plans (AZAHP). The provider will be notified, within 30 days, by the Contractor about next steps in the credentialing process.

If the applicant will be providing services to American Indian members through Arizona Indian Health Program or Tribal ALTCS Fee-For-Service programs and not contracting with an MCO, contact the CSA Compliance Program Specialist below for information on where to send the application.

For technical assistance on the CSA credentialing process, contact the AHCCCS/DHCM CSA Compliance Program Specialist:

Arizona Health Care Cost Containment System

Division of Health Care Management

Attention: CSA Compliance Program Specialist

801 E. Jefferson, MD 6500

Phoenix, Arizona 85034

602-417-4286