AZ AHP

Credentialing Alliance
FACILITY CREDENTIALING & RECREDENTIALING APPLICATION

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable. Attach additional sheets when necessary.

Type of Facility (As listed on License or Accreditation)	
☐ Acute Rehab	☐ ASC
☐ Dialysis	☐ DME/Infusion
☐ Enteral	☐ Family Planning
☐ Home Health	☐ Hospice
☐ Hospital	☐ Lab
☐ O&P	☐ PT/OT/ST
☐ Radiology	☐ Sleep Center
☐ Skilled Nursing Facility	☐ Transportation
☐ Urgent Care	☐ Vision
☐ Wound Care	☐ Behavioral Health
☐ Assisted Living Center	☐ Assisted Living Home
☐ FQHC/RHC	☐ Outpatient Medical Rehab Center (PT/OT/SP)
☐ Pharmacy	☐ Medical/Dental schools
☐ Intensive Outpatient Treatment (BH)	☐ Other (Please Specify):

Facility Demographics		
Legal Business Name (as reported to the IRS):	**Federal Tax Identification Number:**	
Doing Business As (dba) Name (if applicable):	**Hospital or Health System Affiliation:**	
Mailing/Correspondence Address:		
City:	**State:**	**Zip Code:**
Billing Name (if different than dba):		
Billing Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Fax #:**	
Credentialing Contact Name:	**Phone #:**	
Credentialing Mailing/Correspondence Address:		
City:	**State:**	**Zip Code:**
Email Address:		**Fax #:**

AZ AHP

Primary Location		
Street Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Fax #:**	
Please provide a copy of State License and/or business license **State License #:**_____ **Expiration Date:**_____	**CLIA #:**_____ **Expiration Date:**_____	
NPI #: **(Application cannot be processed without a valid 10-digit NPI)**		
Medicare Certified? ☐ **Yes** ☐ **No** ***Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter*** **Medicare #:**_____		
AHCCCS/Medicaid #:_____		
Please indicate if this location has been reviewed by any of the accrediting authorities listed below and provide a copy of <u>most recent</u> accreditation report		
☐ American Association for Accreditation of Ambulatory Surgery Facilities	☐ Det Norske Veritas National Integrated Accreditation for Healthcare Organizations	
☐ American Association for Ambulatory Health Care	☐ Commission on Accreditation of Rehabilitation Facilities	
☐ American College of Radiology	☐ American Osteopathic Association	
☐ Healthcare Facilities Accreditation Program	☐ Accreditation Commission for Health Care Inc	
☐ Commission on Office Laboratory Accreditation	☐ Joint Commission	
☐ Community Health Accreditation	☐ Not Applicable	
Professional Liability: **** Please provide a copy of Current Liability Declaration Sheet*** Name of Carrier:_____ Effective Date:_____ Expiration Date:_____ Per Incident: $_____ Per Aggregate: $ _____	**Comprehensive Liability:** **** Please provide a copy of Current Liability Declaration Sheet*** Name of Carrier:_____ Effective Date:_____ Expiration Date:_____ Per Incident: $_____ Per Aggregate: $_____	

Supplemental Form

For each additional address copy and complete this Supplemental Form

Return all copies with the completed application

Street Address:

City:	**State:**	**Zip Code:**

Phone #:	**Fax #:**
Please provide a copy of State License and/or business license **State License #:** _____ **Expiration Date:** _____	**CLIA #:** _____ **Expiration Date:** _____

NPI #:
(Application cannot be processed without a valid 10-digit NPI)

Medicare Certified? ☐ **Yes** ☐ **No**

Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter

Medicare #: _____

AHCCCS/Medicaid #: _____

Accreditation:
Does this site have the same accrediting agency as the primary address?

☐ **Yes**

☐ **No - Please specify accrediting agency or NONE:** _____

Disclosure Questions

Please answer the following questions by checking the appropriate box. If the answer to any question is yes, please provide a complete description of the facts on a separate attached sheet.	
1. Has the facility license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed?	☐ Yes ☐ No
2. Has the facility been denied participation, suspended from or denied renewal from Medicare or Medicaid?	☐ Yes ☐ No
3. Has the facility ever had its professional liability coverage cancelled or not renewed?	☐ Yes ☐ No
4. Has the facility been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?	☐ Yes ☐ No

Facility Attestation/Consent & Release Form

Any alteration or failure to sign and date this form will result in the delay of processing this application. By signing below, I attest that I am the duly authorized representative of the Facility, that all information on the Application pertains to the above-named Facility, and that such information is current, complete and correct.

Your signature is required to complete this application.

Facility Name: _____

Name (Please Print): _____

Title: _____

Signature: _____

Date: _____

Facility Credentialing and Recredentialing Application Instructions

Please include with your completed/signed application the following items for each location:

- □ Copy of current State License and/or business license (if applicable)
- □ Copy of Medicare Certification letter (if applicable)
- □ Copy of Certifications and/or Accreditation Certificates (e.g. TJC, CHAP, etc)
- □ Copy of your CLIA Certificate (if applicable)
- □ Copy of Declaration Sheet and/or Certificate of Insurance for BOTH Current *Professional* Malpractice and Comprehensive *General* Liability Insurance Policies

If you have any questions, please contact our Provider Network/Operations

Please fax completed application with all required documents to our Provider Network/Operations or as directed, to our credentialing vendor, Aperture to 866-293-0421.

Please Note:

Initial Credentialing – Failure to legibly complete all sections of this Application and submit current copies of all required documentation will result in processing delays.

Recredentialing – Submission of recredentialing information is a contractual obligation. Failure to complete all sections of this Application and submit current copies of all required documentation in a timely manner will be considered a request to terminate the facility's participation in our network.

The fax number and phone number for each participating plan is listed in the table below.

If your intent is to apply for participation in a Health Plan network, please send only to the Plan(s) you are interested in joining. NOT ALL Plans provide services in every county. Please contact the Plan directly to verify that they provide services in your county and that they are accepting new providers.

If you are adding a location/facility under an existing Health Plan contract, please only send to the Plan(s) you are contracted with.

HEALTH PLAN	PHONE	FAX/EMAIL	WEBSITE
Arizona Complete Health-Complete Care Plan	(888) 788-4408	(866)687-0514 AzCHProviderData@azcompletehealth.com	www.azcompletehealth.com
Banner University Health Plans	(520) 874-5290 or (800) 552-5656	Email is the preferred method to submit completed PDFs: BUHPDATATEAM@Bannerhealth.com (520) 874-7142	www.BannerUFC.com/ACC www.BannerUFC.com/ALTCS www.BannerUCA.com www.BannerUHP.com
Care1st Health Plan Arizona	(602) 778-1800 (options in order 5, 7)	(602) 778-1875 SM_AZ_PNO@care1stAZ.com	www.care1staz.com
Comprehensive Medical and Dental Program (CMDP)	(602) 351-2245 or (800) 201-1795 (options in order 1, 2, 3)	(602) 264-3801 CMDPProviderServices@azdcs.gov	https://dcs.az.gov.cmdp
DentaQuest	(800) 233-1468	initialproviderenrollment@dentaquest.com 262-241-7401	http://www.dentaquest.com/state-plans/regions/arizona/az-dentist-page
Magellan Complete Care Arizona	800-424-5891	888-656-0369 MCCAZProvider@MagellanHealth.com	www.mccofaz.com
Mercy Care	(602) 263-3000	Contracting: contractingdepartment@mercycareaz.org If contracted already, email completed forms to Provider Relations at: Providerrelations@mercycareaz.org Or fax to: (860) 975-3201	www.mercycarez.org
Health Choice Arizona	(800) 322-8670 (options in order 4, 7)	Contracting: hchcontracting@healthchoiceaz.com If contracted already, email your provider representative Or fax to: (480) 760-4975	www.healthchoiceaz.com
UnitedHealthcare Community Plan	(877) 842-3210	(855)523-9998 Cred_application@uhc.com	www.uhcprovider.com

Each plan retains the right to make their own contracting decisions (whether or not to add organizations to their network) and also will make their own credentialing committee decisions (review of the primary source verification information obtained by Aperture Credentialing, LLC resulting in approval/denial by the plan's committee). You will receive separate communication from each plan regarding the effective date of your credentialing and the effective date of your contract.