AZ AHP

Credentialing Alliance
ORGANIZATIONAL DATA FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST. New providers receive written confirmation of their effective date with the health plan. Members may not be seen until the provider receives written confirmation that a request or change is approved and completed (this includes approval by the Credentialing Committee if applicable). **Please Type or Print Clearly.**

- Please type or print this form clearly and return the completed form with attachments (attachments will need to be scanned if submitted electronically)
- Please complete a separate Organizational Data Form for entities with different AHCCCS ID #'s and/or License #'s.

Attach the following:

1. IRS 941 coupon or accurate W9
2. Liability insurance face/certificate
3. Copy of all accreditation certificates (including Medicare)
4. Medicaid required insurance certificates as applicable (*see page 2 for requirements*)

NON-ACCREDITED FACILITIES:

1. Copy of most recent State and/or Medicare Survey Audit
2. List of practitioners providing services at each location (See AzAHP Ancillary Provider Roster) (if applicable)

1099 Registered Name (Required):		Tax ID #:
Facility Name/DBA (if applicable):		
Lines of Business: ☐ Medicaid ☐ Medicare ☐ Commercial	License #: State:	Exp. Date:
Is provider a Medicare participating provider? ☐ Yes ☐ No	AHCCCS I.D.#:	Organizational NPI#:

Facility Type (*check all that apply*):

☐ Acute Rehab	☐ Family Planning	☐ O&P	☐ Transportation	☐ Assisted Living Center
☐ ASC	☐ Home Health	☐ PT/OT/ST	☐ Urgent Care	☐ Assisted Living Home
☐ Dialysis	☐ Hospice	☐ Radiology	☐ Vision	☐ FQHC/RHC
☐ DME/Infusion	☐ Hospital	☐ Sleep Center	☐ Wound Care	☐ Outpatient Medical Rehab Center
☐ Enteral	☐ Lab	☐ SNF	☐ Behavioral Health	☐ Other

BILLING SERVICE (If applicable)	Name:		Contact:	
	Address:			Phone:
	City:	State:	Zip Code:	Fax:
PAY TO ADDRESS (All payments sent to this address)	Address:		City:	Zip Code:
	Phone:	Fax:		Zip Code:
PRIMARY ADDRESS (Physical location where services are performed) *Attach a sheet with additional locations including NPI specific to location	Address:		City:	Zip Code:
	Phone:	Fax:	County:	Location NPI:
	Modalities:		Hours:	
	Is Office Accessible to Persons with Disabilities? ☐ Yes ☐ No		List this Address in Directories? ☐ Yes ☐ No	
FACILITY CONTACT/ MAILING ADDRESS:	Contact Name/Title:		Phone:	Fax:
	E-mail Address:		Website Address:	
	Address:		City:	Zip Code:
CREDENTIALING CONTACT:	Name:		E-mail Address:	
	Address:			Phone:
	City:	State:	Zip Code:	Fax:

Describe Your Medical Record Keeping System(s) (i.e. EMR, Paper, etc.):		
Describe Your Cost Record Keeping System(s) (i.e. Billing or A/R system):		
Electronic Claims Submission? ☐ Yes ☐ No	Internet Access? ☐ Yes ☐ No	Is this a minority or female owned business? ☐ Yes ☐ No
Electronic Funds Transfer? ☐ Yes ☐ No		

Facility Assessment of Cognitive and Physical Disabilities Accommodations

Please identify what accommodations you provide at **each of your facility locations** for members with cognitive or physical disabilities. If accommodations are the same at all locations, on Practice Location Address, please state ALL. Please, complete a separate Assessment for each location if accommodations vary.

Facility Location Address:

_____

Accommodation	YES	NO	Comments
Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities			
Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limitations or wheelchair bound			
Flexible appointment times available—sick appointments, same day appts—please specify			
Extended appointment times—before 8 am, after 5pm, Sat and/or Sunday—please specify			
Assistance available to members to fill out forms			
In-home and/or community services			
Large print materials			
Materials in electronic format			
Augmentative/Alternative communication devices			
TDD capabilities			
American Sign Language translator			
Signage with Braille and raised tactile text characters at office, elevator, stairwells and restroom doors mounted 60in from floor			
Visible & Audible alarms – emergency systems			
Dimmable Lights			
Ramps have non-slip surface material			
Railings between 30 & 38in high. On both sides.			
Paths are at least 36in wide and free of protruding objects			
Cane detectible objects on ground as a warning barrier			
Widened doorways (at least 32in clearance)			
Offset (swing-clear) hinges			
Power assisted or automatic door openers			
Door handles no higher than 48in			
Lever or loop handles vs knobs			
5ft circle or T-shaped space for turning a wheelchair completely			
A clear floor space, 30" X 48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer			
Adjustable height exam table or chair (lowers to 17-19in from floor)			

Accommodation	YES	NO	Comments
Positioning and support aids, such as wedges, rolled up blankets, straps and rails			
Ceiling or floor-based patient lift			
Gurneys and/or stretchers			
Wheelchair accessible scales			
Adjustable height radiologic equipment			
Handicap parking			
Handicap accessible restroom			
Access ramps			
Accessible by bus			
Accessible by Valley Metro Rail			
Provider/Staff has completed cultural competence training			
Do you provide Field Clinic services? (A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis)			
Do you provide Virtual Clinic services? (Integrated services provided in community settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)			

Prior to submitting your insurance information complete this checklist, use it as a tool to address everything that's required and send it on top of your insurance document(s).

Commercial General Liability	**Professional Liability**
☐ ATTACHED	☐ ATTACHED ☐ N/A
☐ General Aggregate $2,000,000 ☐ Products Ops Aggregate $1,000,000 ☐ Personal & Adv. Injury $1,000,000 ☐ Damage to Rented Premises $50,000 ☐ Each Occurrence $1,000,000	☐ Each Claim $1,000,000 ☐ Annual Aggregate $2,000,000
Business Automobile Liability	**Workers' Compensation Liability**
☐ ATTACHED ☐ N/A	☐ ATTACHED ☐ N/A
☐ Combined Single Limit $1,000,000	☐ Each Accident $1,000,000 ☐ Disease – Each Employee $1,000,000 ☐ Disease – Policy Limit $1,000,000

Your Certificates of Insurance must include the minimum requirements outlined in the tables above and the following endorsement, waiver of subrogation and/or SAM language as applicable.

☐ **Endorsement – Required for Commercial General and Business Auto Liability**
This policy contains an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ **Waiver of Subrogation – Required for all**
This policy contains a waiver of subrogation endorsement in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ ****Sexual Abuse and Molestation (SAM) – Required for Commercial General Liability or Professional Liability when providing services to children and/or vulnerable adults**
Insurance Certificate(s) must provide the following statement "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded".

- If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should be included with the Professional Liability.

***Please check with health plan if SAM coverage is required for your specific provider type*

AHCCCS INSURANCE REQUIREMENTS – Required ONLY if requesting to participate in the Plan's Medicaid Line of Business

AHCCCS Insurance Requirements

This communication outlines the additional insurance requirements and provides examples to assist you.

AHCCCS Insurance Requirements
The AHCCCS insurance requirements include Commercial General Liability, Business Automobile Liability and Worker's Compensation and Employers' Liability.

Your commercial general liability policy and your business automobile policy (if applicable), need to include an endorsement (see letter a. below under Commercial General Liability and letter a. below under Business Automobile Liability) and a waiver of subrogation (see letter b. below under Commercial General Liability and letter b. below under Business Automobile Liability) in the Description field of your policy.

Your worker's compensation and employers' liability policy requires only the waiver of subrogation language.

Outlined below are the minimum requirements. Policy examples follow.

Commercial General Liability – Occurrence Form
Policy should include bodily injury, property damage, personal and advertising injury and broad form contractual liability coverage. The amounts below are the minimum requirements.

- General Aggregate $2,000,000
- Products – Completed Operations Aggregate $1,000,000
- Personal and Advertising Injury $1,000,000
- Damage to Rented Premises $50,000
- Each Occurrence $1,000,000

a. The policy shall be endorsed (**Blanket Endorsements are not acceptable**) to include the following additional insured language: ***"The State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor."*** Such additional insured shall be covered to the full limits of liability purchased by the Subcontractor, even if those limits of liability are in excess of those required by this contract.

b. Policy shall contain a waiver of subrogation endorsement (**Blanket Endorsements are not acceptable**) in favor of the "State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees" for losses arising from work performed by or on behalf of the Subcontractor.

c. If direct services are provided to children and/or vulnerable adults (as defined by A.R.S §46-451(A)(9)), the policy shall include coverage for Sexual Abuse and Molestation (SAM). This SAM coverage may be sub-limited to no less than $500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits. If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should it be included with the Professional Liability.

d. The following statement must provide on their Certificate(s) of Insurance: "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded."

Business Automobile Liability

Bodily Injury and Property Damage for any owned, hired, and/or non-owned vehicles used in the performance of the services under contract. The amount below is the minimum required.

- Combined Single Limit (CSL) $1,000,000

a. The policy shall be endorsed (**Blanket Endorsements are not acceptable**) to include the following additional insured language: **"*The State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees shall be named as additional insureds with respect to liability arising out of the activities performed by or on behalf of the Contractor, involving automobiles owned, leased, hired or borrowed by the Contractor.*"** Such additional insured shall be covered to the full limits of liability purchased by the Subcontractor, even if those limits of liability are in excess of those required by this contract.

b. Policy shall contain a waiver of subrogation endorsement (**Blanket Endorsements are not acceptable**) in favor of the "State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees" for losses arising from work performed by or on behalf of the Subcontractor.

Worker's Compensation and Employers' Liability

- Workers' Compensation Statutory
- Employers' Liability
  - Each Accident $500,000
  - Disease – Each Employee $500,000
  - Disease – Policy Limit $1,000,000

Policy shall contain a waiver of subrogation endorsement (**Blanket Endorsements are not acceptable**) in favor of the "State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by or on behalf of the Subcontractor."

Two examples for your reference are included on pages 9-10:

1. Commercial General Liability and Business Automobile Liability – includes limits, endorsement and waiver of subrogation language
2. Worker's Compensation and Employers' Liability – includes limits and waiver of subrogation language

We are required to verify your adherence to these insurance requirements. We appreciate you submitting Certificates of Liability with required coverage levels, endorsements and waivers along with the attached checklist

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/01/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Agent Name	
Insurance Company Name License Number Mailing Address City, AZ Zip Code	PHONE (A/C, No, Ext): 602-555-5555 FAX (A/C, No): 602-555-1111 E-MAIL ADDRESS: agent@insco.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: ABC Insurance Company	
INSURED Provider's Group Name Address Suite # City AZ Zip Code	INSURER B: DEF Insurance Company	
	INSURER C: XYZ Insurance Company	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES CERTIFICATE NUMBER: 123456789 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC OTHER:	X		123-ABC-456	09/01/2017	08/31/2018	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50,000 $ $ 1,000,000 $ 2,000,000 $ 1,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS	X		99-000-AB1111	09/01/2017	08/31/2018	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $
D	Professional Liability	X		12345678	09/01/2017	08/31/2018	$1,000,000 Per Claim/ $2,000,000 per Agg	

AHCCCS minimum coverage limits

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

This policy contains an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor, or on behalf of the Subcontractor or Contractor. This policy contains a waiver of subrogation endorsement in favor of the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees for losses arising from work performed by the Subcontractor, or on behalf of the Subcontractor or Contractor. Sexual Abuse and Molestation coverage is included.

AHCCCS required endorsement language and waiver of subrogation language.
NEW – Added Sexual Abuse and Molestation language

CERTIFICATE HOLDER

Arizona Health Care Cost Containment System
Attn: Contracts
700 E. Jefferson St. MD 5700
Phoenix AZ 85034

Add AHCCCS as the Certificate Holder

CANCELLATION

SHOULD ANY OF THE
THE EXPIRATION D

NTATIVE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/01/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Agent Name
Insurance Company Name License Number Mailing Address City, AZ Zip Code	PHONE (A/C, No, Ext): 602-555-5555 FAX (A/C, No): 602-555-1111 E-MAIL ADDRESS: agent@insco.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : SCF Casualty Insurance	13210
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED: Provider's Group Name, Address, City, AZ Zip Code

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	CLAIMS-MADE OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE							$
	DED RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A		C12345			STATUTE / OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

UPDATED – limits to $1,000,000

AHCCCS minimum coverage limits

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

This policy contains a waiver of subrogation endorsement in favor of the State of Arizona, and its departments, agencies, boards, commissions universities, officials, agents, and employees for losses arising from work performed by the Subcontractor or on behalf of the Subcontractor or Contractor.

Only Waiver of Subrogation language is required for Worker's Comp policy

CERTIFICATE HOLDER

Arizona Health Care Cost Containment System
Attn: Contracts
700 E. Jefferson St. MD 5700
Phoenix, AZ 85034

Add AHCCCS as the Certificate Holder

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ITATIVE

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 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 form to (860) 975-3201	www.mercycareaz.org
Health Choice Arizona	(800) 322-8670 (options in order 4, 7)	Contracting: hchcontracting@healthchoiceaz.com If contracted, email your provider representative (480) 760-4975	www.healthchoiceaz.com
UnitedHealthcare Community Plan	(877) 842-3210	(612) 234-0211	www.uhccommunityplan.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.