

### Practitioner/Group Name\_\_\_\_\_

NPI#			CAQH#						
Provider must be in Please add Practiti	n the netwo oner and/or ALL SECTION	rk already. Group Nar IS NEED TO	me, NPI # BE COMF	and CAC PLETED.	)H # on the Fax/emai	e above l l this fori	ines. Only c m and any re	n—change to an existing provider. complete the appropriate change type equired documentation to each of the etc as appropriate.	
Request Type: (Must Complete)	Service A	Address	🗆 Term	ination	🗆 Nam	ne Chang	je 🗆 Billi	ing Contact 🛛 🗆 Billing Name/Address	
(Must Complete)	Credent	ialing Cont	act 🗆	Specialt	v 🗆 P	ractition	er Type	Panel Change	
		0		-	,		- 71		
	🗆 Other (A	AHCCCS Reg	g #, NPI#	etc)					
Practitioner/Group Information: (Must Complete)	Practitior	ner's Name	:				Group Nam	ne:	
(, p,	Practition	ner's NPI#				CAQH #		Practitioner's AHCCCS#	
	Group Fe	deral Tax II	D#				Group NPI	¥	
Service Address	Address 1						Add 🗌 Delete EFFECTIVE DATE:		
Change:	Street:							Suite #:	
Is this a:	City:				State:		Zip Code:		
location	Telephon	e:		Fax:			Email:		
Secondary	Office	Day	Open	Closed	d Day	Open	Closed	Special Considerations:	
location	Hours:	Mon			Fri			(i.e., closed for lunch, etc)	
□ Covering		Tues Wed			Sat Sun				
location		Thurs			Jun				
	List Practi	tioner in Di	rectories	at this a	ddress:		Yes 🗆	No	
***NOTE: If	Location I	NPI:			Hand	licap acc	essible 🗆	Yes 🗆 NO	
adding a new location, please									
complete the	Address 2						Add 🗌 De	lete EFFECTIVE DATE:	
Assessment form	Street:							Suite #:	
(last 2 pages)	City:				State:		Zip Code:		
	Telephone	:		Fax:			Email:		
	Office	Day	Open	Closed	Day	Open	Closed	Special Considerations:	
	Hours:	Mon			Fri			(i.e., closed for lunch, etc)	
		Tues			Sat	_		4	
		Wed Thurs			Sun			4	
	1	inuis	1	1	1	1	1	1	
	List Practit	ioner in Dire	ctories at t	his addre	ss:	🗆 Yes	□ No		



#### Practitioner/Group Name\_\_\_\_\_

NI	DI	#
11	ГІ	HH .

\_\_\_\_\_ CAQH#\_\_\_\_\_

Practitioner	PCP Member Reassignment?   Yes  No	Effective Date of Term:
Termination Request:	Reassigned Practitioner Name:	Reassigned Practitioner NPI:
(Practitioner is leaving the	Reason for Term:  Leaving practice/group Reason for Term:	tired 🗆 Death
practice/group for any reason)	□ Other (Explain):	

Practitioner	PCP Member Reassignment?	Effective Date of Change to New Location:
Location	(Will members remain at previous location?)	
Change:	🗆 Yes 🗆 No	
(Practitioner is remaining with the practice but changing locations)	Reassigned Practitioner Name :	Reassigned Practitioner NPI:

Practitioner Name Change:	Previous Last, First, and Middle Name:	New Last, First, and Middle Name:			
	Effective Date:				
Required	For any name changes, a copy of Practitioner's current license reflecting the change is required to be				
Documentation	submitted with this form and/or AHCCCS Registration, NPI #				

Billing/Remit Address:	Legal Name:			Prev	Previous Legal name		
	Street:				Suite	#:	
	City:			State:		Zip Code:	
	Telephone:	Fax	x:			Email:	
	Effective Date:						
Required							
Documentation							

Billing Contact Change:	Name:				Title:	
	Street:			Suite #:		
	City:		State:	1	Zip Code:	
	Telephone:	Fax:	1		Email:	
	Effective Date:				1	



### Practitioner/Group Name\_\_\_\_\_\_

NPI#		_ CAQH#					
Credentialing Contact Change	Name:				Title:		
	Street:				Suite #:	:	
	City:			State:	1	Zip Code:	
	Telephone:		Fax:			Email:	
	Effective Date:					1	

Practitioner	Previous Practitioner Specialty/Provider Type:			
Specialty or				
Provider Type	New Practitioner Specialty/Provider Type:	Effective Date:		
Change:				
Required	Any change in this section may require a credentialing event. If changing your NPI# and/or AHCCCS			
Documentation	Registration you MUST complete the Practitioner or Organizational/Facility Application as appropriate.			
	Please confirm with your Practitioner Rep at the health plans for what is required.			
	For any change in Specialty, documentation that supports the change in specialty needs to be submitted with			
	this form, i.e., education, certification, etc. update with AHCCCS prior to submitting,			

Panel Change:	Panel			
(Complete for	OPEN		MAX PANEL LIMIT	□ AGES
any change to				
panel—open and	If change in max panel	limit or age range of me	ember, please provide an explanation	on:
closed, number				
of members				
assigned, change				
in ages of				
members with	Effective Date:			
effective date of				
change)				



#### Practitioner/Group Name\_\_\_\_\_

NPI#	CAQH#	
Other Changes (any other change being requested)	<ul> <li>AHCCCS Registration # N</li> <li>Other (Describe i.e., change in lagent set of the set of the</li></ul>	PI#
	Previous #	Current #
	Effective Date:	

Request	Name:	Title:
Request Submitted by		
	Date:	
	Phone:	Email:



### Practitioner/Group Name\_\_\_\_\_

NPI# CAQH#

#### Provider Assessment of Cognitive and Physical Disabilities Accommodations

Please identify what accommodations you provide at each of your practice 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.

#### **Practice Location Address:**

Accommodation	YES	NO	NA	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				
Waiting and Examinations rooms are routinely cleaned (MED 3A factor 3)				
Waiting room space contains seating sufficient for all scheduled appointments (MED 3A factor 4)				
Medical/treatment of members is fully documented (MED 3A Factor 5)				
Records are securely maintained in a confidential and orderly manner (MED 3 factor 5)				
Records are in compliance with HIPAA requirements (MED 3 factor 5)				
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		1	1	
Cane detectible objects on ground as a warning barrier		1	1	
Widened doorways (at least 32in clearance)				
Offset (swing-clear) hinges				
Power assisted or automatic door openers				

# 

# **Practitioner/Practice Change Form**

## Practitioner/Group Name\_\_\_\_\_

NPI# CAQH#	CAQH#				
Accommodation	YES	NO	NA	Comments	
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)					
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 Taxis or other similar options (Uber/Lyft)					
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 settingsthrough the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)					



## Practitioner/Group Name\_\_\_\_\_\_

NPI# CAQH#

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

HEALTH PLAN	PHONE	FAX/EMAIL	WEBSITE
Arizona Complete	(888)788-4408	(866)687-0514	www.azcompletehealth.com
Health - Complete		AzCHProviderData@azcompletehealth.com	
Care Plan			
Banner	(520) 874-5290	Email is preferred method to send	www.BannerUFC.com/ACC
University	or	completed PDFs:	www.BannerUFC.com/ALTCS
Health Plans	(800) 582-8686	BUHPDATATEAM@Bannerhealth.com	www.BannerUFC.com
		(520) 874-7142	www.BannerUHP.com
	(222) 222 2572		1 11 1 1
BCBSAZ Health	(800) 322-8670	Preferred: E-apply through the BCBSAZ	www.healthchoiceaz.com
Choice	(options in order 4, 7)	Health Choice Provider Portal Alternate: Request to participate/Contract:	www.healthchoicepathway.com
		hchcontracting@azblue.com	
		Request to credential/Already Contracted:	
		hchcredentialing@azblue.com	
		neneredentiding@dzbide.com	
Care1st Health Plan	(866) 560-4042	(833) 618-1507	www.care1staz.com
Arizona	(options in order 5, 7)	SM_AZ_PNO@care1stAZ.com	
DentaQuest	(800) 233-1468	initialproviderenrollment@dentaquest.com	http://www.dentaquest.com/state-
			plans/regions/arizona/az-dentist-
		(262)241-7401	page
Molina	(800) 424-5891	(888)656-0369	http://www.molinahealthcare.co
Healthcare of		MCCAZProvider@molinahealthcare.com	m/members/az/en-
Arizona	(602) 262 2020		US/pages/home.aspz
Mercy Care	(602) 263-3000	Network Management (Provider Relations	www.mercycareaz.org
		and Contracting) MercyCareNetworkManagement@MercyCar	
		eAZ.org	
		Fax: (860)975-3201	
		Tax. (000)373-3201	
UnitedHealthcare	For questions please email	Submission to the RFP Portal is the preferred	www.uhcprovider.com
Community Plan	networkhelp@uhc.com	method for accepting the pdf UHC RFP Portal	www.uneprovider.com
		(855) 523-9998	
		Cred_applications@uhc.com	

Each plan retains the right to make their own contracting decisions (whether or not to add practitioners 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.

CYE 2024