THE NAVAJO NATION

JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

February 13, 2022

Hon. Seth Damon
Office of the Speaker
Post Office Box 3390
Window Rock, AZ 86515

RE: CJA-06-22, *An Action Relating to Health, Education and Human Services, Budget and Finance and Naabik'iyati' Committees and the Navajo Nation Council; Approving a Limited Waiver of Sovereign Immunity in the Arizona Health Care Cost Containment System Provider Participation Agreements Between the Navajo Nation Division of Behavioral and Mental Health Services and the Arizona Health Care Cost Containment System*

Dear Speaker Damon,

Pursuant to the authority vested in the Navajo Nation President, I am signing CJA-06-22 into law.

We appreciate the Navajo Nation Council addressing this matter and providing the waiver for the Division of Behavioral and Mental Health Services for participation in the Arizona Health Care Cost Containment System Provider Participation Agreements. This participation will allow the program to continue to provide services for our people.

Allowing a waiver of sovereign immunity is a necessary step in accessing state services and we urge the program be responsible in this situation.

Sincerely,

Jonathan Nez, President
THE NAVAJO NATION

Myron Lizer, Vice President
THE NAVAJO NATION

RESOLUTION OF THE
NAVAJO NATION COUNCIL
24th NAVAJO NATION COUNCIL - FOURTH YEAR, 2022

AN ACTION
RELATING TO HEALTH, EDUCATION AND HUMAN SERVICES, BUDGET AND FINANCE, AND NAABIK'ÍYÁTI' COMMITTEES AND THE NAVAJO NATION COUNCIL; APPROVING A LIMITED WAIVER OF SOVEREIGN IMMUNITY IN THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PROVIDER PARTICIPATION AGREEMENTS BETWEEN THE NAVAJO NATION DIVISION OF BEHAVIORAL AND MENTAL HEALTH SERVICES AND THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

BE IT ENACTED:

SECTION ONE. AUTHORITIES

A. The Health, Education and Human Services Committee is a standing committee of the Navajo Nation Council and has authority to review and recommend contracts negotiated with state governments and Navajo health authorities subject to applicable laws of the Navajo Nation. 2 N.N.C. §§ 400(A) and 401(B)(6)(b).

B. The Budget and Finance Committee is a standing committee of the Navajo Nation Council and has authority to authorize to approve and accept contracts between the Navajo Nation and the State upon the recommendation of the standing committee which has oversight of the program that requested the contract. 2 N.N.C. §§ 300(A) and 301(B)(15).

C. The Naabik'íyáti' Committee is a standing committee of the Navajo Nation Council and reviews legislation which requires final action by the Navajo Nation Council. 2 N.N.C. §§ 700(A) and 164(A)(9).

D. The Navajo Nation Council is the governing body of the Navajo Nation, 2 N.N.C. § 102(A).

E. The Navajo Nation Code provides, "[c]ontracts shall not waive the sovereign immunity of the Navajo Nation or its entities unless approved by two-thirds (2/3) vote of the full membership of the Navajo Nation Council." 2 N.N.C. § 223(C).

SECTION TWO. FINDINGS

A. The Navajo Division of Behavioral and Mental Health Services (DBMHS) is a program under the Navajo Department of Health with

the purpose of providing "a comprehensive, culturally-centered holistic approach for prevention, treatment, and aftercare of alcohol, controlled substance use disorder, and violent behavior through an integrated behavior and mental health system." Plan of Operation, Resolution HEHSCJA-01-18.

B. In order for Division of Behavioral and Mental Health Services to provide services, bill for services, such as outpatient and residential behavioral and mental health treatment services, and receive Medicaid reimbursement payments for those services from the Arizona Health Care Cost Containment System (AHCCCS), the Division of Behavioral and Mental Health Services must enter into Provider Participation Agreements with AHCCCS.

C. The Provider Enrollment Forms contain the Provider Participation Agreement on pages 15—19 in **Exhibit A-1 through A-13**.

D. DBMHS completed the Participation Agreements for each of the sites it operates at the following locations: Chinle Outpatient Treatment Center (see **Exhibit A-1**), Dilkon Outpatient Treatment Center (**Exhibit A-2**), Fort Defiance Outpatient Treatment Center (**Exhibit A-3**), Kaibeto Outpatient Treatment Center (**Exhibit A-4**), Kayenta Outpatient Treatment Center (**Exhibit A-5**), Tuba City Outpatient Treatment Center (**Exhibit A-6**), Red Mesa Outpatient Treatment Center (**Exhibit A-7**), Shiprock (NRBHC) Outpatient Treatment Center (**Exhibit A-8**), Newlands Outpatient Treatment Center (**Exhibit A-9**), Gallup Outpatient Treatment Center (**Exhibit A-10**), Chinle Residential Treatment Center (**Exhibit A-11**), and Navajo Regional Behavioral Health Center Adult Residential and Adolescent Residential Centers (**Exhibit A-12** and **Exhibit A-13**).

E. Navajo Nation Department of Justice reviewed the Arizona Health Care Cost Containment System Provider Enrollment Forms for DBMHS to enter into a Provider Participation Agreement with the Arizona Health Care Cost Containment System and provided a memo expressing concerns regarding an indirect waiver of sovereign immunity.

F. The Provider Participation Agreement requires the Navajo Nation to consent:

1. to indemnification of the state at Section B(12),

2. agree that any appeals or claims filed by DBMHS shall be adjudicated in accordance with the AHCCCS Rules under Arizona Administrative Code at Section B(14),

3. to waiving any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of or otherwise related to the Agreement, at Section B(14),

4. agree that if DBMHS uses the AHCCCS/ALTCS/Kids care or other program logo or design without written approval, AHCCCS may seek injunctive relief and DBMHS shall bear the cost and expense of any judicial proceeding including all attorney's fees and costs incurred by AHCCCS at Section B(21).

SECTION THREE. APPROVING A LIMITED WAIVER OF SOVEREIGN IMMUNITY

A. The Navajo Nation hereby approves a limited waiver of sovereign immunity for the Navajo Nation Division of Behavioral and Mental Health Services to enter into the Provider Participation Agreements with the State of Arizona attached as **Exhibit A-1 through A-13**.

B. The Navajo Nation authorizes the President of the Navajo Nation to sign the Provider Participation Agreement on page 19 of the Provider Enrollment Form attached as **Exhibit A-1 through A-13.**

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the 24th Navajo Nation Council at a duly called meeting in Window Rock, Navajo Nation (Arizona), at which a quorum was present and that the same was passed by a vote of 22 in Favor, and 00 Opposed, on this 26th day of January 2022.

Honorable Seth Damon, Speaker
24th Navajo Nation Council

Feb 4, 2022
DATE

Motion: Honorable Edison J. Wauneka
Second: Honorable Vince R. James

Speaker Seth Damon not voting

ACTION BY THE NAVAJO NATION PRESIDENT:

1. I, hereby, sign into law the foregoing legislation, pursuant to 2 N.N.C. § 1005 (C)(10), on this 13 day of February, 2022.

Jonathan Nez, President
Navajo Nation

2. I, hereby, veto the foregoing legislation, pursuant to 2 N.N.C. § 1005 (C)(11), on this _____ day of _____, 2022 for the reason(s) expressed in the attached letter to the Speaker.

Jonathan Nez, President
Navajo Nation

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I		
Select **One** Applicable Request Type.*		
☐New Enrollment	☐Revalidation	■Provider Modification *List section numbers modified APEP Re-Registration

Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *

Provider Number/AHCCCS ID: 329533 ☐N/A

If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.

NPI: 1356555387 ☐N/A

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.

SECTION I-A		
☐Individual/Sole Proprietor	☐Rendering Servicing Provider	☐Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

SECTION I-B		
☐Group Practice (Corporation, Partnership, LLC, etc.)	■Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐Contractor/ MCO	Sub Type:	
	☐Correctional Facilities	☐Department of Economic Security
	■Tribal Behavioral Health	☐Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II
Complete required fields based on enrollment type, using the Category Key at the bottom of this page.

First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Chinle Outpatient Treatment Center
Home Address*A	City*A	State*A
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 1/1/2019	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B Navajo Route 7, Duplex Unit 2004		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 777	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Chinle	State/Province*A&B Arizona	County*A&B Apache County
Country*A&B United State of America	Zip Code*A&B 86503	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi
☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)674-2190		Fax Number (928)674-2196
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1.	
	2.	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	▣ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	▣ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	▣ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq*. to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*							
Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French							
Other(s) (specify):_____ ☐Handicap Accessible							

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X			
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE
153	SURGERY-PEDIATRIC	974	MEDICINE REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-ONCOLOGY
215	SURGERY-MAXILLOFACIAL	966	RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
✓	SSN/EIN/TIN is at the bottom of each page	All
✓	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
✓	Section IV Pay To information	All
✓	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
✓	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
✓	Section XI Add Taxonomy	All
✓	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement One of these Agreements must be signed and accompany all applications	All
	Appendix A – Additional Service Locations	All
	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D – Additional Owner(s)	All
	Appendix E – Additional Adverse Actions	All
	Appendix F – Provider Type Codes	All
	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

AHCCCS
Arizona Health Care Cost Containment System

EXHIBIT
tabbies
A-2

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:
Attn: AHCCCS Provider Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I			
Select **One** Applicable Request Type.*			
☐New Enrollment	☐Revalidation	■Provider Modification *List section numbers modified	APEP Re-Registration
Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *			
Provider Number/AHCCCS ID: 329484 ☐N/A			
If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.			
NPI: 1528270113 ☐N/A			

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.		
SECTION I-A		
☐Individual/Sole Proprietor	☐Rendering Servicing Provider	☐Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-B		
☐Group Practice (Corporation, Partnership, LLC, etc.) ☐Contractor/ MCO	■Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities) Sub Type: ☐Correctional Facilities ■Tribal Behavioral Health	☐Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.) ☐Department of Economic Security ☐Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II Complete required fields based on enrollment type, using the Category Key at the bottom of this page.		
First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Dilkon Outpatient Treatment Center
Home Address*A	City*A	State*A
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 1/1/2019	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B Northeast of Bashas'		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 7072	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Winslow	State/Province*A&B Arizona	County*A&B Navajo County
Country*A&B United State of America	Zip Code*A&B 86047	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)657-8000		Fax Number (928)657-8009
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1.	
	2.	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	⊡ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	⊡ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	⊡ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*							
Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French							
Other(s) (specify):_____ ☐Handicap Accessible							

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X	
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE
153	SURGERY-PEDIATRIC	974	MEDICINE REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
✓	SSN/EIN/TIN is at the bottom of each page	All
✓	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
✓	Section IV Pay To information	All
✓	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
✓	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
✓	Section XI Add Taxonomy	All
✓	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement One of these Agreements must be signed and accompany all applications	All
	Appendix A – Additional Service Locations	All
	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D – Additional Owner(s)	All
	Appendix E – Additional Adverse Actions	All
	Appendix F – Provider Type Codes	All
	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

AHCCCS
Arizona Health Care Cost Containment System

EXHIBIT
tabbies
A-3

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I		
Select **One** Applicable Request Type.*		
☐New Enrollment	☐Revalidation	■Provider Modification *List section numbers modified APEP Re-Registration
Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. * Provider Number/AHCCCS ID: 329541 ☐N/A		
If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type. NPI: 1740400365 ☐N/A		

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.		
SECTION I-A		
☐Individual/Sole Proprietor	☐Rendering Servicing Provider	☐Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-B		
☐Group Practice (Corporation, Partnership, LLC, etc.) ☐Contractor/ MCO	■Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities) Sub Type: ☐Correctional Facilities ■Tribal Behavioral Health	☐Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.) ☐Department of Economic Security ☐Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II Complete required fields based on enrollment type, using the Category Key at the bottom of this page.		
First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Fort Defiance Outpatient Treatment C
Home Address*A	City*A	State*A
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 1/1/2019	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B .5 Miles SW of the FD Field House BLDG #6905		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 1490	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Fort Defiance	State/Province*A&B Arizona	County*A&B Apache County
Country*A&B United State of America	Zip Code*A&B 86504	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)729-4012		Fax Number (928)729-4200
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1.	
	2.	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	☒ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	☒ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	☒ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*							
Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French							
Other(s) (specify):_____ ☐Handicap Accessible							

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X	
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE MEDICINE
153	SURGERY-PEDIATRIC	974	REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
✓	SSN/EIN/TIN is at the bottom of each page	All
✓	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
✓	Section IV Pay To information	All
✓	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
✓	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
✓	Section XI Add Taxonomy	All
✓	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement **One of these Agreements must be signed and accompany all applications**	All
	Appendix A – Additional Service Locations	All
	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D – Additional Owner(s)	All
	Appendix E – Additional Adverse Actions	All
	Appendix F – Provider Type Codes	All
	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I		
Select **One** Applicable Request Type.*		
☐New Enrollment	☐Revalidation	■Provider Modification *List section numbers modified APEP Re-Registration
Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *		
Provider Number/AHCCCS ID: 822909 ☐N/A		
If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.		
NPI: 1083835458 ☐N/A		

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.		
SECTION I-A		
☐Individual/Sole Proprietor	☐Rendering Servicing Provider	☐Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-B		
☐Group Practice (Corporation, Partnership, LLC, etc.) ☐Contractor/ MCO	■Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities) Sub Type: ☐Correctional Facilities ■Tribal Behavioral Health	☐Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.) ☐Department of Economic Security ☐Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II Complete required fields based on enrollment type, using the Category Key at the bottom of this page.		
First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Kaibeto Outpatient Treatment Center
Home Address*A	City*A	State*A
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 1/1/2019	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B 0.5 Mile South of Kaibeto Market		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 2147	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Kaibeto	State/Province*A&B Arizona	County*A&B Coconino County
Country*A&B United State of America	Zip Code*A&B 86053	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ☒N/A	Address Line 3 ☒N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)673-3267		Fax Number (928)673-3269
Method of Communication*A&B Only select 1 option ☒Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ☒N/A		Address Line 3 ☒N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1.	
	2.	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	⊡ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	⊡ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	⊡ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*							
Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French							
Other(s) (specify):_____ ☐Handicap Accessible							

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X			
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Provider SSN/EIN/TIN: 86-0092335
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Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE
153	SURGERY-PEDIATRIC	974	MEDICINE REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
✓	SSN/EIN/TIN is at the bottom of each page	All
✓	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
✓	Section IV Pay To information	All
✓	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
✓	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
✓	Section XI Add Taxonomy	All
✓	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement **One of these Agreements must be signed and accompany all applications**	All
	Appendix A – Additional Service Locations	All
	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D – Additional Owner(s)	All
	Appendix E – Additional Adverse Actions	All
	Appendix F – Provider Type Codes	All
	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

AHCCCS
Arizona Health Care Cost Containment System

EXHIBIT
tabbies
A-5

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I		
Select **One** Applicable Request Type.*		
☐New Enrollment	☐Revalidation	■Provider Modification *List section numbers modified APEP Re-Registration
Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. * Provider Number/AHCCCS ID: 329559 ☐N/A		
If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type. NPI: 1811109762 ☐N/A		

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.		
SECTION I-A		
☐Individual/Sole Proprietor	☐Rendering Servicing Provider	☐Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-B		
☐Group Practice (Corporation, Partnership, LLC, etc.) ☐Contractor/ MCO	■Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities) Sub Type: ☐Correctional Facilities ■Tribal Behavioral Health	☐Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.) ☐Department of Economic Security ☐Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II Complete required fields based on enrollment type, using the Category Key at the bottom of this page.		
First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Kayenta Outpatient Treatment Center
Home Address*A	City*A	State*A
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 1/1/2019	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B HWY 394.3 US-160		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 487	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Kayenta	State/Province*A&B Arizona	County*A&B Navajo County
Country*A&B United State of America	Zip Code*A&B 86033	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)697-5570		Fax Number (928)697-5574
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1._____	
	2._____	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

☒No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	⊡ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	⊡ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	⊡ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:

Provider SSN/EIN/TIN: 86-0092335

Be sure to include this identification at the bottom of each page

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X	
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE MEDICINE
153	SURGERY-PEDIATRIC	974	REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
✓	SSN/EIN/TIN is at the bottom of each page	All
✓	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
✓	Section IV Pay To information	All
✓	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
✓	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
✓	Section XI Add Taxonomy	All
✓	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement **One of these Agreements must be signed and accompany all applications**	All
	Appendix A – Additional Service Locations	All
	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D – Additional Owner(s)	All
	Appendix E – Additional Adverse Actions	All
	Appendix F – Provider Type Codes	All
	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I			
Select **One** Applicable Request Type.*			
☐New Enrollment	☐Revalidation	■Provider Modification *List section numbers modified	APEP Re-Registration

Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *

Provider Number/AHCCCS ID: 329492 ☐N/A

If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.

NPI: 1558483677 ☐N/A

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.

SECTION I-A

☐Individual/Sole Proprietor	☐Rendering Servicing Provider	☐Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

SECTION I-B

☐Group Practice (Corporation, Partnership, LLC, etc.)	■Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐Contractor/ MCO	Sub Type:	
	☐Correctional Facilities	☐Department of Economic Security
	■Tribal Behavioral Health	☐Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II Complete required fields based on enrollment type, using the Category Key at the bottom of this page.		
First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Tuba City Outpatient Treatment Cent
Home Address*A	City*A	State*A
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 1/1/2019	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■ Primary Practice Location*A&B Main Street BLDG 25		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 1350	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Tuba City	State/Province*A&B Arizona	County*A&B Coconino County
Country*A&B United State of America	Zip Code*A&B 86045	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)283-3346		Fax Number (928)283-3039
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1._____	
	2._____	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV		
Owner Name Jonathan Nez	Response: 1g.	☐ Yes ■ No
	Response: 2.	☐ Yes ☒ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes ■ No
	Response: 4.	☐ Yes ■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes ☒ No
	Response: 2.	☐ Yes ■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes ☒ No
	Response: 4.	☐ Yes ■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.		

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Provider Enrollment Form

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X	
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE
153	SURGERY-PEDIATRIC	974	MEDICINE REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-ONCOLOGY
215	SURGERY-MAXILLOFACIAL	966	RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
✓	SSN/EIN/TIN is at the bottom of each page	All
✓	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
✓	Section IV Pay To information	All
✓	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
✓	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
✓	Section XI Add Taxonomy	All
✓	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement **One of these Agreements must be signed and accompany all applications**	All
	Appendix A – Additional Service Locations	All
	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D – Additional Owner(s)	All
	Appendix E – Additional Adverse Actions	All
	Appendix F – Provider Type Codes	All
	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I		
Select **One** Applicable Request Type.*		
■ New Enrollment	☐ Revalidation	☐ Provider Modification *List section numbers modified

Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *

Provider Number/AHCCCS ID:_____ ☐N/A

If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.

NPI: 1316545940 ☐N/A

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.

SECTION I-A		
☐ Individual/Sole Proprietor	☐ Rendering Servicing Provider	☐ Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

SECTION I-B		
☐ Group Practice (Corporation, Partnership, LLC, etc.)	■ Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐ Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐ Contractor/ MCO	Sub Type: ☐ Correctional Facilities ■ Tribal Behavioral Health	☐ Department of Economic Security ☐ Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II
Complete required fields based on enrollment type, using the Category Key at the bottom of this page.

First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Red Mesa Outpatient Treatment Cent
Home Address*A	City*A	State*A
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 10/19/2020	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B US HWY 160 & NAVAJO ROUTE 35		End Date*A&B MMDDYYYY Current
Address Line 1*A&B	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Red Mesa	State/Province*A&B Arizona	County*A&B Apache County
Country*A&B United State of America	Zip Code*A&B 86514	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)871-6235		Fax Number (928)871-6456
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1._____	
	2._____	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner
Dr. Sidney Brown		Director	Self	Employee

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	⊡ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	⊡ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	⊡ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

AHCCCS
Arizona Health Care Cost Containment System

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ______________	Effective Date:	Expiration Date:

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X	
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE
153	SURGERY-PEDIATRIC	974	MEDICINE REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

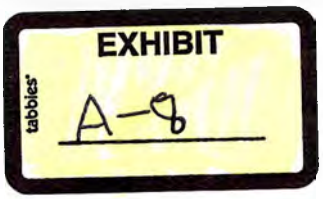
Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
☑	SSN/EIN/TIN is at the bottom of each page	All
☑	Section I Enrollment Type , I-A, I-B	All
☐	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
☐	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
☑	Section IV Pay To information	All
☑	Section V Correspondence Address	All
☑	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
☐	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
☐	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
☐	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
☑	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
☑	Section XI Add Taxonomy	All
☑	Section XII Fees	All
☐	**Provider Participation Agreement or Group Biller Participation Agreement** **One of these Agreements must be signed and accompany all applications**	All
☐	Appendix A – Additional Service Locations	All
☐	Appendix B – Associate Billing Provider/Other Associations	All
☐	Appendix C - Additional License/Certification/Other	All
☐	Appendix D – Additional Owner(s)	All
☐	Appendix E – Additional Adverse Actions	All
☐	Appendix F – Provider Type Codes	All
☐	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

AHCCCS
Arizona Health Care Cost Containment System



Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I		
Select **One** Applicable Request Type.*		
■ New Enrollment	☐ Revalidation	☐ Provider Modification *List section numbers modified

Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *

Provider Number/AHCCCS ID:_____ ☐N/A

If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.

NPI: 1487876991 ☐N/A

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.

SECTION I-A

☐ Individual/Sole Proprietor	☐ Rendering Servicing Provider	☐ Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

SECTION I-B

☐ Group Practice (Corporation, Partnership, LLC, etc.)	■ Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐ Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐ Contractor/ MCO	Sub Type:	
	☐ Correctional Facilities	☐ Department of Economic Security
	■ Tribal Behavioral Health	☐ Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II
Complete required fields based on enrollment type, using the Category Key at the bottom of this page.

First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Navajo Regional Behavioral Health C
Home Address*A PINON & COTTONWOOD DR BU	City*A Shiprock	State*A New Mexico
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 10/19/2020	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B PINON & COTTONWOOD DR BUILDING #2301		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 1830	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Shiprock	State/Province*A&B New Mexico	County*A&B San Juan County
Country*A&B United State of America	Zip Code*A&B 87420	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)871-6235		Fax Number (928)871-6456
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1._____	
	2._____	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner
Dr. Sidney Brown		Director	Self	Employee

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV		
Owner Name Jonathan Nez	Response: 1g.	☐ Yes ■ No
	Response: 2.	☐ Yes ☒ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes ■ No
	Response: 4.	☐ Yes ■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes ☒ No
	Response: 2.	☐ Yes ■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes ☒ No
	Response: 4.	☐ Yes ■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.		

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

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4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

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Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi
☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X	
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No

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Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

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Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE MEDICINE
153	SURGERY-PEDIATRIC	974	REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
☑	SSN/EIN/TIN is at the bottom of each page	All
☑	Section I Enrollment Type , I-A, I-B	All
☐	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
☐	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
☑	Section IV Pay To information	All
☑	Section V Correspondence Address	All
☑	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
☐	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
☐	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
☐	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
☑	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
☑	Section XI Add Taxonomy	All
☑	Section XII Fees	All
☐	**Provider Participation Agreement or Group Biller Participation Agreement** **One of these Agreements must be signed and accompany all applications**	All
☐	Appendix A – Additional Service Locations	All
☐	Appendix B – Associate Billing Provider/Other Associations	All
☐	Appendix C - Additional License/Certification/Other	All
☐	Appendix D – Additional Owner(s)	All
☐	Appendix E – Additional Adverse Actions	All
☐	Appendix F – Provider Type Codes	All
☐	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

AHCCCS
Arizona Health Care Cost Containment System

EXHIBIT
tabbies
A-9

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I

Select **One** Applicable Request Type.*

■ New Enrollment	☐ Revalidation	☐ Provider Modification *List section numbers modified

Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *

Provider Number/AHCCCS ID:_____ ☐N/A

If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.

NPI: 1316129216 ☐N/A

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.

SECTION I-A

☐ Individual/Sole Proprietor	☐ Rendering Servicing Provider	☐ Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

SECTION I-B

☐ Group Practice (Corporation, Partnership, LLC, etc.)	■ Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐ Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐ Contractor/ MCO	Sub Type: ☐ Correctional Facilities ■ Tribal Behavioral Health	☐ Department of Economic Security ☐ Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II
Complete required fields based on enrollment type, using the Category Key at the bottom of this page.

First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Newland Outpatient Treatment Cente
Home Address*A	City*A	State*A
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 7/1/2020	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B 1/4 Miles South of Sanders High School, Shondiin Street Bldg #6909		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 1086	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Sanders	State/Province*A&B Arizona	County*A&B Apache County
Country*A&B United State of America	Zip Code*A&B 86512	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)871-6235		Fax Number (928)871-6456
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1._____	
	2._____	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	☒ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	☒ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	☒ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq*. to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi
☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Provider Enrollment Form

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:

Provider SSN/EIN/TIN: 86-0092335

Be sure to include this identification at the bottom of each page

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Provider SSN/EIN/TIN: 86-0092335

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Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X			
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

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Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE
153	SURGERY-PEDIATRIC	974	MEDICINE REHABILITATION MEDICINE

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

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SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

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SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

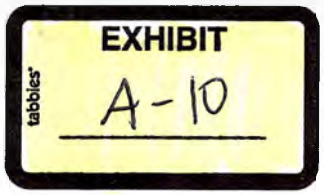
Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
☑	SSN/EIN/TIN is at the bottom of each page	All
☑	Section I Enrollment Type , I-A, I-B	All
☐	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
☐	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
☑	Section IV Pay To information	All
☑	Section V Correspondence Address	All
☑	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
☐	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
☐	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
☐	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
☑	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
☑	Section XI Add Taxonomy	All
☑	Section XII Fees	All
☐	**Provider Participation Agreement or Group Biller Participation Agreement** **One of these Agreements must be signed and accompany all applications**	All
☐	Appendix A – Additional Service Locations	All
☐	Appendix B – Associate Billing Provider/Other Associations	All
☐	Appendix C - Additional License/Certification/Other	All
☐	Appendix D – Additional Owner(s)	All
☐	Appendix E – Additional Adverse Actions	All
☐	Appendix F – Provider Type Codes	All
☐	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page



AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I		
Select **One** Applicable Request Type.*		
■ New Enrollment	☐ Revalidation	☐ Provider Modification *List section numbers modified
Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. * Provider Number/AHCCCS ID:_____ ☐ N/A		
If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type. NPI: 1588925788 ☐ N/A		

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.		
SECTION I-A		
☐ Individual/Sole Proprietor	☐ Rendering Servicing Provider	☐ Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-B		
☐ Group Practice (Corporation, Partnership, LLC, etc.)	■ Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐ Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐ Contractor/ MCO	Sub Type: ☐ Correctional Facilities ■ Tribal Behavioral Health	☐ Department of Economic Security ☐ Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II Complete required fields based on enrollment type, using the Category Key at the bottom of this page.		
First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Gallup Outpatient Treatment Center
Home Address*A 300 WEST NIZHONI BLVD.SUITI	City*A Gallup	State*A New Mexico
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 10/19/2020	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ■N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ☐Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B 300 WEST NIZHONI BLVD.SUITE A		End Date*A&B MMDDYYYY Current
Address Line 1*A&B 300 WEST NIZHONI BLVD.SUITE A	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Gallup	State/Province*A&B New Mexico	County*A&B McKinley County
Country*A&B United State of America	Zip Code*A&B 87301	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	8-5 ■AM ■PM	☐AM ☐PM
Close	Closed ■AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	Closed ■AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)871-6235		Fax Number (928)871-6456
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. BH Outpatient Clinic (77)	1._____	
	2._____	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
☐Substance Abuse Bed(s)			
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner
Vera John		Director	Self	Employee

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	☒ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	☒ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	☒ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Community/Behavioral Health	Description: Behavioral Health Outpatient
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi
☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

Provider Enrollment Form

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X			
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE
153	SURGERY-PEDIATRIC	974	MEDICINE REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
✓	SSN/EIN/TIN is at the bottom of each page	All
✓	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
✓	Section IV Pay To information	All
✓	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
✓	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
✓	Section XI Add Taxonomy	All
✓	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement **One of these Agreements must be signed and accompany all applications**	All
	Appendix A – Additional Service Locations	All
	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D – Additional Owner(s)	All
	Appendix E – Additional Adverse Actions	All
	Appendix F – Provider Type Codes	All
	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I		
Select **One** Applicable Request Type.*		
■ New Enrollment	☐ Revalidation	☐ Provider Modification *List section numbers modified

Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *

Provider Number/AHCCCS ID:_____ ☐N/A

If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.

NPI: 1427656065 ☐N/A

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.

SECTION I-A

☐ Individual/Sole Proprietor	☐ Rendering Servicing Provider	☐ Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

SECTION I-B

☐ Group Practice (Corporation, Partnership, LLC, etc.)	■ Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐ Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐ Contractor/ MCO	Sub Type:	
	☐ Correctional Facilities	☐ Department of Economic Security
	■ Tribal Behavioral Health	☐ Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II
Complete required fields based on enrollment type, using the Category Key at the bottom of this page.

First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Chinle Adult Residential Treatment
Home Address*A PO BOX 777	City*A Chinle	State*A Arizona
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 12/1/2020	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B NAVAJO ROUTE 7, DUPLEX UNIT 2004		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 777	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Chinle	State/Province*A&B Arizona	County*A&B Apache County
Country*A&B United State of America	Zip Code*A&B 86503	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:0(■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM
Close	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:5(☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi
☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)871-6235		Fax Number (928)871-6456
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. Residential Treatment Center - 1	1._____	
	2._____	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
■Substance Abuse Bed(s)	16	1/1/21	
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner
Miranda Blatchford		Director	Self	Employee

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	▣ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	▣ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	▣ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Substance Abuse Rehabilitation Facil	Description: BHRF - Non secured
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq*. to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

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4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*							
Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.							
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French							
Other(s) (specify):_____ ☐Handicap Accessible							

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

AHCCCS
Arizona Health Care Cost Containment System

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ____________	Effective Date:	Expiration Date:

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X			
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No
Owner Name	Response: 1g.	☐ Yes	☐No
SSN/EIN/TIN	Response: 2.	☐ Yes	☐No
	Response: 3.	☐ Yes	☐No
	Response: 4.	☐ Yes	☐No

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE MEDICINE
153	SURGERY-PEDIATRIC	974	REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-ONCOLOGY
215	SURGERY-MAXILLOFACIAL	966	RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
✓	SSN/EIN/TIN is at the bottom of each page	All
✓	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
✓	Section IV Pay To information	All
✓	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
✓	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
✓	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
✓	Section XI Add Taxonomy	All
✓	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement **One of these Agreements must be signed and accompany all applications**	All
	Appendix A – Additional Service Locations	All
	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D – Additional Owner(s)	All
	Appendix E – Additional Adverse Actions	All
	Appendix F – Provider Type Codes	All
	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

EXHIBIT
tabbies
A-12

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:
Attn: AHCCCS Provider Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I

Select **One** Applicable Request Type.*

■New Enrollment	☐Revalidation	☐Provider Modification *List section numbers modified

Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *

Provider Number/AHCCCS ID:_____ ☐N/A

If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.

NPI: 1366040818 ☐N/A

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.

SECTION I-A

☐Individual/Sole Proprietor	☐Rendering Servicing Provider	☐Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

SECTION I-B

☐Group Practice (Corporation, Partnership, LLC, etc.)	■Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐Contractor/ MCO	Sub Type:	
	☐Correctional Facilities	☐Department of Economic Security
	■Tribal Behavioral Health	☐Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II Complete required fields based on enrollment type, using the Category Key at the bottom of this page.		
First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Navajo Regional Behavioral Health C
Home Address*A PO Box 1830	City*A Shiprock	State*A New Mexico
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 12/1/2020	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■ Primary Practice Location*A&B PINON & COTTONWOOD DR BUILDING #2301		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 1830	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Shiprock	State/Province*A&B New Mexico	County*A&B San Juan County
Country*A&B United State of America	Zip Code*A&B 87420	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM
Close	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)871-6235		Fax Number (928)871-6456
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. Residential Treatment Center - I	1. Adult Substance Use RTC	
	2.	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
■Substance Abuse Bed(s)	16	1/1/21	
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner
Dr. Sidney Brown		Director	Self	Employee

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	⊡ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	⊡ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	⊡ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Substance Abuse Rehabilitation Facil	Description: BHRF - Non secured
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

AHCCCS
Arizona Health Care Cost Containment System

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X	
Owner Name	Response: 1g. ☐ Yes ☐ No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3. ☐ Yes ☐ No
	Response: 4. ☐ Yes ☐ No
Owner Name	Response: 1g. ☐ Yes ☐ No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3. ☐ Yes ☐ No
	Response: 4. ☐ Yes ☐ No
Owner Name	Response: 1g. ☐ Yes ☐ No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3. ☐ Yes ☐ No
	Response: 4. ☐ Yes ☐ No
Owner Name	Response: 1g. ☐ Yes ☐ No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3. ☐ Yes ☐ No
	Response: 4. ☐ Yes ☐ No
Owner Name	Response: 1g. ☐ Yes ☐ No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3. ☐ Yes ☐ No
	Response: 4. ☐ Yes ☐ No
Owner Name	Response: 1g. ☐ Yes ☐ No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3. ☐ Yes ☐ No
	Response: 4. ☐ Yes ☐ No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE
153	SURGERY-PEDIATRIC	974	MEDICINE REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-
215	SURGERY-MAXILLOFACIAL	966	ONCOLOGY RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
☑	SSN/EIN/TIN is at the bottom of each page	All
☑	Section I Enrollment Type , I-A, I-B	All
☐	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
☐	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
☑	Section IV Pay To information	All
☑	Section V Correspondence Address	All
☑	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
☐	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
☐	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
☑	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
☑	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
☑	Section XI Add Taxonomy	All
☑	Section XII Fees	All
☐	**Provider Participation Agreement or Group Biller Participation Agreement** **One of these Agreements must be signed and accompany all applications**	All
☐	Appendix A – Additional Service Locations	All
☐	Appendix B – Associate Billing Provider/Other Associations	All
☐	Appendix C - Additional License/Certification/Other	All
☐	Appendix D – Additional Owner(s)	All
☐	Appendix E – Additional Adverse Actions	All
☐	Appendix F – Provider Type Codes	All
☐	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

Provider Enrollment Form

Welcome to the Arizona Health Care Cost Containment System (AHCCCS) Provider Enrollment Form. This form should be used for Provider enrollment, revalidation, and/or modification requests.

Important:

1. Please do not duplicate entries.
2. All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
3. If you need additional pages of the Provider Service Locations, Associate Billing Provider/Other Associations, Adverse Actions, License/Certifications/Other, or Provider Controlling. Interest/Ownership, see the appendix for additional forms you may duplicate. You may elect to send a spreadsheet. **The spreadsheet must mirror all required fields on these forms in order to be considered.**
4. Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
5. Throughout this application you will see 2 category keys at the bottom of applicable pages. These keys will be important as you complete the application.
6. A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
7. You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
C	Corporation

Completed Forms: Mail or fax completed and signed forms to:

Mail:
AHCCCS Provider Enrollment
P.O. Box 25520, Mail Drop 8100
Phoenix, AZ 85002

Fax:

Attn: AHCCCS Provider
Enrollment 602-256-1474

Reminder: Be sure to add the providers SSN/EIN/TIN to the bottom of each page before sending. This will help to ensure all pages of this form are directed to the correct identifying numbers.

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

AHCCCS
Arizona Health Care Cost Containment System

Provider Enrollment Form

Table of Contents

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Before You Begin Checklist

This checklist will help you prepare to complete this application by having the necessary data available as you complete this application.

☑	Description	Enrollment Type this applies to...
☑	Add SSN/EIN/TIN to the bottom of each page	All
☑	National Provider Identification (NPI)	Group, FAO, Individual
☐	AHCCCS ID (if applicable)	All
☑	Profit Type	All (except individual rendering / servicing)
☐	W-9 (You must attach a completed W-9 form. This can be found at IRS.GOV)	All
☑	Practice address details & hours of operation	All
☑	Pay to details	All
☑	Correspondence address	All
☑	Provider type and specialty if applicable	All
☐	Associate Billing Provider details	All (and is required for rendering/servicing)
☐	Copies of all licensing, and certifications, etc.	All (except group)
☐	Bed unit information, if applicable.	FAO and Atypical Agency only
☑	Controlling interest/ownership details, managing employee, and owner relationship	All
☑	Owners Adverse action(s) information	All
☑	Taxonomy	All (except atypical agency & atypical individual)
☐	Authorized signor for Provider Participation/Group Biller Participation Agreement	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Type

- You must select one applicable request type (New Enrollment, Revalidation, or Modification).
- Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.
- If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.
- If you have a provider number or provider AHCCCS ID, it is required for you to disclose this information.
  If you **do not** have a provider number, or provider AHCCCS ID, select the N/A box ☒.
- If you select the enrollment type, Contractor/MCO or Atypical, you *must also select one subcategory* from the list below these enrollment types.

SECTION I

Select **One** Applicable Request Type.*

■ New Enrollment	☐ Revalidation	☐ Provider Modification *List section numbers modified

Complete only if you are currently registered and have a Provider Number or Provider AHCCCS ID. *

Provider Number/AHCCCS ID:_____ ☐ N/A

If you **do not** have an NPI, select the N/A box ☒ and select Atypical Agency for the enrollment type.

NPI: 1073711693 ☐ N/A

Select One Enrollment Type (and Subtype if applicable) from either section I-A or I-B.

SECTION I-A

☐ Individual/Sole Proprietor	☐ Rendering Servicing Provider	☐ Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)

SECTION I-B

☐ Group Practice (Corporation, Partnership, LLC, etc.)	■ Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)	☐ Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
☐ Contractor/ MCO	Sub Type: ☐ Correctional Facilities ■ Tribal Behavioral Health	☐ Department of Economic Security ☐ Managed Care Organization

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Basic Provider Information

- Complete all required fields, unless enrollment type specific is not applicable.
  Use the Category Key at the bottom of the page to determine required fields by the letter following the asterisk. Example: First Name*A; would be a required field for enrollment types; Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual.
- For the W-9 Entity type field, fill in the correct type. You will also need to complete the IRS W-9 form available at irs.gov.
- In the Profit Type field, select the applicable type. For "other", please fill in the accurate information. The Profit Type is not applicable when the individual only practices as a part of a group (rendering/servicing).
- In the Tribal Type field select one of the 3 selections listed. If none of the options listed is applicable, select N/A.

SECTION II
Complete required fields based on enrollment type, using the Category Key at the bottom of this page.

First Name*A	Middle Initial ☐N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A MMDDYYYY	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Navajo Regional Behavioral Health C
Home Address*A PO Box 1830	City*A Shiprock	State*A New Mexico
EIN/TIN*A&B 86-0092335	Requested enrollment effective begin date *A&B MMDDYYYY 12/1/2020	Zip Code*A
W-9 Entity Type*A&B Tribal 638 You must also attach completed W-9 form. This can be found at IRS.GOV	Profit Type*A&B ☐501(C)(3) NON-PROFIT ☐For Profit Closely Held ☐For Profit, Publicly Traded ■Other Tribal 638 ☐N/A – The individual only practices as part of a group	Tribal Type *A&B ☐N/A ☐Indian Health Service ☐Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Primary Practice Location

- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		
■Primary Practice Location*A&B PINON & COTTONWOOD DR BUILDING #2301		End Date*A&B MMDDYYYY Current
Address Line 1*A&B PO Box 1830	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Shiprock	State/Province*A&B New Mexico	County*A&B San Juan County
Country*A&B United State of America	Zip Code*A&B 87420	

Location specific information is required for all locations.

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:0(■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM	12:00 ■AM ☐PM
Close	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:5(☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM	11:59 ☐AM ■PM

Language(s) Spoken ■ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ■Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Pay To Information

- The pay to information is required for all provider types.
- If the "Pay To" address is the same as the primary practice location, select this option ☒.

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice Location		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

Correspondence Address

- The correspondence address is required for all provider types.
- If the "Correspondence" address is the same as the primary practice location, select this option ☒.
- All correspondence for this provider will be sent to the correspondence address or email provided.
- Be sure to select only one option as the method of communication (Email or Standard Mail).
- Selecting more than one option or not selecting any option will default to standard U.S. mail.

SECTION V				
Correspondence Address*A&B ☐Same as Primary Practice Location		Phone Number*A&B (928)871-6235		Fax Number (928)871-6456
Method of Communication*A&B Only select 1 option ■Email ☐Standard Mail		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A		Address Line 3 ■N/A	
City/Town* A&B Window Rock	State/Province* A&B AZ	County* A&B Apache	Country* A&B United States of	Zip Code* A&B 86515

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
B	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Add Provider Type and Specialty

- This section is required for all provider types.
- Physicians, Dentists, Podiatrists, Osteopaths, and Registered Nurse Practitioners, **must** select a specialty type.
- All other provider types are not required to select a specialty.
- See Appendix F&G for provider types & specialty codes.

SECTION VI		
Provider Type	Specialty (if applicable)	End Date MMDDYY
1. Residential Treatment Center -]	1. Adolescent Substance Use RTC	
	2.	

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- Enter AHCCCS ID or NPI of Billing Provider/Other Associations.
- If additional space is needed, you may attach a spreadsheet. The spreadsheet must include all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY: End Date MMDDYYYY:
☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*	☐AHCCCS ID or ☐NPI ID*_____ Provider Name:*_____ Start Date MMDDYYYY:* End Date MMDDYYYY:*

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

License/Certification/Other List

- This section is required for all enrollment types, **except group**.
- Be sure to include copy of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.)
- Additional space for additional License/Certifications/Others can be found in the Appendix C.

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Add Additional Information

This section is specific to enrollment types FAO and Atypical Agency.

SECTION IX			
Select Bed Type	Number of bed units	Begin Date	End Date
☐Acute Care Bed(s)			
☐Licensed LTC Unit(s)			
☐Licensed Medicaid Bed(s)			
☐ Licensed Medicare Bed(s)			
☐Licensed Medicaid/Medicare Bed(s)			
☐Medicare Surgery Bed(s)			
☐Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
☐Psych Bed(s)			
☐Rehab Bed(s)			
☐Skilled Nursing Bed(s)			
■Substance Abuse Bed(s)	16	12/1/20	
☐Swing Bed(s)			
☐Temporarily Non Available Bed(s)			
☐Ventilator Dependent Unit(s)			

Provider Controlling Interest/Ownership

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, 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

Provider Controlling Interest/Ownership

- For Corporate entities, enter primary business address and every business location and P.O Box. *Use Appendix D or submit spreadsheet. The spreadsheet must include all required 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 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, address, date of birth and Social Security Number of any managing employee.

SECTION X-I	
Select one* ☐Individual or ■Corporation	
Title*I&C Navajo Nation	Percentage Owned*I&C 100%
SSN*I&C 86-0092335	EIN/TIN*C 86-0092335
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and M
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*I&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date MMDDYYYY
Home address for Individual or business address for Corporation	
Address Line 1*I&C PO Box 709	Address Line 2
Address Line 3	City/Town*I&C Window Rock
State/Province*I&C Arizona	County*I&C Apache
Country*I&C United States	Zip Code*I&C 86515

Category Key	Description
I	Individual
C	Corporation

Provider Controlling Interest/Ownership

- A Managing Employee is **required** for all enrollment types.
- There **must** be at least one other ownership type in addition to Managing Employee.
- You **must** provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name* Michelle	Last Name* Brandser
Suffix	DOB*
Phone Number* (928)871-6235	Email mbrandser@navajo-nsn.gov
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1* PO Box 709	Address Line 2
Address Line 3	City/Town* Window Rock
State/Province* A&B Arizona	County* Apache
Country* United States	Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

■No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner
Dr. Sidney Brown		Director	Self	Employee

Add Owners Adverse Actions

This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged or any appeals are pending.

Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.

1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 C.F.R. § 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following:
   a. A federal or state felony;
   b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   c. Any criminal offense, under state or federal law, related to the abuse or neglect 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);
   d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;
   e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. § 1001.101 or 1001.201;
   f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or
   g. Any criminal offense related to public assistance or welfare fraud. Yes/No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program? Yes/No
3. Have any Responsive Entities had their business or professional license, certification, 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 on probation, or restricted by Agreement by any licensing authority in any State? Yes/No
4. Is there currently any pending proceedings, such as but not limited to an indictment, 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 plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity? Yes/No

SECTION X-IV			
Owner Name Jonathan Nez	Response: 1g.	☐ Yes	■ No
	Response: 2.	☐ Yes	▣ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■ No
	Response: 4.	☐ Yes	■ No
Owner Name Myron Lizer	Response: 1g.	☐ Yes	▣ No
	Response: 2.	☐ Yes	■ No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	▣ No
	Response: 4.	☐ Yes	■ No
If additional space is needed see Appendix E. Supporting documentation is required for all adverse actions.			

Add Taxonomy

- This is not required for atypical enrollment types.
- The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

SECTION XI	
Taxonomy Code: Substance Abuse Rehabilitation Facil	Description: BHRF - Non secured
Start Date: MMDDYYYY* 10/19/2020	End Date: MMDDYYYY

Fees

Section 1866(j)(2)(C) of the Act requires the imposition of an application fee on each institutional provider. States must collect the applicable enrollment fee prior to executing a provider agreement from a prospective or reenrolling provider. The application fee increases each calendar year based on the consumer price index. The provider applying will be notified to pay the enrollment fee after the state reviews the application. Please do not mail in check payments along with this application.

SECTION XII		
	Options	**Description**
☑	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/ Confirmation # | Date:
☐	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. Confirmation # | Date:
☐	Fee Paid to Medicaid in another State	Select this option if you can supply documentation demonstrating that you have already paid the enrollment fee to the Medicaid program of another state. Select the program name and payment date in the section below Upload your receipt or documentation of payment in the "Upload Documents" step This is subject to federal and state approval. Paid To: | Date: Confirmation # | Note:
☐	Request Hardship Waiver	Select this option to request "Hardship Waiver" from the Provider Registration unit A "Hardship Letter" must be written and sent in with this application. You can continue submitting the enrollment application/modification request This is subject to federal and state approval.
☐	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. Confirmation # | Date:

Participation Agreement

SECTION XIII
Provider Participation Agreement - Complete the participation agreement applicable to your enrollment type. If you are a Group Biller, complete the Group Biller Participation Agreement. All other types complete the Provider Participation Agreement. **A signed agreement must accompany an application.**

PROVIDER PARTICIPATION AGREEMENT

Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
And Provider

A. PURPOSE:
This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the 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 govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a 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 Agreement, and for good and valuable consideration, AHCCCS 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 participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Provider thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Provider. If the Provider gives written notice to AHCCCS of Provider's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.
4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by a Provider will not be made to or through a factor, either directly or by power of attorney.

5. The Provider shall maintain all records relating to performance of this Agreement in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made to the Provider. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Provider at the Provider's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Provider with sufficient time to copy records for the Provider's use at the Provider's own expense. The Provider's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made to the Provider. Provider expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Provider shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Provider until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Provider shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Provider's records and the inspection of the Provider's facilities. If the Provider is an inpatient facility, the Provider shall file uniform reports and Title XVIII and XIX cost reports with AHCCCS.
7. The Provider must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Provider shall comply with the requirements of the Agreement as amended, unless and until the Provider and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Provider shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Provider has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
9. The Provider, by execution of this Agreement, warrants that it has the ability, authority, skill, expertise and capacity to perform and provide the services governed by this Agreement. The Provider must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Provider shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Provider's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Provider's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Provider shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Provider's preclusion or exclusion from a federal program.
10. The Provider agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Provider or Provider's agents, officers, or employees or contractors.

11. The Provider expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Provider through this Agreement. The Provider is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Provider.
12. The Provider must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Provider agrees that any insurance protection required by the Agreement, or otherwise obtained by the Provider, shall not limit the responsibility of the Provider to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Provider bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
13. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
14. Any appeals or claim disputes filed by the Provider shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Provider waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
15. For Fee-For-Service Providers, AHCCCS agrees to make payments to the Provider consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Provider to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Provider agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Provider via the AHCCCS Internet website (www.azahcccs.gov).
16. With respect to any services furnished by the Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 14 or 15 above. The Provider agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between the Provider and a Contractor. If the contract between the Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
17. The Provider shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Provider must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Provider must disclose to AHCCCS which code sets the Provider uses prior to any audit of the Provider. Any Provider changes to its methodology must be documented in writing with the date of change.
18. The Provider must ensure that its Electronic Health Records (EHR) System is developed and implemented to accurately record, maintain, and reflect all original entries including but not limited to original signatures, credentials and dates of entry, as well as any changes or modifications to an EHR ("Audit Trail"). The Provider shall ensure that the EHR System Audit Trail captures and stores, without alteration or deletion, the identity of an individual who authorized and/or implemented the modification or change as well as the date, time, and substance of each and every modification or change.
19. The Provider agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
20. No Provider may bill with another Provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
21. No Provider may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Provider, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Provider agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Provider agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.

22. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due to the Provider any overpayments, expenses or costs incurred by AHCCCS concerning the Provider's non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Provider may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
23. The Provider shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Provider agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Provider from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due to the Provider any amounts collected from AHCCCS eligible persons contrary to this provision. The Provider expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
24. The Provider must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.
25. Any Provider who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
26. If the Provider or any employee or contractor of the Provider discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Provider must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
27. By signing this Agreement, the Provider certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Provider through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Provider certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
28. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
29. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
30. AHCCCS may require the Provider or any employees or contractors of the Provider to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Provider or any employees or contractors of the Provider; or require the Provider to demonstrate the Provider's compliance with all such checks and screenings with respect to Provider's employees or contractors, whether required by federal or state law, rule or regulation.
31. Upon thirty (30) calendar day's written notice, either AHCCCS or Provider may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Provider fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Provider's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Provider or any agent or representative of the Provider to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.

32. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Provider pending an investigation of a credible allegation of fraud against the Provider as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.
33. Upon any termination of this Agreement, the Provider expressly agrees to assist in providing for the smooth and orderly transition of care for members assigned to the Provider.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

■ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

PROVIDER SIGNATURE

Jonathan Nez/Myron Lizer

PROVIDER NAME (PLEASE TYPE OR PRINT)

Navajo Nation President/Navajo Nation Vice Presiden

TITLE

DATE

GROUP BILLER PARTICIPATION AGREEMENT
Between
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)
And Group Biller

A. PURPOSE:

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System ("AHCCCS" or the "Administration") and the Group Biller, as identified above, pursuant to Title XIX and Title XXI of the Social Security Act and A.R.S. §36-2901 *et seq.* to govern the registration of, and payment to, the Group Biller on behalf of Affiliated Providers for the health care services provided by the Affiliated Providers to persons who have been determined eligible for health care coverage through AHCCCS.

As used in this Agreement:

"Group Biller" means an organization acting as the financial representative of any Affiliated Provider or group of Affiliated Providers who have authorized the organization to act on the Provider(s) behalf.

"Affiliated Provider" means a provider of health care of medical services who has entered into a separate Provider Participation Agreement with AHCCCS and has authorized the Group Biller to act as its financial representative.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Group Biller do hereby acknowledge and expressly agree as follows:

B. GENERAL TERMS AND CONDITIONS:

1. Pursuant to 42 C.F.R. §431.107, an Affiliated Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Group Biller may not submit claims or receive payment for services provided by any Affiliated Provider who does not have in effect a Provider Participation Agreement with AHCCCS at the time services are rendered.
2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Clues, and Reporting Guides are hereby incorporated by reference into this Agreement. Guidelines, policies and manuals are available on the AHCCCS website.
3. When AHCCCS issues an amendment, revision, update or other change to modify this Agreement or documents incorporated by reference that are a part of this Agreement, the provisions of such amendment, revision, update or other change will be deemed accepted by the Group Biller thirty (30) calendar days after the date AHCCCS publishes the change to the AHCCCS website, even if the amendment, revision, update or other change has not been signed by the Group Biller. If the Group Biller gives written notice to AHCCCS of Group Biller's refusal to adhere to the amendment, revision, update or other change prior to the end of the thirty (30) calendar days stated above, this Agreement shall automatically terminate.

4. Pursuant to 42 C.F.R. §447.10 (h), payment for any service furnished to an AHCCCS eligible person by an Affiliated Provider will not be made to or through a factor, either directly or by power of attorney. Group Biller will not act as factor for or on behalf of an Affiliated Provider. By signing the agreement, Group Biller attests that it is a billing agent described in 42 C.F.R. 447.10 (f) and that the Group Biller's compensation for it services to Affiliated Provider is (1) related to the cost of processing the billing; (2) not related on a percentage or other basis to the amount that is billed or collected; and (3) not dependent upon the collection of the payment.
5. The Group Biller shall maintain all records relating to performance of this Agreement and to performance of the Group Biller's agreements with Affiliated Providers in compliance with all specifications for record-keeping established by AHCCCS. All books and records shall be maintained in such detail as to reflect each service provided and all other costs and expenses of whatever nature for which payment is made. Such material shall be subject to inspection, audit or copying by the state, AHCCCS, the U.S. Department of Health and Human Services, and any other duly authorized representative of the state or federal government during normal business hours at the Group Biller's principal place of business or where services to AHCCCS eligible persons were rendered. The AHCCCS Office of Inspector General (AHCCCS-OIG) reserves the right to request and secure original records from the Group Biller at the Group Biller's expense. AHCCCS-OIG is responsible for maintaining and safeguarding the integrity of these records, and will provide the Group Biller with sufficient time to copy records for the Group Biller's use at the Group Biller's own expense. The Group Biller's inability, failure or refusal to retain and/or produce records relating to the performance of this Agreement, including all items or services provided or alleged to be provided be in accordance with this Agreement, except in instances of force majeure, shall constitute an overpayment of all items, services, costs and expenses of whatever nature for which payment was made. Group Biller expressly agrees to the reasonableness of this provision as a measure of the Administration's damages, and to return all overpayments to the Administration within sixty (60) calendar days of notice of the overpayment by the Administration.
6. The Group Biller shall preserve and make available the records described in Paragraph 5 above for a period of six (6) years from the date of payment under this Agreement, except: (a) if this Agreement is terminated, the records shall be preserved and made available for a period of six (6) full calendar years from the date of such termination; (b) records which relate to disputes, appeals, litigation or the settlement of claims arising out of this Agreement, or costs and expenses of this Agreement to which exception has been taken by the state, shall be retained by the Group Biller until six (6) full calendar years after such disputes, appeals, litigation, claims or exceptions have been fully and completely resolved. The Group Biller shall comply with all the applicable state and federal rules and regulations as well as AHCCCS' rules and policies relating to the audit of the Group Biller's records and the inspection of the Group Biller's facilities.
7. The Group Biller must comply with all the federal, state and local laws, rules, regulations, policies, standards, and executive orders governing or otherwise related to the performance of duties under this Agreement, without limitation to those designated within this Agreement. In the event that a provision of federal, state or local law, regulation, rule or policy is repealed or otherwise modified during the term of this Agreement, effective on the date the repeal or other modification by its own terms takes effect, the provision of this Agreement shall be deemed to have been amended to incorporate the repeal or modification, and the Group Biller shall comply with the requirements of the Agreement as amended, unless and until the Group Biller and AHCCCS, as evidenced by a duly authorized representative, otherwise stipulate in writing.
8. The Group Biller shall ensure that every Affiliated Provider has completed an AHCCCS Provider Participation Agreement, is registered with AHCCCS, and has signed an AHCCCS Group Billing Authorization form. Each Affiliated Provider shall be considered part of the billing group until the Affiliated Provider furnishes written notification of its termination of the group billing arrangement to the AHCCCS Provider Enrollment Section.
9. The Group Biller shall include the individual Affiliate Provider's AHCCCS Provider ID number on each claim submitted by the Group Biller on behalf of the Affiliated Provider.

10. The Group Biller shall provide services, bill for services, accept payment, and otherwise be in compliance with all AHCCCS and/or Contractor Provider Manuals and Policy Guidelines, including the AHCCCS Minimum Subcontract Provisions available at the AHCCCS public website, and any amendments thereto, all of which are incorporated by reference into this Agreement. The Group Biller has an affirmative obligation to routinely check the AHCCCS website for any revisions or new information and to ensure compliance.
11. The Group Biller must obtain and maintain all licenses, permits and certifications necessary to do business and render services under this Agreement and, as applicable, must comply with all laws regarding safety, unemployment insurance, disability insurance and worker's compensation. The Group Biller shall notify AHCCCS within twenty-four (24) hours of a termination, sanction, suspension, revocation, exclusion, preclusion, determination, conclusion, finding or other adverse or potentially adverse action (an "Action") that impacts the Group Biller's license, certification or permit status. An Action subject to the twenty-four (24) hour notice requirement includes but is not limited to an Action that in any way impacts the Group Biller's registration with, authorization by, enrollment in, qualification for, and/or billing of, to, for, or on behalf of, any federal or state health care program, operated by, or financed in whole or in part, by any federal, state or local government agency. The Group Biller shall send a separate and distinct notice to the Administration within twenty-four (24) hours of notification of Group Biller's preclusion or exclusion from a federal program.
12. The Group Biller agrees to hold harmless the state, all state officers and employees, AHCCCS, and any other applicable state agencies, and all officers and employees of AHCCCS against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against the state, AHCCCS, its agents, officers, employees or AHCCCS' Contractors, through the intentional conduct, negligence or omission of the Group Biller or Group Biller's agents, officers, or employees or contractors.
13. The Group Biller expressly acknowledges and agrees that AHCCCS is in no way establishing any sort of employment relationship with the Group Biller through this Agreement. The Group Biller is not the employee of AHCCCS. AHCCCS bears no responsibility for taxes, unemployment insurance, or workers compensation or, for, or on behalf of the Group Biller.
14. The Group Biller must maintain for the duration of this Agreement all the necessary policies of professional liability insurance, comprehensive general liability insurance and automobile liability insurance. The Group Biller agrees that any insurance protection required by the Agreement, or otherwise obtained by the Group Biller, shall not limit the responsibility of the Group Biller to indemnify, hold harmless and defend the state and AHCCCS, and their agents, officers and employees as provided herein. The Group Biller bears all responsibility for taxes, worker's compensation insurance, unemployment insurance, and any other applicable insurance coverage for itself and its employees or, as applicable, its contractors.
15. Confidential and protected health information shall be safeguarded pursuant to all applicable federal and state rules and regulations. Substance Abuse and Mental Health information (Part 2 data) shall be safeguarded as specifically set forth in 42 C.F.R. Part 2.
16. Any appeals or claim disputes filed by the Group Biller shall be adjudicated in accordance with AHCCCS Rules as published in the Arizona Administrative Code. AHCCCS will reject and not process any claim disputes received from anyone other than persons permitted to do so under A.R.S. 36-2903.01(b)(4) and Arizona Supreme Court Rule 31. The Group Biller waives any right to attorneys' fees in any administrative or judicial proceeding concerning, arising out of, or that is otherwise related to, this Agreement.
17. For Fee-For-Service Affiliated Providers, AHCCCS agrees to make payments to the Group Biller consistent with state and federal rules and regulations, the terms of this Agreement, and the AHCCCS Capped Fee-For-Service Payment Schedule (including amendments thereto and as are hereby incorporated by reference) for services provided by the Affiliated Provider(s) to fee-for-service eligible persons. With respect to fee-for-service eligible persons, the Group Biller agrees to bill and accept payment in accordance with the terms of this Agreement, state and federal rules and regulations, and all pertinent documents incorporated by reference. AHCCCS documents are made available to the Group Biller via the AHCCCS Internet website (www.azahcccs.gov).

18. With respect to any services furnished by an Affiliated Provider to an AHCCCS eligible person enrolled with a Contractor, the terms and conditions of the payment shall be as stated in the contract between the Affiliated Provider and the Contractor notwithstanding any inconsistent provisions as set forth in Paragraph 16 or 17 above. The Group Biller agrees to hold AHCCCS harmless, and agrees not to seek reimbursement from AHCCCS, for services rendered to an enrolled member pursuant to a contract between an Affiliated Provider and a Contractor. If the contract between an Affiliated Provider and Contractor is silent on a claims issue, the AHCCCS Fee-For-Service provisions will govern.
19. The Group Biller shall conform its billing practices to the International Classification of Diseases (ICD9 or ICD10), whichever is in effect on the date of service in accordance with 45 CFR 162.1002. The Group Biller must comply with the Current Procedural Terminology (CPT), National Drug Codes (NDC), Health Care Financing Administration Common Procedure Coding System (HCPCS), the Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association, for dental services, CDT and HIPAA TCS compliance standards as applicable. Upon request, the Group Biller must disclose to AHCCCS which code sets the Group biller uses prior to any audit of the Group Biller. Any Group Biller changes to its methodology must be documented in writing with the date of change.
20. The Group Biller agrees to bill AHCCCS only after a potential third party payer has adjudicated the claim unless an exemption applies under A.A.C. R9-22-1003 or any other federal or state law, as amended, based on the item(s) or service(s) provided.
21. The Group Biller shall not bill for an Affiliated Provider using another provider's ID number, except in locum tenens situations and in accordance with applicable AHCCCS policy.
22. No Group Biller may use the AHCCCS/ALTCS/KidsCare or any other AHCCCS program logo or design on any written materials disseminated by Group Biller, absent written approval by AHCCCS. Without waiving any other remedies under this Agreement or provided by law, the Group Biller agrees that, in the event of non-compliance with this provision, AHCCCS may seek injunctive relief, and Group Biller agrees that it shall bear the cost and expense of any such judicial proceeding including any and all attorney fees and costs incurred by AHCCCS.
23. In addition to any other remedies available under this Agreement, AHCCCS is entitled to offset against any amounts due for any overpayments, civil monetary penalties and assessments, expenses or costs incurred by AHCCCS concerning non-compliance with this Agreement or due to investigations of fraud, waste or abuse. AHCCCS also retains the right to offset for Medicare sanctions. The Group Biller may be held financially liable for acts committed by its independent subcontractors that would constitute non-compliance with this Agreement. The rights and remedies of AHCCCS under this Agreement are not exclusive nor waived if unasserted in whole or in part.
24. The Group Biller shall not bill, nor attempt to collect payment directly or through a collection agency from a person claiming to be AHCCCS eligible without first receiving verification from AHCCCS that the person was ineligible for AHCCCS on the date of service, or that the services provided were not AHCCCS-covered services. The Group Biller agrees to comply with A.R.S. §36-2903.01 and A.A.C. R9-22-702, which prohibits the Group Biller from charging, collecting or attempting to collect payment from an AHCCCS eligible person or the financially responsible relative or representative. AHCCCS retains the right to offset against any amounts due any amounts collected from AHCCCS eligible persons contrary to this provision. The Group Biller expressly agrees not to accept cash payments from AHCCCS eligible and enrolled persons.
25. The Group Biller must comply with all the applicable provisions contained in the False Claims Act and as amended by the Federal Fraud Enforcement and Recovery Act of 2009 (FERA). AHCCCS applies the term "claim" as a request or demand for money or property that is presented or encountered to the government, state, Contractor, grantee or other recipient, if the money or property is to be spent or used on the government's behalf or to advance the government's interest.

26. Any Group Biller who receives or makes annual Medicaid payments under the State Plan of at least $5 million dollars must establish written policies that provide detailed information and ongoing training and education regarding the provisions under the Federal False Claims Acts and FERA to their employees to certify its compliance with the Public Law (PL) 109-171 Section 6032 of the 2005 Deficit Reduction Act (DRA) [42 U.S.C. §1396a(a)(68)].
27. If the Group Biller or any employee or contractor of the Group Biller discovers, or is made aware, that an incident of potential fraud, waste or abuse may occur or has occurred, the Group Biller must report the incident immediately upon discovery to AHCCCS-OIG in accordance with federal regulations, state statutes and AHCCCS policy.
28. By signing this Agreement, the Group Biller certifies that it is in compliance with 42 CFR §455.101 through 106, 42 CFR §455.436 and the State Medicaid Director Letter (SMDL) 09-001 and has confirmed the identity and reported the exclusion status of any person with an ownership or control interest or any person who is an agent or managing employee of the Group Biller through monthly checks of Federal databases as outlined in 42 CFR §455.436. The Group Biller certifies that it has disclosed the identity of any of these excluded persons to AHCCCS-OIG, including those who have ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
29. Pursuant to Section 6505 of the Affordable Care Act of 2010 [42 U.S.C. §1396a(a)(80)], AHCCCS shall not make any payments for items or services provided under the State Plan or under a waiver to any financial institution or entity located outside of the United States.
30. Pursuant to 42 USCS § 1320a-7k(d) an overpayment must be reported and returned within sixty (60) days after the date on which the overpayment was identified.
31. AHCCCS may require the Group Biller or any employees or contractors of the Group Biller to verify United States citizenship or lawful permanent resident status prior to the signing of this Agreement. AHCCCS may, at its sole discretion, conduct criminal and/or fingerprint background checks, or screen for exclusion/termination/suspension/revocation status of the Group Biller or any employees or contractors of the Group Biller; or require the Group Biller to demonstrate the Group Biller's compliance with all such checks and screenings with respect to Group Biller's employees or contractors, whether required by federal or state law, rule or regulation.
32. Upon thirty (30) calendar day's written notice, either AHCCCS or Group Biller may voluntarily terminate this Agreement. AHCCCS has the right to terminate or suspend this Agreement upon twenty-four (24) hours written notice when AHCCCS deems the health or welfare of a member is endangered; the Group Biller fails to comply with this Agreement or with federal and state laws, rules and/or regulations; or there is a cancellation, termination, suspension, revocation or other material modification, as determined by AHCCCS, in the Group Biller's qualifications to provide services. AHCCCS may also terminate this Agreement if it is found that gratuities in the form of entertainment, gifts, or otherwise, were offered or given by the Group Biller or any agent or representative of the Group Biller to any officer or employee of the State, or AHCCCS eligible and enrolled member, with a view towards securing a contract, favorable treatment with respect to a contract, or the right to render and request reimbursement for an AHCCCS covered item or service.
33. In accordance with the provisions set forth in 42 C.F.R. §455.23, AHCCCS will suspend any payments to Group Biller pending an investigation of a credible allegation of fraud against the Group Biller as determined by AHCCCS-OIG or a law enforcement authority, unless the state determines that good cause exists not to suspend such payments.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

☐ The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this agreement and has entered into an agreement effective on the date indicated below.
☐ I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.
☐ I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.
☐ I have read, understand, and agree to abide by all the terms and conditions set forth in this Agreement.

_____
PROVIDER SIGNATURE

_____
PROVIDER NAME (PLEASE TYPE OR PRINT)

_____
TITLE

_____
DATE

Appendix A

Additional Service Locations

- This page is for Providers who have more than one service location.
- If you have multiple provider service locations, you may duplicate this page or send a spreadsheet.
  Note: The spreadsheet must contain all of the required location details.
- This page is applicable to all enrollment types.

Additional Service Location		
All fields with an asterisk symbol (*) are required information.		
Service Location		End Date
Address Line 1*	Address Line 2	Address Line 3
City/Town*	State/Province*	County*
Country*	Zip Code*	

Location Specific Information for Primary Practice Location is required.*

Enter the business hours of operation. State "closed" on days the business is closed. Select AM or PM where applicable.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Language(s) Spoken ☐ English ☐ Spanish ☐ Arabic ☐Cantonese ☐Chinese ☐Navajo ☐Farsi ☐Native American ☐Mandarin ☐Korean ☐French

Other(s) (specify):_____ ☐Handicap Accessible

Appendix B

Associate Billing Provider/Other Associations

- Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf.
- This section is required for rendering/servicing providers.
- To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed).
- If additional space is needed, you may attach a spreadsheet with all of the required fields.

SECTION VII	
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY
☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date:MMDDYYYY End Date: MMDDYYYY	☐AHCCCS ID or ☐NPI ID _____ Provider Name:_____ Start Date: MMDDYYYY End Date: MMDDYYYY

AHCCCS Arizona Health Care Cost Containment System

Appendix C

License/Certification/Other List

Important: You must send proof of all licensing/certifications (i.e., Auto insurance policy, CLIA, DEA, tribal business license, etc.).

SECTION VIII		
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency: ________________	Effective Date:	Expiration Date:

Provider SSN/EIN/TIN: 86-0092335

Be sure to include this identification at the bottom of each page

Appendix D

Provider Controlling Interest/Ownership

- A Managing Employee is required for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- You must provide the home address of this provider. Failure to do so may result in this application/modification being denied.

SECTION X-II	
Managing Employee*	SSN*
First Name*	Last Name*
Suffix	DOB*
Phone Number*	Email
Start Date*	End Date
Managing Employee Home Address*	
Address Line 1*	Address Line 2
Address Line 3	City/Town*
State/Province* A&B	County*
Country*	Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse) ?

☐No ☐Yes If yes, list names and relationship.

SECTION X-III				
Assoc. Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner

Appendix E

Adverse Actions

- For supporting disclosures and details see Adverse Action Section XI.
- Supporting documentation is required for all adverse actions.

SECTION X	
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No
Owner Name	Response: 1g. ☐ Yes ☐No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐No
	Response: 3. ☐ Yes ☐No
	Response: 4. ☐ Yes ☐No

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
B1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
B6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
B7	CRISIS SERVICES PROVIDER	Y	Y	N
B8	BEHAVIORAL HEALTH RESIDENTIAL FACILITY	Y	Y	N
BC	BOARD CERTIFIED BEHAVIOR ANALYST (BCBA)	Y	N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	SPECIALTY PER DIEM HOSPITAL	Y	N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
E1	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
F1	FISCAL INTERMEDIARIES	N	Y	N
IC	INTEGRATED CLINIC	Y	Y	Y
SA	SPEECH LANGUAGE PATHOLOGY ASSISTANT	Y	N	N
NA	NEMT NON-AMBULANCE AIR	N	N	N
NE	NEMT EQUINE	N	N	N
NT	TRANSPORTATION NETWORK COMPANY	N	Y	Y
TR	TREAT & REFER	Y	Y	Y
TS	TRAVEL SERVICES	N	N	N
01	GROUP-PAYMENT ID	Y	N	N
02	ACUTE HOSPITAL	Y	Y	N
03	PHARMACY	Y	Y	N

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED REGISTERED NURSE-ANESTHETIST	Y	N	N
13	OCCUPATIONAL THERAPIST	Y	N	N
14	PHYSICAL THERAPIST	Y	N	Y
15	SPEECH/HEARING THERAPIST	Y	N	N
16	CHIROPRACTOR	Y	N	N
17	NATUROPATHIC PHYSICIAN	Y	N	N
18	PHYSICIANS ASSISTANT	Y	N	N
19	REGISTERED NURSE PRACTITIONER	Y	N	N
20	RESPIRATORY THERAPIST	Y	N	N
22	NURSING HOME	Y	Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	ADULT DAY HEALTH	N	Y	N
28	NON-EMERGENCY TRANSPORTATION PROVIDERS	N	Y	Y
29	COMMUNITY/RURAL HEALTH CENTER	Y	Y	N
30	DME SUPPLIER	Y	Y	Y
31	DO-PHYSICIAN OSTEOPATH	Y	N	N
32	MEDICAL FOODS	N	Y	N
35	HOSPICE	Y	Y	Y
36	ASSISTED LIVING HOME	N	Y	N
37	HOMEMAKER	N	N	N
39	HABILITATION PROVIDER	N	N	N
40	ATTENDANT CARE (COMPANIES ONLY)	N	Y	N
41	DIALYSIS CLINIC	Y	Y	N
43	AMBULATORY SURGICAL CENTER	Y	Y	N
44	ENVIRONMENTAL (LTC)	N	Y	N
46	INDEPENDENT RN	Y	N	N

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Appendix F

NPI, Enrollment Fee and/or Site Visit Required by Provider Type				
Provider Type	**Description**	**National Provider Identifier (NPI)**	**Enrollment Fee**	**Site Visit**
47	REGISTERED DIETICIAN (RD)	N	N	N
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
50	ADULT FOSTER CARE	N	N	N
54	AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N	Y	N
56	BOARDING HOME	N	Y	N
62	AUDIOLOGIST	Y	N	N
67	PERFUSIONIST	Y	N	N
68	HOMEOPATHIC	Y	N	N
69	OPTOMETRIST	Y	N	N
70	HOME DELIVERED MEALS	N	Y	N
71	PSYCHIATRIC HOSPITAL	Y	Y	N
77	MENTAL HEALTH REHABILATATION	Y	Y	Y
78	MENTAL HEALTH RESIDENTIAL TREATMENT CENTER	Y	Y	N
79	VISION CENTER	Y	Y	N
81	EPD HCBS	N	Y	N
82	SURGICAL FIRST ASSISTANT	Y	N	N
83	FREE-STANDING BIRTHING CENTER	Y	Y	N
84	LICENSED MIDWIFE	Y	N	N
85	LICENSED CLINICAL SOCIAL WORKER	Y	N	N
86	LICENSED MARRIAGE & FAMILY THERAPIST	Y	N	N
87	LICENSED PROFESSIONAL COUNSELOR	Y	N	N
90	QMB ONLY PROVIDER	N	N	N
92	SCHOOL BASED BUS TRANSPORTATION	N	Y	N
93	SCHOOL BASED ATTENDANT CARE	N	N	N
94	SCHOOL BASED NURSE (RN/LP)	Y	N	N
95	NON-MEDICARE CERTIFIED HOME HEALTH AGENCIES	N	Y	Y
97	AIR TRANSPORTATION	Y	Y	N

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION
019	GENETICIST	162	SPORTS MEDICINE
020	ANESTHESIOLOGIST	170	SURGERY-PLASTIC
030	SURGERY-COLON/RECTAL	171	SURGERY-PLASTIC OTOLARYNGOLOGICAL FACIAL
040	DERMATOLOGIST	175	ACUPUNCTURIST
050	FAMILY PRACTICE	178	HYPNOTIST
055	GENERAL PRACTICE	184	PUBLIC HEALTH
060	INTERNAL MEDICINE	185	AEROSPACE MEDICINE
062	CARDIOVASCULAR MEDICINE	191	PEDIATRIC - PSYCHIATRIST
063	ENDOCRINOLOGIST	192	PSYCHIATRIST
064	GASTROENTEROLOGIST	195	PSYCHIATRIST AND NEUROLOGIST
065	HEMATOLOGIST	200	RADIOLOGY
066	INFECTIOUS DISEASES	201	RADIOLOGY-DIAGNOSTIC
067	NEPHROLOGIST	205	RADIOLOGY-THERAPEUTIC
068	PULMONARY DISEASES	210	SURGERY
069	RHEUMATOLOGIST	212	SURGERY-CARDIOVASCULAR
070	SURGERY-NEUROLOGY	213	SURGERY-HAND
075	NEUROLOGIST	214	SURGERY-HEAD AND NECK
076	PEDIATRIC NEUROLOGIST	217	SURGERY-UROLOGICAL

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR MEDICINE	218	SURGERY-VASCULAR
082	GERONTOLOGIST	219	SURGERY-GYNECOLOGICAL
083	PSYCHOLOGIST	220	SURGERY-THORACIC
089	OBSTETRICIAN AND GYNECOLOGIST	230	UROLOGIST
090	GYNECOLOGIST	241	ONCOLOGIST
091	OBSTETRICIAN	250	EMERGENCY MEDICINE
092	MATERNAL AND FETAL MEDICINE	251	CRITICAL CARE MEDICINE
100	OPTHALMOLOGIST	440	VIROLOGY
101	TRANSPLANT HEPATOLOGY	530	PATHOLOGY
110	SURGERY-ORTHOPEDIC	585	OTHER CLINICAL CHEMISTRY
120	OTOLARYNGOLOGIST	901	EMERGENCY ROOM PHYSICIANS
083	PSYCHOLOGIST	927	CARDIOLOGIST
089	OBSTETRICIAN AND GYNECOLOGIST	935	OTORHINOLARYNGOLOGIST (ENT)
090	GYNECOLOGIST	950	ORTHOPEDIST
091	OBSTETRICIAN	962	NUCLEAR RADIOLOGY
092	MATERNAL AND FETAL MEDICINE	964	PAIN CONTROL
125	RHINOLOGIST	965	PSYCHOANALYSIS
131	BLOOD BANKING	967	PATHOLOGY, RADIOISOTOPIC
135	ANATOMICAL/ CLINICAL PATHOLOGY	969	MEDICAL TOXICOLOGY
143	DERMATOPATHOLOGY	970	HEMATOLOGY & ONCOLOGY
150	PEDIATRICIAN	971	INDUSTRIAL MEDICINE
151	PEDIATRIC CARDIOLOGIST	972	OSTEOPATHIC MANIPULATIVE MEDICINE
153	SURGERY-PEDIATRIC	974	REHABILITATION MEDICINE

Appendix G

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	441	SURGERY - OPTHALMOLOGICAL
073	OTHER IMMUNOHEMATOLOGY	450	MYCOLOGY
074	HISTOPATHOLOGY	460	PARASITOLOGY
077	HOMEOPATHIC	464	BLOOD GROUPING/RH TYPING
078	ELECTROPHYSIOLOGY	490	IMMUNOHEMATOLOGY
093	REPRODUCTIVE ENDOCRINOLOGIST	524	URINALYSIS
122	LARYNGOLOGIST	574	HISTOCOMPATABILITY
124	OTOLOGIST	880	PEDIATRIC-
136	FORENSIC PATHOLOGY	913	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
141	NEUROPATHOLOGY	925	AUDIOLOGIST
152	PEDIATRIC HEMATOLOGIST	943	PEDIATRIC ORTHOPEDIST
154	PEDIATRIC NEPHROLOGIST	951	ADDICTION MEDICINE
156	PEDIATRIC ENDOCRINOLOGIST	952	ANATOMIC PATHOLOGY
157	PEDIATRIC ALLERGIST	953	BRONCHO-ESOPHAGOLOGY
158	RADIOLOGY PEDIATRIC	954	CHEMICAL DEPENDENCY
176	ADOLESCENT MEDICINE	955	CHEMICAL PATHOLOGY
180	ADMINISTRATIVE MEDICINE	956	DIABETES
182	PREVENTIVE MEDICINE	957	DIAGNOSTIC LABORATORY IMMUNOLOGY
183	OCCUPATIONAL MEDICINE	958	GYNECOLOGICAL ONCOLOGY
187	NUTRITIONIST	959	IMMUNOPATHOLOGY
188	PHARMACOLOGIST	960	LEGAL MEDICINE
189	PSYCHOSOMATIC MEDICINE	961	NEOPLASTIC DISEASES
211	SURGERY-ABDOMINAL	963	PEDIATRIC HEMATOLOGY-ONCOLOGY
215	SURGERY-MAXILLOFACIAL	966	RETIRED
216	SURGERY-TRAUMA	968	RADIOLOGY, ONCOLOGY
400	MICROBIOLOGY	976	SCLEROTHERAPY
410	BACTERIOLOGY	999	OTHER
430	SEROLOGY		

SPECIALTY CODES			
MEDICAL SPECIALTY CODES FOR D.O.'S (PT 31)			
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES - REGISTERED NURSE PRACTITIONER CODES (PT 19)			
CODE	DESCRIPTION	CODE	DESCRIPTION
084	FAMILY NURSE PRACTITIONER	085	SCHOOL NURSE PRACTITIONER
086	PEDIATRIC NURSE ASSOCIATE	087	PEDIATRIC NURSE PRACTITIONER
088	GERIATRIC NURSE PRACTITIONER	095	WOMEN'S HC/OB – GYN NP
096	WOMEN'S HC/OB – GYN NP	097	ADULT NURSE PRACTITIONER
098	PSYCH/MENTAL HEALTH NURSE PRACTITIONER	978	ACUTE CARE NURSE PRACTITIONER
SPECIALTY CODES - OTHER REGISTERED NURSE CATEGORIES			
NURSE –MIDWIFE (PT 09)		CERTIFIED REGISTERED NURSE ANESTHETIST (PT 12)	
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
PODIATRIST CODES (PT 10)		DENTISTRY CODES (PT 07)	
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
DENTISTRY CODES (PT 07)			
CODE	DESCRIPTION	CODE	DESCRIPTION
809	ANESTHESIOLOGIST	804	PEDIATRIC DENTIST
802	ENDODONTIST	806	PERIODONTIST
800	GENERAL	805	PROSTHODONTIST
803	ORAL PATHOLOGIST	807	PUBLIC HEALTH
808	ORAL SURGEON	977	SURGERY-ORAL & MAXILLOFACIAL
801	ORTHODONTIST		
SPECIALTY CODES FOR NON-PHYSICIAN CATEGORIES			
LABORATORY SPECIALTY CODES (PT 04)			
CODE	DESCRIPTION	CODE	DESCRIPTION
072	OTHER MICROBIOLOGY	073	OTHER IMMUNOHEMATOLOGY
080	NUCLEAR MEDICINE	131	BLOOD BANKING
158	RADIOLOGY PEDIATRIC	200	RADIOLOGY
201	RADIOLOGY DIAGNOSTIC	205	RADIOLOGY THERAPEUTIC
400	MICROBIOLOGY	410	BACTERIOLOGY
430	SEROLOGY	431	SYPHILIS
437	OTHER SEROLOGY	440	VIROLOGY
450	MYCOLOGY	460	PARASITOLOGY
464	BLOOD GROUPING & RH TYPING	470	PREGNANCY TESTING
490	IMMUNOHEMATOLOGY	500	RH TITERS
501	CROSSMATCHING	503	PHYSIOLOGICAL TESTING
504	EKG SERVICES	510	CLINICAL CHEMISTRY
511	ROUTINE CHEMISTRY	524	URINALYSIS
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB
913	DIALYSIS	962	NUCLEAR RADIOLOGY
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)

Appendix G

SPECIALTY CODES FOR NON-PHYSICIAN SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
015	OPTICIAN	071	MSW SOCIAL WORKER
083	PSYCHOLOGIST	166	THERAPIST-OCCUPATIONAL
167	THERAPITST-PHYSICAL	175	ACUPUNCTURE
178	HYPNOTIST	184	PUBLIC HEALTH
187	NUTRITIONIST	188	PHARMACOLOGIST
600	OPTOMETRIST	650	PODIATRIST
798	PHYSICIAN ASSISTANT	925	AUDIOLOGIST
RADIOLOGIST SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
PATHOLOGY SPECIALIST			
CODE	DESCRIPTION	CODE	DESCRIPTION
530	PATHOLOGY	074	HISTOPATHOLOGY
532	ORAL PATHOLOGY	540	EXFOLIATIVE CYTOLOGY
135	ANATOMICAL/CLINICAL PATHOLOGY	136	FORENSIC PATHOLOGY
138	MEDICAL CHEMISTRY	141	NEUROPATHOLOGY
143	DERMATOPATHOLOGY		
MISCELLANEOUS SPECIALTIES			
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
SPECIALTY: BED COUNT INFORMATION			
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		

Provider Pre-submittal Checklist

☑	Description	Enrollment Type this applies to...
☑	SSN/EIN/TIN is at the bottom of each page	All
☑	Section I Enrollment Type , I-A, I-B	All
☐	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
☐	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
☑	Section IV Pay To information	All
☑	Section V Correspondence Address	All
☑	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
☐	Section VII Associate Billing Provider/Other Associations - If another provider will be billing on your behalf, other must be an approved provider by the State of AZ and have an AHCCCS or NPI.	All
☐	Section VIII License/ Certification/ Other - If you have any applicable license(s), certification(s), other, be sure to send copies of supporting documents.	FAO, Atypical Agency, Atypical Individual, Individual
☑	Section IX Add Additional Information. Bed count specific	FAO & Atypical Agency only
☑	Section X Provider Controlling Interest/Ownership • X-I Controlling Interest/Ownership • X-II Managing Employee • X-III Owners Relationship - If there is any relationship between owners, you must disclose. • X-IV Owners Adverse Action - If any owners have or had adverse actions, you must disclose here. Be sure to send copies of any supporting documentation along with the paper application.	All
☑	Section XI Add Taxonomy	All
☑	Section XII Fees	All
☐	**Provider Participation Agreement or Group Biller Participation Agreement** **One of these Agreements must be signed and accompany all applications**	All
☐	Appendix A – Additional Service Locations	All
☐	Appendix B – Associate Billing Provider/Other Associations	All
☐	Appendix C - Additional License/Certification/Other	All
☐	Appendix D – Additional Owner(s)	All
☐	Appendix E – Additional Adverse Actions	All
☐	Appendix F – Provider Type Codes	All
☐	Appendix G – Provider Type Specialty Codes	All

Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

Enrollment Checklist/Questionnaire		
Question	**Answer**	**Comments**
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered.	☐Yes ■No	
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐Yes ■No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐Yes ■No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐Yes ■No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐Yes ■No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐Yes ■No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐Yes ■No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐Yes ■No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐Yes ■No	
Are 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 again.	☐Yes ■No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐Yes ■No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐Yes ☐No	?
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐Yes ■No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐Yes ■No	

NAVAJO NATION

972

1/26/2022

Navajo Nation Council 2022 Winter Session

02:30:11 PM

Amd# to Amd#	11. NEW BUSINESS - Item (D)	PASSED
MOT Wauneka, E	Legislation 0244-21: Approving	
SEC James, V	a Limited Waiver of Sovereign Immunity in the Arizona...	

Yeas : 22 **Nays : 0** **Excused : 1** **Not Voting : 0**

Yea : 22

Begay, E	Freeland, M	Smith	Tso, E
Begay, K	Halona, P	Stewart, W	Walker, T
Begay, P	Henio, J	Tso	Wauneka, E
Brown	James, V	Tso, C	Yazzie
Charles-Newton	Nez, R	Tso, D	Yellowhair
Daniels	Slater, C		

Nay : 0

Excused : 1

Crotty

Not Voting : 0

Presiding Speaker: Damon