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),
 - 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 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

- 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.
- 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, ZOZZ
> > 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
		egoing le				
		I.N.C. §				
		🔧 day c	f Feb	MARIA	W,	2022.
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			rajo Nat			

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





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.
- All fields in this form marked by asterisk (*) are required information. Failure to complete required data will delay the processing of your request.
- 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.
- Be sure to review and complete the checklists/questionnaire at the beginning and end of this application.
- 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.
- A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
- 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
В	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: Fax:

AHCCCS Provider Enrollment

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



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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
1	Add SSN/EIN/TIN to the bottom of each page	All
1	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
1	Practice address details & hours of operation	All
1	Pay to details	All
1	Correspondence address	All
V	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
V	Controlling interest/ownership details, managing employee, and owner relationship	All
1	Owners Adverse action(s) information	All
V	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 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 <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I						
Select One_Applicable Req	uest Type.*					
□New Enrollment	Revalidation Provider Modification *List section numbers modified APEP Re-Registration					
Complete only if you are Provider Number/AHCC		nd have a Provider Number or Provider AHCCCS ID. *				
f you do not have an NF NPI:1356555387	I, select the N/A box ⊠	and select Atypical Agency for the enrollment type. □N/A				
Select One Enrollment	Гуре (and Subtype if ap	pplicable) from either section I-A or I-B.				
□ Individual/Sole □ Rendering : Proprietor Provider		icing 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-Hoursing Facility, Varientities)					
□Contractor/ MCO	Sub Type: Correctional Facilit Tribal Behavioral F	ies Department of Economic Security				

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 or	n 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 ммрручуч	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	Profit Type*A&B □501(C)(3) NON-PROFIT □For Profit Closely Held	Tribal Type *A&B □N/A □Indian Health Service		
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other Tribal 638 ☐ N/A – The individual only practices as part of a group	□ Privately Owned on Tribal Land ■ Tribally Owned on Tribal Land		

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 Navajo Route 7, Duplex Unit 2		End Date*A&B ммррүүүү 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.

	he busines applicable		of op	eration.	Stat	e "close	d" on d	lays the	busin	ess is clo	osed.	Select A	M or PM
	Sun	day	Mo	onday	Tu	esday	Wed	nesday	Thu	ırsday	F	riday	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
	ige(s) Spol		Engli Nati	sh 🗆 S ve Amer	Spani		Arabic ndarin	□Canto		□Chi □Fre	nch	■ Nav	ajo □Farsi Accessible

Category Key	Enrollment Types					
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual					
В	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 ммрруууу 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 Addr □Same as Primary Prim		Phone Number*	A&B	Fax Number (928)674-2196
Method of Communic Only select 1 option ■Email	ation*A&B Standard Mail	Email Address*	A&B n@navajo-nsn.gov	End Date ммрруууу Current
Address Line 1*A&B PO Box 709	Address Line 2 = N/A	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
В	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	
I. Dir Supulon Sinne (77)	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*	□AHCCCS ID or □NPI 1D*	
Provider Name:*Start Date ммрруучу:* End Date ммрруучу:*	Provider Name:* Start Date ммррууч:* End Date ммррууч:*	-
□AHCCCS ID or □NPI ID*	□AHCCCS ID or □NPI ID*	
Provider Name:*Start Date MMDDYYYY:* End Date MMDDYYYY:*	Provider Name:* Start Date ммрруууу: End Date ммрруууу:	
□AHCCCS ID or □NPI ID*	□AHCCCS ID or □NPI ID*	
Provider Name:* Start Date ммррүүүү:* End Date ммррүүүү:*	Provider Name:* Start Date ммррүүү:* End Date ммррүүү:*	

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.

Number:		
үүү Expiration Date: мморүүүү		
License/Certification Number:		
YYY Expiration Date: MMDDYYYY		
Number:		
YYY Expiration Date: MMDDYYYY		
Number:		

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



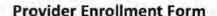


Provider Controlling Interest/Ownership

- 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 an	
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 ммррууу	End Date ммррууу	
Home address for Individual or business addre	ess 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
4	Individual
С	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*	

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.

Relationship Type	Relation to (name)	Relation to Assoc. Owner
1		



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.

- 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;
 - 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;
 - 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
- 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
- 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			
0	Response: 1g.	☐ Yes	■No
Owner Name Jonathan Nez	Response: 2.	☐ Yes	■No
CON /DIN /MIN	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
Action (Artista de la company)	Response: 1g.	☐ Yes	■No
Owner Name Myron Lizer	Response: 2.	☐ Yes	■No
CONT. (Print ferrit	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
If additional space is needed see Appendactions.	x E. Supporting documentation	on is requi	red for all adverse





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: ммрруучу* 10/19/2020	End Date: ммррүүү

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.

Jul	TION XII	1				
50	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.				
	DOVE SERVICE SE	Confirmation #	Date:			
	Fee Paid to Medicaid in another State	already paid the enrollment the program name and pay	supply documentation demonstrating that you have t fee to the Medicaid program of another state. Select ment date in the section below Upload your receipt or in the "Upload Documents" step This is subject to			
		Paid To:	Date:			
		Confirmation #	Note:			
		Select this option to request "Hardship Waiver" from the Provider Registration un 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.				
	Request Hardship Waiver	A "Hardship Letter" must be continue submitting the en	e written and sent in with this application. You can rollment application/modification request This is			
	Hardship	A "Hardship Letter" must be continue submitting the ensubject to federal and state Select this option if you have	e written and sent in with this application. You can rollment application/modification request This is			





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, 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'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.

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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.

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 SIGNATURE Jonathan Nez/Myron Lizer
Jonathan Nez/Myron Lizer

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 recordkeeping 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.
- 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 noncompliance 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.



PROVIDER NAME (PLEASE TYPE OR PRINT)

TITLE

DATE

Provider Enrollment Form

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

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to





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.

	business hours oplicable.	of operation.	State "close	d" on days the b	ousiness is clos	sed. Select Al	M or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	□РМ	□РМ	□PM	□РМ	□РМ
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	□РМ	□РМ	□РМ	□РМ	□РМ
Language		English 🗆 S Native Amer		arabic □Canto ndarin □Kor			ajo □Farsi
Other(s)	(specify):					□Handicap A	Accessible

Provider SSN/EIN/TIN: 86-0092335

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

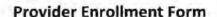


Appendix B

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	□AHCCCS ID or □NPI ID	
Provider Name:Start Date: ммрруууу End Date: ммрруууу	Provider Name: Start Date: ммрруууу End Date: ммрруууу	-
□AHCCCS ID or □NPI ID	□AHCCCS ID or □NPI ID	
Provider Name: Start Date: ммрруучу End Date: ммрруучу	Provider Name: Start Date: ммррууу End Date: ммррууу	
□AHCCCS ID or □NPI ID	□AHCCCS ID or □NPI ID	
Provider Name:Start Date:ммрруууу End Date: ммрруууу	Provider Name: Start Date: ммррүүү End Date: ммррүүү	-1





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

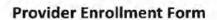
Do any of the Owners have the following relationship (Daughter, Daughter-In Law, Father, Father-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

□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



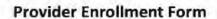


Appendix E

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
7	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
Partition of the same of the s	Response: 3.	☐ Yes	□No
	Response: 4.	☐ Yes	□No
Owner Name	Response: 1g.	☐ Yes	□No
SSN/EIN/TIN	Response: 2.	☐ Yes	□No
22.17 = 21.7	Response: 3.	☐ Yes	□No
	Response: 4.	☐ Yes	□No





Appendix F

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
В3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
В6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
В7	CRISIS SERVICES PROVIDER	Y	Y	N
В8	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
El	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

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

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



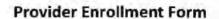


	SPEC	LIALTY CODI	ES		
	MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)				
CODE	DESCRIPTION	CODE	DESCRIPTION		
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE		
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE		
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/REHABILITATION		
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		





	SPECIA	LTY CODI	ES	
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	





	SPE	CIALTY CODI	ES		
	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 CODE	S
	MEDICAL S	SPECIALTY CODES FO	R D,O,'S (PT 31)
CODE	DESCRIPTION	CODE	DESCRIPTION
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)





CODE	SPECIALTY CODES - REGISTER DESCRIPTION	CODE	DESCRIPTION		
084	FAMILY NURSE PRACTITIONER	085			
086	PEDIATRIC NURSE ASSOCIATE		SCHOOL NURSE PRACTITIONER		
		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	27.0	ACUTE CARE NURSE PRACTITIONER		
	SPECIALTY CODES - OTHE	The state of the s	Warner and the second s		
NURSE -MIDWIFE (PT 09)			CERTIFIED REGISTERED NURSE ANESTHETIST (PT 1		
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		
		TRY CODES (
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 FO	R NON-PHYS	CIAN CATEGORIES		
	LABORATORY	SPECIALTY CO	DES (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)		



	SPECIALTY CODES FOR NO	N-PHYS	ICIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC	100	
	PATHOLOGY	Y SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	OUNT IN	FORMATION
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

Ø	Description	Enrollment Type this applies to
√	SSN/EIN/TIN is at the bottom of each page	All
1	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
7	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, Atypica 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
ī	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

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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				





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.
- 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.
- 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
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
1	Individual
C	Corporation

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

Mail: Fax:

AHCCCS Provider Enrollment

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

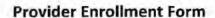
Provider SSN/EIN/TIN: 86-0092335

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



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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
1	Add SSN/EIN/TIN to the bottom of each page	All
1	National Provider Identification (NPI)	Group, FAO, Individual
	AHCCCS ID (if applicable)	All
V	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
1	Practice address details & hours of operation	All
1	Pay to details	All
1	Correspondence address	All
1	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
1	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 <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I		
Select One_Applicable Req		
□New Enrollment	□ Revalidation ■ I	rovider Modification APEP Re-Registration
Complete only if you are		d have a Provider Number or Provider AHCCCS ID. *
Provider Number/AHCC	CS ID: 329484	□N/A
If you do not have an NI	I, select the N/A box ⊠	and select Atypical Agency for the enrollment type.
NPI: 1528270113	Andrew St. St. Salls Co.	□N/A
Select One Enrollment	Гуре (and Subtype if app	licable) from either section I-A or I-B.
SECTION I-A	- E	
□Individual/Sole □Rendering Se Proprietor Provider		ing □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-Ho- Nursing Facility, Vario	#1000 DB
rarthership, bbc, etc.)		그렇게 그리고 그는 그 그리고 아들은 아름이 아들이 가지 않는 것이 없는 그리고 있다면 하는 것이 없는 것이 없는 것이 없는 것이 없는 것이 없는 것이 없는 것이 없다면 없다면 없다면 없다면 없다면 그리고 있다면 없다면 없다면 없다면 없다면 없다면 없다면 없다면 없다면 없다면 없
□Contractor/MCO	Entities) Sub Type: Correctional Facilitie Tribal Behavioral He	Company, Local Education Agency etc.) Bes Department of Economic Security

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.

Complete required fields based or First Name*A	Middle Initial □N/A	Last Name*A		
Suffix*A	Gender*A	SSN*A		
Date of Birth*A ммрруучу	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	Profit Type*A&B □501(C)(3) NON-PROFIT □For Profit Closely Held	Tribal Type *A&B □N/A □Indian Health Service		
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other <u>Tribal 638</u> ☐ N/A – The individual only practices as part of a group	□ 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 Agen	



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 Northeast of Bashas'	*A&B	End Date*A&B ммррүүүү 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.

	he busines applicable		of op	eration.	Stat	e "close	d" on c	days the	busin	ess is clo	osed.	Select A	M or PM
	Sun	day	M	onday	Tu	esday	Wed	nesday	Thu	ırsday	F	riday	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	IE	□AM □PM		□AM □PM		□AM □PM		□AM □PM		□AM □PM	Closed ■AM
	ge(s) Spol		Engli Nati	sh 🗆 S ve Amei	Spani rican		Arabic ndarin		onese rean	□ Chi	nch	■ Nav	ajo □Farsi Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ⋈.

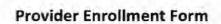
SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice	End Date ммрруууу Current	
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache
Country*A&B United States of America	Zip Code*A&B 86515	

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 Add □Same as Primary P		Phone Number* (928)657-8000	A&B	Fax Number (928)657-8009	
Method of Communic Only select 1 option ■Email	ation*A&B Standard Mail	Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date ммрручуч 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
В	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 MMDDY
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*	□AHCCCS ID or □NPI ID*	
Provider Name:*	Provider Name:*Start Date ммрруучу:* End Date ммрруучу:*	_
□AHCCCS ID or □NPI ID*	□AHCCCS ID or □NPI ID*	
Provider Name:*Start Date MMDDYYYY:* End Date MMDDYYYY:*	Provider Name:* Start Date ммрруучу; End Date ммрруучу;	-1,
□AHCCCS ID or □NPI ID*	□AHCCCS ID or □NPI ID*	
Provider Name:* Start Date MMDDYYYY:* End Date MMDDYYYY:*	Provider Name:*Start Date ммррүүү:* End Date ммррүүү:*	



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 Nu	mber:
Issuing Agency:	Effective Date: ммррүүүү	Expiration Date: мморуууу
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: ммррүүүү
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: ммррүүүү	Expiration Date: мморуууу

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)		1		
☐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)			11,	
□Swing Bed(s)				
☐Temporarily Non Available Bed(s)			111-	
□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:

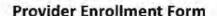
- The name and address of any person (individual or corporation) with ownership or control interest. The
 address for corporate entities must include, as applicable, primary business address, every business
 location and P.O. Box address.
- · Date of birth and Social Security Number (in the case of an 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 SSN/EIN/TIN: 86-0092335

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



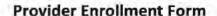


Provider Controlling Interest/Ownership

- 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	
Owner NPI		
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation	
Suffix	DOB*I&C MMDDYYYY	
Phone Number*1&C (928)871-6235	Email	
Start Date*I&C MMDDYYYY	End Date ммрруучу	
Home address for Individual or business addre	ess 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
1	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-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.

- 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;
 - 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;
 - 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
- 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
Living and the second	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No





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: ммрруууу* 10/19/2020	End Date: ммррүүү	

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.

SEC	TION XII			
Žių i	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		paid the enrollment fee to the Centers for Medicare	
ш	Medicare	Services This is subject to fe		
	carcarc	Confirmation #	Date:	
	Medicaid in another State	the program name and payn documentation of payment i federal and state approval.	fee to the Medicaid program of another state. Select nent date in the section below Upload your receipt or n the "Upload Documents" step This is subject to	
		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 from the current date for a r	e paid the fee to AHCCCS within the last 12 months elated provider entity within your organization.	
	C. 4322 22 4	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 recordkeeping 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.



DATE

Provider Enrollment Form

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)



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.

ion		
ymbol (*) are required informatio	n,	
	End Date	
Address Line 2	Address Line 3	
State/Province*	County*	
Zip Code*		
	ymbol (*) are required information Address Line 2 State/Province*	ymbol (*) are required information. End Date Address Line 2 State/Province* County*

	business hours oplicable.	of operation.	State "close	d" on days the b	ousiness is clos	sed. Select Al	d or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□АМ	□AM	□AM	□AM	□AM
	□РМ	□РМ	□РМ	□РМ	□РМ	□PM	□PM
Close	□AM	□АМ	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	□РМ	□РМ	□РМ	□PM	□PM
Language		English S Native Amer		rabic □Canto ndarin □Kor			ijo □Farsi
Other(s)	(specify):					□Handicap A	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	□AHCCCS ID or □NPI		
ID	ID		
Provider Name:	Provider Name:		
Start Date: ммрруууу	Start Date: MMDDYYYY		
End Date: ммррүүүү	End Date: MMDDYYYY		
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI		
ID	ID		
Provider Name:	Provider Name:		
Start Date: MMDDYYYY	Start Date: ммрруууу		
End Date: ммрруууу	End Date: ммрруууу		
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI		
ID	ID		
Provider Name:	Provider Name:	-	
Start Date: MMDDYYYY	Start Date: MMDDYYYY		
End Date: ммррүүү	End Date: ммрруууу		





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	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n 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*
State/Province* A&B	County*

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



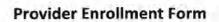


Appendix E

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





Appendix F

Provider Type	Description	National Provider Identifier (NPI)	Enrollment Fee	Site
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
ВІ	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
В3	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
El	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
FI	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

Provider Type	Description	National Provider Identifier (NPI)	Enrollment Fee	Site
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	Ÿ	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





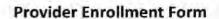
Appendix F

Provider	NPI, Enrollment Fee and/or Site Visit Requir Description	National Provider	Enrollment	Site
Type 47	REGISTERED DIETICIAN (RD)	Identifier (NPI)	Fee	Visi
48	NUTRITIONIST	N	N	N
49	ASSISTED LIVING CENTER	N	Y	N
		N	N	N
50	ADULT FOSTER CARE AFFILIATED PRACTICE HYGIENIST	Y	N	N
55	HOTELS	N N	Y	N
202	Jany Comercia	17.6		
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	N
	70 HOME DELIVERED MEALS		Y	N
	71 PSYCHIATRIC HOSPITAL		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



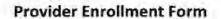


	SPEC	IALTY CODI	ES		
MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)					
CODE	DESCRIPTION	CODE	DESCRIPTION		
010	ALLERGIST/IMMUNOLOGIST	155	PEDIATRIC - NEONATAL/PERINATAL MEDICINE		
011	ALLERGIST	159	PEDIATRIC PULMONARY DISEASE		
012	IMMUNOLOGIST	160	PHYSICAL MEDICINE/ REHABILITATION		
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		





	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			





	SPE	CIALTY CODI	ES
	MEDICAL SPECIAL	TY CODES FO	R 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)		





	SPECIALTY CODES - REGISTERED		
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	REGISTERE	ED NURSE CATEGORIES
-	NURSE -MIDWIFE (PT 09)	CERTIF	IED 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
	DENTISTR	Y 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-PHYSI	ICIAN CATEGORIES
	LABORATORY SPI	CIALTY CO	DES (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)





	SPECIALTY CODES FOR NO	N-PHYSI	CIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
	PATHOLOGY	SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	DUNT INI	FORMATION
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

Ø	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
1	Section IV Pay To information	All
7	Section V Correspondence Address	All
7	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
1	Section XI Add Taxonomy	All
/	Section XII Fees	All
٦	Provider Participation Agreement or Group Biller Participation Agreement One of these Agreements must be signed and accompany all applications	All
Ī	Appendix A – Additional Service Locations	All
	Appendix B - Associate Billing Provider/Other Associations	All
Ħ	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
T	Appendix G - Provider Type Specialty Codes	All



Enrollment Checklis	st/Questionnai	re
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	





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.
- 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.
- A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
- 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
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
	Individual
С	Corporation

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

Mail:

Fax:

AHCCCS Provider Enrollment

P.O. Box 25520, Mail Drop 8100

Attn: AHCCCS Provider

Phoenix, AZ 85002

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.

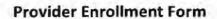
Provider SSN/EIN/TIN: 86-0092335

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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.

\square	Description	Enrollment Type this applies to
V	Add SSN/EIN/TIN to the bottom of each page	All
1	National Provider Identification (NPI)	Group, FAO, Individual
	AHCCCS ID (if applicable)	All
V	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
V	Practice address details & hours of operation	All
1	Pay to details	All
1	Correspondence address	All
1	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
V	Controlling interest/ownership details, managing employee, and owner relationship	All
1	Owners Adverse action(s) information	All
V	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 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 <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I		
Select One_ Applicable Req		
□New Enrollment	Revalidation	Provider Modification APEP Re-Registration
Complete only if you are		nd have a Provider Number or Provider AHCCCS ID. *
Provider Number/AHCC	CS ID: 329541	□N/A
If you do not have an NI	PI, select the N/A box ⊠	and select Atypical Agency for the enrollment type.
NPI: 1740400365		□N/A
Select One Enrollment	Type (and Subtype if ap	plicable) from either section I-A or I-B.
SECTION I-A		
□Individual/Sole	☐ Rendering Serv	icing Atypical (non-medical) provider
Proprietor	Provider	Individual (Driver, Home Help/Personal
SECTION I-B		그는 가득하다.
SECTION I-B		Individual (Driver, Home Help/Personal
	Provider	Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-B □ Group Practice	Provider Facility/Agency	Individual (Driver, Home Help/Personal Care, Carpenter, etc.) Atypical (non-medical) provider ospital, Agency (Child Care Institution, Home
SECTION I-B Group Practice (Corporation,	Provider Facility/Agency Organization (FAO-Ho Nursing Facility, Vario Entities) Sub Type:	Individual (Driver, Home Help/Personal Care, Carpenter, etc.) Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
SECTION I-B Group Practice (Corporation, Partnership, LLC, etc.)	Provider Facility/Agency Organization (FAO-Ho Nursing Facility, Vario	Individual (Driver, Home Help/Personal Care, Carpenter, etc.) Atypical (non-medical) provider Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)

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





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.

First Name*A	Middle Initial □N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A ммрруууу	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Fort Defiance Outpatient Treatment
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	Profit Type*A&B □501(C)(3) NON-PROFIT □For Profit Closely Held	Tribal Type *A&B □N/A □Indian Health Service
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other <u>Tribal 638</u> ☐ N/A – The individual only practices as part of a group	□ Privately Owned on Tribal Land ■ Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 .5 Miles SW of the FD Field Ho	*A&B buse BLDG #6905	End Date*A&B ммррүүүү 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.

Locatio	on Specifi	c Inform	natio	n for Pr	ima	ry Prac	tice Lo	cation is	requ	uired.*			
	he busine: applicable		of op	eration.	Stat	e "close	d" on o	days the	busin	ess is cl	osed.	Select A	M or PM
	Sun	day	M	onday	Tu	esday	Wed	nesday	Th	ursday	F	riday	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 ■ PM
	ge(s) Spo		Engli Nati	sh 🗆 S ve Amer	Spani rican		Arabic ndarin		onese rean	□Chi □Fre	nch	■Nav	ajo □Farsi Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	End Date ммррууу	
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 Add □Same as Primary P		Phone Number* (928)729-4012	A&B	Fax Number (928)729-4200
Method of Communication*A&B		Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date ммррүүүү Current
Address Line 1*A&B PO Box 709	Address Line 2 = N/A	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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	
1. Bit outputient clime (77)	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*	□AHCCCS ID or □NPI ID*	
Provider Name:*	Provider Name:*Start Date ммрруууу:* End Date ммрруууу:*	
□AHCCCS ID or □NPI ID*	□AHCCCS ID or □NPI ID*	
Provider Name:*Start Date ммрруууу:* End Date ммрруууу:*	Provider Name:* Start Date ммрруууу: End Date ммрруууу:	=<
□AHCCCS ID or □NPI ID*	□AHCCCS ID or □NPI ID*	
Provider Name:*Start Date ммррүүүү:* End Date ммррүүүү:*	Provider Name:*Start Date ммррүүүү:* End Date ммррүүүү:*	

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 Nu	mber:
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: ммррүүү
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: ммррүүүү
AHCCCS Provider Registration	der Registration License/Certification Number:	
Issuing Agency:	Effective Date: ммррууч	Expiration Date: ммррүүүү

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
Owner NPI	
First Name*I&C Navajo Nation	Last Name*I&C Navajo Nation
Suffix	DOB*I&C MMDDYYYY
Phone Number*1&C (928)871-6235	Email
Start Date*I&C MMDDYYYY	End Date ммррүүү
Home address for Individual or business addre	ess for Corporation
Address Line 1*1&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
1	Individual
С	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.

- 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;
 - 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;
 - 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
- 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
- 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			
20000	Response: 1g.	☐ Yes	■No
Owner Name Jonathan Nez	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
Land Andrews Control	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No





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: ммррүүүү	

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.

SEC	TION 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:	
Ц	Fee Paid to Medicare Fee Paid to Medicaid in another State	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:	
		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, 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 recordkeeping 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.



DATE

Provider Enrollment Form

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)





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.

tion		
symbol (*) are required informatio	n.	
	End Date	
Address Line 2	Address Line 3	
State/Province*	County*	
Zip Code*		
	Address Line 2 State/Province*	Symbol (*) are required information. End Date Address Line 2 State/Province* County*

Enter the	business hours oplicable.	of operation.	State "close	d" on days the b	ousiness is clos	sed. Select Al	M or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM
132	□РМ	□РМ	□РМ	□РМ	□РМ	□PM	□PM
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□PM	□РМ	□РМ	□РМ	□РМ	□РМ	□PM
Language		English 🗆 S Native Amer		arabic □Canto ndarin □Kor			ajo □Farsi
Other(s)	(specify):					□Handicap A	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	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: MMDDYYYY	
End Date: ммрруууу	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: MMDDYYYY	
End Date: ммррүүүү	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: MMDDYYYY	Start Date: ммрруууу	
End Date: ммррүүүү	End Date: ммрруууу	





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	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n 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.
Owner Name	Response: 1g. □ Yes □No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3. □ Yes □No
	Response: 4. ☐ Yes ☐ No
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3.
	Response: 4.
Owner Name	Response: 1g. □ Yes □No
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g. □ Yes □No
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3. ☐ Yes ☐ No
	Response: 4. Yes No





Appendix F

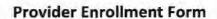
Provider Type	NPI, Enrollment Fee and/or Site Visit Requ Description	National Provider Identifier (NPI)	Enrollment Fee	Site
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Y	N	N
A6	RURAL SUBSTANCE ABUSE TRANSITIONAL AGENCY	Y	Y	N
A8	IHR-INDIVIDUAL HOME RESPITE	Y	Y	N
BI	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
В3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
В6	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

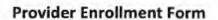
Provider Type	Description	National Provider Identifier (NPI)	Enrollment Fee	Site
04	LABORATORY	Y	Y	Y
05	NON- HOSPITAL AFFILATED CLINIC	Y	Y	N
06	EMERGENCY TRANSPORTATION	Y	Y	Y
07	DENTIST	Y	N	N
08	MD-PHYSICIAN	Y	N	N
09	CERTIFIED NURSE-MIDWIFE (CNM)	Y	N	N
10	PODIATRIST	Y	N	N
11	PSYCHOLOGIST	Y	N	N
12	CERTIFIED 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

Provider	NPI, Enrollment Fee and/or Site Visit Requir Description	National Provider	Enrollment	Site
Type 47	REGISTERED DIETICIAN (RD)	Identifier (NPI)	Fee N	Visit
48	NUTRITIONIST	N	N N	N
- 17.5	ASSISTED LIVING CENTER	N	Y	N
49				7.1
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





	SPEC	IALTY CODI	ES		
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		





	SPECIA	LTY CODI	ES			
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			



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	SPE	CIALTY COD	ES	
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)					
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY		
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)		





	SPECIALTY CODES - REGISTER	RED NURSE PR	ACTITIONER 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 - OTH	ER REGISTERI	ED NURSE CATEGORIES
	NURSE -MIDWIFE (PT 09)	CERTIF	IED REGISTERED NURSE ANESTHETIST (PT 12
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
	PODIATRIST CODES (PT 10)	T-41 P T-11	DENTISTRY CODES (PT 07)
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
	DENTIS	TRY 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 FO	OR NON-PHYSI	CIAN CATEGORIES
	LABORATORY	SPECIALTY CO	DES (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	RHTITERS
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)





	SPECIALTY CODES FOR NO	N-PHYS	ICIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC	.77	
	PATHOLOGY	SPECIA	LIST
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		
1 5	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	DUNT IN	FORMATION
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS	1	



Provider Pre-submittal Checklist

Ø	Description	Enrollment Type this applies to
1	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
7	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
7	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
1	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
ī	Appendix B - Associate Billing Provider/Other Associations	All
T	Appendix C - Additional License/Certification/Other	All
Ī	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



Enrollment Checkli	st/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





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.
- 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.
- A Provider Participation Agreement or Group Provider Participation Agreement is required to accompany all applications.
- You must save a copy from the AZAHCCCS site to your computer. Complete, and save your completed copy before submitting.

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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: Fax:

AHCCCS Provider Enrollment

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



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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
1	Add SSN/EIN/TIN to the bottom of each page	All
1	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
1	Practice address details & hours of operation	All
1	Pay to details	All
1	Correspondence address	All
1	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
1	Controlling interest/ownership details, managing employee, and owner relationship	All
1	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 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 <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I			
Select One_ Applicable Req			
□New Enrollment	□ Revalidation ■ Provider Modification *List section numbers modified APEP Re-Registration		
Complete only if you are Provider Number/AHCO	currently registered an	d have a Provider Number or Provider AHCCCS ID. *	
If you do not have an NI NPI: 1083835458	PI, select the N/A box ⊠	and select Atypical Agency for the enrollment type.	
Select One Enrollment	Type (and Subtype if app	olicable) from either section I-A or I-B.	
□Individual/Sole Proprietor	☐Rendering Servi Provider	cing □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-Ho Nursing Facility, Vario Entities)		
□Contractor/ MCO	Sub Type: □Correctional Faciliti ■Tribal Behavioral Ho	es Department of Economic Security	

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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.

First Name*A	Middle Initial □N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A мморуууу	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	Profit Type*A&B □501(C)(3) NON-PROFIT □For Profit Closely Held	Tribal Type *A&B □N/A □Indian Health Service
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other Tribal 638 ☐ N/A – The individual only practices as part of a group	□ Privately Owned on Tribal Land ■ Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ммррүүүү 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.

	he busine applicable		of op	eration.	Stat	e "close	d" on o	lays the	busin	ess is cl	osed.	Select A	M or PM
	Sun	day	Me	onday	Tu	esday	Wed	nesday	Th	ursday	F	riday	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
Langua	ge(s) Spo		Engli Nati	sh 🗆 S ve Amei	Spani ican		Arabic ndarin	□Canto		□Chi □Fre	nch	■Nav	ajo □Farsi Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ⋈.

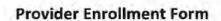
SECTION IV				
Pay To Address*A&B ☐ Same as Primary Practice	End Date MMDDYYYY Current			
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	Address Line 3 ■N/A		
City/Town*A&B Window Rock	State/Province*A&B Arizona	County*A&B Apache		
Country*A&B United States of America	Zip Code*A&B 86515			

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 Add □Same as Primary P		Phone Number* (928)673-3267	Fax Number (928)673-3269	
Method of Communication*A&B Only select 1 option ■Email □Standard Mail		Email Address*	End Date ммрруууу Current	
Address Line 1*A&B Address Line 2 BN/A PO Box 709		Ā	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
В	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 MMDDY
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*	□AHCCCS ID or □NPI ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date ммрруучу:*	End Date MMDDYYYY:*	
□AHCCCS ID or □NPI ID*	□AHCCCS ID or □NPI ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:	
End Date ммррүүүү:*	End Date ммррүүүү:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date ммрруууу:*	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.

License/Certification Number:				
Effective Date: ммррүүүү	Expiration Date: ммррүүүү			
License/Certification Number:				
Effective Date: ммррүүү	Expiration Date: ммррүүү			
License/Certification Number:				
Effective Date: ммррүүү	Expiration Date: мморуууу			
	Effective Date: ммрруучу License/Certification Num Effective Date: ммрруучу License/Certification Num			

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)			1
☐ Medicare Surgery Bed(s)			
□Obstetrics (OB/GYN) Bed(s)			
☐ Pediatrics Bed(s)			
□Psych Bed(s)			
□ Rehab Bed(s)		1	
□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	
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 ммррууу	End Date ммрруууч	
Home address for Individual or business addre	ss for Corporation	
Address Line 1*I&C PO Box 709	s 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
1	Individual
С	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*	

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.

- 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;
 - 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;
 - 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
- 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
- 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
and the first with the second	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
If additional space is needed see Append actions.	ix E. Supporting documentation	on is requi	red for all adverse





Add Taxonomy

This is not required for atypical enrollment types.

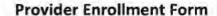
The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes
are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/

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

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.

SEC	TION XII			
	Options	Description		
√	Pay Fee	received via correspondence or if there is an existing AHCCCS Provider pay the fee in the payment gateway using the following link: https://www.azahcccs.gov/PlansProviders/NewProviders/EnrollmentFee/		
		Confirmation #	Date:	
Fee Paid to Select this option if you have paid the enrollment fee to the Medicare Services This is subject to federal and state approval.				
	2.02.000	Confirmation #	Date:	
	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.		
		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.		
	AHCCCS Prior Payment			





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, 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'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.
- 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 recordkeeping 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)

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.

n		
nbol (*) are required informatio	on.	
	End Date	
Address Line 2	Address Line 3	
State/Province*	County*	
Zip Code*		
	Address Line 2 State/Province*	Address Line 2 State/Province* End Date Address Line 3 County*

	business hours oplicable.	of operation.	State "close	d" on days the b	ousiness is clo	sed. Select Al	M or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□PM	□PM	□РМ	□РМ	□PM	□РМ
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□PM	□РМ	□РМ	□РМ	□РМ	□РМ	□PM
Language		English 🗆 S Native Amer		arabic □Canto ndarin □Kor			ajo □Farsi
Other(s)	(specify):					□Handicap A	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	□AHCCCS ID or □NPI ID	
Provider Name:		
Start Date: ммррүүүү	Start Date: ммррүүү	
End Date: MMDDYYYY	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: MMDDYYYY	Start Date: MMDDYYYY	
End Date: MMDDYYYY	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: MMDDYYYY	Start Date: MMDDYYYY	
End Date: MMDDYYYY	End Date: MMDDYYYY	



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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.).

License/Certification	n Number:	
Effective Date:	Expiration Date:	
License/Certification	n Number:	
Effective Date:	Expiration Date:	
License/Certification	n Number:	
Effective Date:	Expiration Date:	
License/Certification	n Number:	
Effective Date:	Expiration Date:	
License/Certification Number:		
Effective Date:	Expiration Date:	
License/Certification Number:		
Effective Date:	Expiration Date:	_
License/Certification	n Number:	
Effective Date:	Expiration Date:	
License/Certification	n Number:	
Effective Date:	Expiration Date:	
License/Certification Number:		
Effective Date:	Expiration Date:	
License/Certification	n Number:	
Effective Date:	Expiration Date:	
	Effective Date: License/Certification Effective Date: License/Certification	License/Certification Number: Effective Date: Expiration Date: License/Certification Number:





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.

SSN*
Last Name*
DOB*
Email
End Date
Address Line 2
City/Town*
County*
Zip Code*

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, 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				4
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		□ Yes	□No
		□ Yes	□No
	Response: 4.	□ Yes	□No





Appendix F

Provider Type	Description	National Provider Identifier (NPI)	Enrollment Fee	Site
A3	COMMUNITY SERVICE AGENCY	Y	Y	Y
A4	LICENSED INDEPENDANT SUBSTANCE ABUSE	Y	N	N
A5	BEHAVIORAL HEALTH THERAPEUTIC HOME	Ý	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
EI	INDEPENDENT TESTING FACILITIES	Y	Y	N
ED	FREE STANDING EMERGENCY DEPARTMENT	Y	N	N
Fl	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

Provider Type	Description	National Provider Identifier (NPI)	Enrollment Fee	Site
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 Requir	ed by Provider Typ	e	
Provider Type	Description	National Provider Identifier (NPI)	Enrollment Fee	Site
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





	SPEC	IALTY CODI	ES			
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			





	SPECIA	LTY CODI	ES			
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			





	SPE	CIALTY CODI	ES
	MEDICAL SPECIAL	TY CODES FO	R 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 CODE	S			
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)			





	SPECIALTY CODES - REGISTER	ED NURSE PR	ACTITIONER 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
7 T.K.A.	SPECIALTY CODES - OTH	ER REGISTERE	ED NURSE CATEGORIES
	NURSE -MIDWIFE (PT 09)	CERTIF	IED 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
	DENTIS	TRY 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 FO	OR NON-PHYSI	CIAN CATEGORIES
	LABORATORY	SPECIALTY CO	DES (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)





	SPECIALTY CODES FOR NO	N-PHYS	CIAN 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
The Land	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
	PATHOLOGY	SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	DUNT INI	FORMATION
CODE	DESCRIPTION	CODE	DESCRIPTION
ACUT	ACUTE BEDS	ICF	INTERMEDIATE CARE FACILITY
ICFM	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED	SNF	SKILLED NURSING FACILITY
SWBD	SWING BEDS		



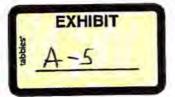
Provider Pre-submittal Checklist

	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
1	Section IV Pay To information	All
/	Section V Correspondence Address	All
7	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, Atypica 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
7	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
ī	Appendix B - Associate Billing Provider/Other Associations	All
Ħ	Appendix C - Additional License/Certification/Other	All
	Appendix D - Additional Owner(s)	All
T	Appendix E - Additional Adverse Actions	All
i	Appendix F - Provider Type Codes	All
Ħ	Appendix G - Provider Type Specialty Codes	All



Enrollment Checkli	st/Questionnair	e
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	





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:

- 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.
- 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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
1	Individual
C	Corporation

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

Mail:

Fax:

AHCCCS Provider Enrollment

P.O. Box 25520, Mail Drop 8100 Phoenix, AZ 85002

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

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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
V	Add SSN/EIN/TIN to the bottom of each page	All
1	National Provider Identification (NPI)	Group, FAO, Individual
	AHCCCS ID (if applicable)	All
V	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
1	Practice address details & hours of operation	All
1	Pay to details	All
1	Correspondence address	All
1	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)
П	Bed unit information, if applicable.	FAO and Atypical Agency only
1	Controlling interest/ownership details, managing employee, and owner relationship	All
1	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 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 <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I		
Select One_Applicable Req	uest Type.*	
□New Enrollment	Revalidation Provider Modification *List section numbers modified APEP Re-Registration	
Complete only if you are	currently registered and h	ave a Provider Number or Provider AHCCCS ID. *
Provider Number/AHCC	CCS ID: 329559	□N/A
If you do not have an Ni	PI, select the N/A box ⊠ an	d select Atypical Agency for the enrollment type.
NPI: 1811109762		□N/A
	Type (and Subtype if applic	able) from either section I-A or I-B.
Select One Enrollment SECTION I-A	Type (and Subtype if applic	able) from either section I-A or I-B.
	Type (and Subtype if applic	
SECTION I-A		g Atypical (non-medical) provider Individual (Driver, Home Help/Personal
SECTION I-A Individual/Sole	☐Rendering Servicin	g
SECTION I-A Individual/Sole Proprietor SECTION I-B	□Rendering Servicin Provider	g Atypical (non-medical) provider Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-A Individual/Sole Proprietor SECTION I-B Group Practice	□Rendering Servicin Provider ■Facility/Agency	g
SECTION I-A Individual/Sole Proprietor SECTION I-B Group Practice (Corporation,	☐ Rendering Servicin Provider ■ Facility/Agency Organization (FAO-Hospi	g
SECTION I-A Individual/Sole Proprietor SECTION I-B Group Practice	□Rendering Servicin Provider ■Facility/Agency Organization (FAO-Hospi Nursing Facility, Various	g
SECTION I-A Individual/Sole Proprietor SECTION I-B Group Practice (Corporation, Partnership, LLC, etc.)	□Rendering Servicin Provider ■Facility/Agency Organization (FAO-Hospi Nursing Facility, Various Entities)	g
SECTION I-A Individual/Sole Proprietor SECTION I-B Group Practice (Corporation,	□Rendering Servicin Provider ■Facility/Agency Organization (FAO-Hospi Nursing Facility, Various	g

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 or	n 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	Profit Type*A&B □501(C)(3) NON-PROFIT □For Profit Closely Held	Tribal Type *A&B □N/A □Indian Health Service
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other <u>Tribal 638</u> ☐ N/A – The individual only practices as part of a group	□ Privately Owned on Tribal Land ■ Tribally Owned on Tribal Land

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 HWY 394.3 US-160	*A&B	End Date*A&B ммррүүү 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.

Locati	on Specifi	c Infor	natio	n for Pr	ima	ry Prac	tice Lo	cation is	s requ	iired.*			
	he busine: applicable		of op	eration.	Stat	e "close	d" on c	lays the	busin	ess is cl	osed.	Select A	M or PM
	Sun	day	Mo	nday	Tu	esday	Wed	nesday	Thu	ursday	F	riday	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
Langua	ige(s) Spol		Englis Nativ	sh 🗆 S ve Amer	Spani		Arabic ndarin	□Canto		□Chi □Fre		■Nav	ajo □Farsi
Other(s) (specify)::									□H:	andicap	Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	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 \boxtimes .
- 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.

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

Category Key	Euro Iment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммрруучу:*	Start Date MMDDYYYY:*	
End Date ммрручуч:*	End Date ммрруучу:*	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммррүүү:*	Start Date ммрруууу:	
End Date ммррүүү:*	End Date ммрруууу:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммрруууу:*	Start Date ммрруучу:*	
End Date ммрруууу:*	End Date ммрруучу:*	

Provider SSN/EIN/TIN: 86-0092335



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: ммррууч	Expiration Date: ммррүүүү		
AHCCCS Provider Registration	License/Certification Number:			
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: ммррүүү		
AHCCCS Provider Registration	License/Certification Nun	nber:		
Issuing Agency:	Effective Date: ммрруууу	Expiration Date: мморуууу		

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 Beh		
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 ммррүүү	End Date ммррүүү	
Home address for Individual or business address	ss 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
С	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.

- 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;
 - 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
- 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

nse: 1g.	☐ Yes	■No
nse: 2.	☐ Yes	■No
nse: 3.	☐ Yes	■No
nse: 4.	☐ Yes	■No
nse: 1g.	☐ Yes	■No
nse: 2.	☐ Yes	■No
nse: 3.	☐ Yes	■No
nse: 4.	☐ Yes	■No
		e: 4.



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: ммррүүүү		

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.

SEC	TION 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 Select this option if you have paid the fee to AHCCCS within the last 12 mg from the current date for a related provider entity within your organization.		to AHCCCS within the last 12 months er entity within your organization.	
		Confirmation #	Date:	

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



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

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"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.

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- 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.

AHCCCS Arizona Health Care Cost Containment System

Provider Enrollment Form

- 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 recordkeeping 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 noncompliance 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)

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.

ol (*) are required informatio	n.	
	End Date	
Address Line 2	Address Line 3	
State/Province*	County*	
Zip Code*		
	Address Line 2 State/Province*	Address Line 2 Address Line 3 State/Province* County*

Location	n Specific Inform	ation for Pr	imary Pract	tice Location is	required.*		
	e business hours pplicable.	of operation.	State "close	d" on days the l	ousiness is clo	sed. Select A	M or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM
-	□РМ	□РМ	□PM	□РМ	□РМ	□PM	□PM
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	□РМ	□РМ	□РМ	□РМ	□PM
Languag	Language(s) Spoken □ English □ Spanish □ Arabic □ Cantonese □ Chinese □ Navajo □ Farsi						ajo □Farsi
		Native Amer	ican □Ma	ndarin □Koi	rean 🗆 Frei	nch	
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	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммррүүү	Start Date: ммрручуч	
End Date: ммрруууу	End Date: ммррууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: ммррууу	
End Date: ммррүүүү	End Date: ммррууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: MADDYYYY	Start Date: MMDDYYYY	
End Date: MMDDYYYY	End Date: MMDDYYYY	
LIIU Date. MMDDITTI	Life Date. Mindbilli	





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	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n 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.
	Response: 3. □ Yes □No
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2. □ Yes □ No
	Response: 3. □ Yes □ No
	Response: 4. \square Yes \square No
Owner Name	Response: 1g. ☐ Yes ☐ No
SSN/EIN/TIN	Response: 2.
	Response: 3. □ Yes □ No
	Response: 4.
Owner Name	Response: 1g. □ Yes □ No
SSN/EIN/TIN	Response: 2.
	Response: 3. □ Yes □ No
	Response: 4. □ Yes □ No
Owner Name	Response: 1g. ☐ Yes ☐ No
SSN/EIN/TIN	Response: 2.
	Response: 3. □ Yes □ No
	Response: 4.
Owner Name	Response: 1g. □ Yes □No
SSN/EIN/TIN	Response: 2.
	Response: 3. ☐ Yes ☐ No
	Response: 4.





Appendix F

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
В3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
В6	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 (FOHC)	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

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

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





	SPEC	IALTY CODI	ES			
	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			





	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			





	SPE	CIALTY CODI	ES		
	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-		
			BEHAVIORAL/DEVELOPMENTAL		
136	FORENSIC PATHOLOGY	913	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		957	DIAGNOSTIC LABORATORY		
102	PREVENTIVE MEDICINE		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				
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





	SPECIALTY CODES - REGISTERED I	NURSE PR	ACTITIONER 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 R	EGISTERE	ED NURSE CATEGORIES
	NURSE -MIDWIFE (PT 09)	CERTIF	ED 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 N	ON-PHYSI	CIAN CATEGORIES
	LABORATORY SPEC	CIALTY CO	DES (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 NO	N-PHYSI	ICIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
	PATHOLOGY	Y SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	DUNT INI	FORMATION
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

Ø	Description	Enrollment Type this applies to	
\checkmark	SSN/EIN/TIN is at the bottom of each page	All	
V	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	
V	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. 		
/	Section XI Add Taxonomy	All	
V	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

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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





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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description	
I	Individual	
С	Corporation	

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

Mail: Fax:

AHCCCS Provider Enrollment

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



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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
\checkmark	Add SSN/EIN/TIN to the bottom of each page	All
✓	National Provider Identification (NPI)	Group, FAO, Individual
П	AHCCCS ID (if applicable)	All
V	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
V	Practice address details & hours of operation	All
V	Pay to details	All
V	Correspondence address	All
V	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
V	Controlling interest/ownership details, managing employee, and owner relationship	All
V	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 \boxtimes .
- If you select the enrollment type, Contractor/MCO or Atypical, you <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I			
Select One_ Applicable Requ	uest Type.*		
□New Enrollment	☐ Revalidation		
Complete only if you are	currently registered a	nd have a	Provider Number or Provider AHCCCS ID. *
Provider Number/AHCC	CS ID: 329492		□N/A
If you do not have an NP	PI, select the N/A box [☑ and sele	ect Atypical Agency for the enrollment type.
NPI: 1558483677			□N/A
Select One Enrollment 7	Гуре (and Subtype if a	pplicable)) from either section I-A or I-B.
SECTION I-A			
□Individual/Sole	☐ Rendering Ser	vicing	☐Atypical (non-medical) provider
Proprietor	Provider		Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-B	1.550		
☐Group Practice	Facility/Agency		□ Atypical (non-medical) provider
(Corporation,	Organization (FAO-H	lospital,	Agency (Child Care Institution, Home
Partnership, LLC, etc.)	Nursing Facility, Var Entities)	ious	Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
□Contractor/MCO	Sub Type:		
	☐ Correctional Facili	ties	☐ Department of Economic Security
	■Tribal Behavioral	Health	☐ Managed Care Organization

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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.

Complete required fields based or First Name*A	Middle Initial □N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A ммрручч	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Tuba City Outpatient Treatment Cen
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	Profit Type*A&B □501(C)(3) NON-PROFIT □For Profit Closely Held	Tribal Type *A&B □N/A □Indian Health Service
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other <u>Tribal 638</u> ☐ N/A – The individual only practices as part of a group	□ Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 Main Street BLDG 25	*A&B	End Date*A&B ммррүүү 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	n Specific	c Inforn	natio	n for Pr	imaı	y Prac	tice Lo	cation is	requ	ired.*			
	e busines oplicable.		of op	eration.	Stat	e "close	d" on d	lays the l	busine	ess is clo	sed.	Select A	M or PM
	Sun	day	Мо	nday	Tu	esday	Wed	nesday	Thu	ırsday	Fr	riday	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
Language(s) Spoken ■ English □ Spanish □ Arabic □ Cantonese □ Chinese ■ Navajo □ Farsi □ Native American □ Mandarin □ Korean □ French													
Other(s)	(specify)):									□На	ndicap	Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 1	End Date ммррууу	
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 \boxtimes .
- 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 Addı ☐ Same as Primary Pr		Phone Number*. (928)283-3346	Fax Number (928)283-3039 End Date MMDDYYYY Current	
Method of Communic Only select 1 option ■Email	ation*A&B Standard Mail	Email Address*A&B arceniocharleston@navajo-nsn.gov		
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	À	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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	
I. Dir outputtont ommo (77)	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	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммрруууу:*	Start Date ммрруучу:*	
End Date ммррүүүү:*	End Date ммррүүүү:*	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммррүүүү:*	Start Date MMDDYYYY:	
End Date ммррүүүү:*	End Date MMDDYYYY:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date MMDDYYYY:*	End Date ммрруучу:*	

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.

License/Certification Nu	Certification Number:			
Effective Date: ммррүүүү	Expiration Date: ммррүүүү			
License/Certification Number:				
Effective Date: MMDDYYYY	Expiration Date: ммррүүү			
AHCCCS Provider Registration License/Certification Number:				
Effective Date: ммррүүү	Expiration Date: ммррүүү			
	License/Certification Num Effective Date: MMDDYYYY License/Certification Num			

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
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 ммррүүү	End Date ммррүүү
Home address for Individual or business addre	ss 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		
С	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
			4	



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			
	Response: 1g.	☐ Yes	■No
Owner Name Jonathan Nez	Response: 2.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 3.	☐ Yes	■No
	Response: 4.	☐ Yes	■No
A	Response: 1g.	☐ Yes	■No
Owner Name Myron Lizer	Response: 2.	☐ Yes	■No
	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
If additional space is needed see Appendi actions.		on is requi	red for all adverse



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: ммррууу

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.

SEC	TION XII				
	Options	Description			
\checkmark	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:			

Provider SSN/EIN/TIN: 86-0092335

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



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, 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.



AHCCCS Arizona Health Care Cost Containment System

Provider Enrollment Form

- 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 recordkeeping 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 noncompliance 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.



DATE

Provider Enrollment Form

l 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.
\Box 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.
\square 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 .



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 informatio	n.				
Service Location		End Date				
Address Line 1*	Address Line 2	Address Line 3				
City/Town*	State/Province*	County*				
Country*	Zip Code*		-			
Country*	Zip Code*					

Enter th	n Specific Inform e business hours pplicable.					sed. Select A	M or PM
where a	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□АМ	□AM	□AM	□AM	□AM
•	□РМ	□РМ	□РМ	□РМ	\Box PM	□РМ	\square PM
Close	□AM	□AM	\Box AM	□АМ	□АМ	□AM	□AM
	□РМ	□РМ	\square PM	□РМ	□РМ	□PM	□РМ
Languag	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	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: MMDDYYYY	Start Date: ммррүүүү	
End Date: ммррүүүү	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммррүүү	Start Date: MMDDYYYY	
End Date: ммррүүүү	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date:ммррууу	Start Date: ммррүүү	
End Date: ммррүүүү	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.).

License/Certification Number:		
Effective Date:	Expiration Date:	
License/Certification Nu	mber:	
Effective Date:	Expiration Date:	
License/Certification Nu	mber:	
Effective Date:	Expiration Date:	
License/Certification Nu	mber:	
Effective Date:	Expiration Date:	
License/Certification Number:		
Effective Date:	Expiration Date:	
License/Certification Number:		
Effective Date:	Expiration Date:	
License/Certification Nu	mber:	
Effective Date:	Expiration Date:	
License/Certification Nu	mber:	
Effective Date:	Expiration Date:	
License/Certification Number:		
Effective Date:	Expiration Date:	
License/Certification Number:		
Effective Date:	Expiration Date:	
	Effective Date: License/Certification Nu	





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.

SSN*	
Last Name*	
DOB*	
Email	
End Date	
Address Line 2	
City/Town*	
County*	
Zip Code*	
	Last Name* DOB* Email End Date Address Line 2 City/Town* County*

Add Owners Relationship

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

 \square No \square Yes If ves, 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.
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
331, 2311,	Response: 3. Yes No
	Response: 4. □ Yes □No
Owner Name	Response: 1g. □ Yes □ No
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3. ☐ Yes ☐ No
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4. □ Yes □ No





Appendix F

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
В1	RESIDENTIAL TREATMENT CTR-SECURE (17+BEDS) (IMD)	Y	Y	N
B2	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
В3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
В6	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

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 Description National Provider Enrollment Site					
Provider Type	Description	Identifier (NPI)	Enrollment Fee	Visi	
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	



	SPEC	IALTY CODI	ES			
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			





SPECIALTY CODES MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)					
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		





SPECIALTY CODES MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)				
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-	
			BEHAVIORAL/DEVELOPMENTAL	
136	FORENSIC PATHOLOGY	913	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)		





	SPECIALTY CODES - REGISTER	ED NURSE PR	ACTITIONER 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 - OTHI	ER REGISTERE	ED NURSE CATEGORIES
	NURSE -MIDWIFE (PT 09)	CERTIF	IED 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
	DENTIS	TRY 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 FO	R NON-PHYSI	ICIAN CATEGORIES
	LABORATORY	SPECIALTY CO	DDES (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)



	SPECIALTY CODES FOR NO	N-PHYSI	ICIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
	PATHOLOGY	Y SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	INI TNUC	FORMATION
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

V	Description	Enrollment Type this applies to
V	SSN/EIN/TIN is at the bottom of each page	All
V	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
V	Section V Correspondence Address	All
V	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
1	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

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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							



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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
С	Corporation

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

Mail: Fax:

AHCCCS Provider Enrollment

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

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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
\checkmark	Add SSN/EIN/TIN to the bottom of each page	All
✓	National Provider Identification (NPI)	Group, FAO, Individual
	AHCCCS ID (if applicable)	All
V	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
V	Practice address details & hours of operation	All
V	Pay to details	All
√	Correspondence address	All
V	Provider type and specialty if applicable	All
	Associate Billing Provider details	All (and is required for rendering/servicing)
П	Copies of all licensing, and certifications, etc.	All (except group)
	Bed unit information, if applicable.	FAO and Atypical Agency only
V	Controlling interest/ownership details, managing employee, and owner relationship	All
V	Owners Adverse action(s) information	All
V	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 \boxtimes .
- If you select the enrollment type, Contractor/MCO or Atypical, you <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I					
Select One _Applicable Requ	uest Type.*				
New Enrollment		Modification numbers modified			
Complete only if you are	currently registered and have a	Provider Number or Provider AHCCCS ID. *			
Provider Number/AHCC	CS ID:	□N/A			
If you do not have an NF	PI, select the N/A box ⊠ and sel	ect Atypical Agency for the enrollment type.			
NPI: 1316545940	[□N/A			
Select One Enrollment	Гуре (and Subtype if applicable) from either section I-A or I-B.			
SECTION I-A					
□Individual/Sole	☐ Rendering Servicing	☐ Atypical (non-medical) provider			
Proprietor	Provider	Individual (Driver, Home Help/Personal Care, Carpenter, etc.)			
SECTION I-B					
☐Group Practice	■ Facility/Agency	☐ Atypical (non-medical) provider			
(Corporation,	Organization (FAO-Hospital,	Agency (Child Care Institution, Home			
Partnership, LLC, etc.)	Nursing Facility, Various	Help/Personal Care Agency, Transportation			
• • • • • • • • • • • • • • • • • • • •	Entities)	Company, Local Education Agency etc.)			
□Contractor/MCO	Sub Type:				
	☐ Correctional Facilities	☐ Department of Economic Security			
	■Tribal Behavioral Health	☐ Managed Care Organization			
L					

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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.

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

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



Primary Practice Location

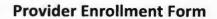
- This section is for the primary practice location only.
- The primary practice location may also be the home address, if applicable.
- Primary Practice Location is applicable to all Enrollment Types A&B of the Category Key.

SECTION III		-
■Primary Practice Location US HWY 160 & NAVAJO ROU		End Date*A&B ммрруууу 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.*													
	e busines oplicable		of op	eration.	Stat	e "close	d" on d	lays the l	busin	ess is clo	sed.	Select A	M or PM
	Sun	day	Мс	nday	Tu	esday	Wed	nesday	Thu	ırsday	Fr	riday	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 ■ PM
Languag	Language(s) Spoken ■ English □ Spanish □ Arabic □ Cantonese □ Chinese ■ Navajo □ Farsi □ Native American □ Mandarin □ Korean □ French												
Other(s)	Other(s) (specify):												

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ммррүүү
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 \boxtimes .
- 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.

Correspondence Address*A&B □Same as Primary Practice Location Method of Communication*A&B Only select 1 option ■Email □Standard Mail		Phone Number*A&B (928)871-6235 Email Address*A&B arceniocharleston@navajo-nsn.gov		Fax Number (928)871-6456 End Date ммррүүү Current
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

(ategory Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	
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	□AHCCCS ID or □NPI	-
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date ммррүүүү:*	End Date MMDDYYYY:*	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:	
End Date ммрруучу:*	End Date ммррүүүү:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммррүүүү:*	Start Date MMDDYYYY:*	
End Date ммрруучу:*	End Date ммрруучу:*	

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 Nu	mber:
Issuing Agency:	Effective Date: ммррүүүү	Expiration Date: ммрруучу
AHCCCS Provider Registration	License/Certification Number:	
Issuing Agency:	Effective Date: ммррууу	Expiration Date: ммррүүү
AHCCCS Provider Registration	License/Certification Nur	mber:
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: мморуууу

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 SSN/EIN/TIN: 86-0092335

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



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
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 ммррууу	End Date MMDDYYYY
Home address for Individual or business addre	ss 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
С	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-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.

- 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;
 - 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
- 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			
0	Response: 1g.	☐ Yes	■No
Owner Name Jonathan Nez	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
CCN (TVN /TVN)	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
If additional space is needed see Appendiactions.			



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: ммрруучу* 10/19/2020	End Date: ммррууу

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.

SEC	TION XII		
	Options	Description	
√	Pay Fee	Select this option in order to pay fee to Al- received via correspondence or if there is pay the fee in the payment gateway using https://www.azahcccs.gov/PlansProviders/ Confirmation #	an existing AHCCCS Provider ID, please the following link:
	Fee Paid to Medicare	Select this option if you have paid the enr Services This is subject to federal and stat Confirmation #	
	Fee Paid to Medicaid in another State	Select this option if you can supply docum already paid the enrollment fee to the Me the program name and payment date in the documentation of payment in the "Upload federal and state approval.	dicaid program of another state. Select ne section below Upload your receipt or I Documents" step This is subject to
		Paid To: Confirmation #	Date:
	Request Hardship Waiver		aiver" from the Provider Registration unit sent in with this application. You can
	AHCCCS Prior Payment	Select this option if you have paid the fee from the current date for a related provid Confirmation #	to AHCCCS within the last 12 months er entity within your organization. Date:

Provider SSN/EIN/TIN: 86-0092335

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



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 recordkeeping 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).

Provider SSN/EIN/TIN: 86-0092335

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



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 noncompliance 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.



TITLE

DATE

Provider Enrollment Form

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)

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to



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

	n Specific Inform					1 C.1 - A	M DM
	e business hours oplicable.	of operation.	State "close	d" on days the t	ousiness is cic	sed. Select A	M or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□AM	□AM	□AM	□AM	□АМ
	□РМ	□РМ	□РМ	□РМ	□РМ	□РМ	□РМ
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	\Box PM	□РМ	□PM	□РМ	□РМ
Languag	e(s) Spoken \square	English \square S	panish \square A	Arabic	nese 🗆 Chii	nese 🗆 Nav	ajo □Farsi
		Native Amer	ican \square Ma	ndarin 🗆 Kor	rean 🗆 Frei	nch	
Other(s)	(specify):					\square 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	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммррууу	Start Date: ммрруууу	
End Date: ммрруууу	End Date: ммрруучу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммррууу	Start Date: MMDDYYYY	
End Date: ммррүүүү	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	9
Provider Name:	Provider Name:	
Start Date:ммрруууу	Start Date: ммррүүү	
End Date: ммррүүү	End Date: ммррүүүү	





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	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	cense/Certification Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
		1	





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)?

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





Appendix F

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
В3	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
В7	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

Provider Type	Description	National Provider Identifier (NPI)	Enrollment Fee	Site Visi
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

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



SPECIALTY CODES MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)				
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	



SPECIALTY CODES MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)				
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	





	SPE	CIALTY CODI	ES	
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-	
			BEHAVIORAL/DEVELOPMENTAL	
136	FORENSIC PATHOLOGY	913	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)		





	SPECIALTY CODES - REGISTERED	NURSE PR	ACTITIONER 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 F	REGISTER	ED NURSE CATEGORIES	
	NURSE -MIDWIFE (PT 09)	CERTIF	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 N	ION-PHYSI	ICIAN CATEGORIES	
	LABORATORY SPE	CIALTY CO	DDES (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)	



	SPECIALTY CODES FOR NO	N-PHYSI	ICIAN 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	
	RADIOLOGIS	ST SPECIA	ALIST	
CODE	DESCRIPTION	CODE	DESCRIPTION	
080	NUCLEAR	200	RADIOLOGY	
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC	
205	RADIOLOGY-THERAPEUTIC			
	PATHOLOG	Y SPECIA	LIST	
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			
	MISCELLANEO	US SPEC	IALTIES	
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

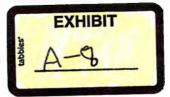
	Description	Enrollment Type this applies to
✓	SSN/EIN/TIN is at the bottom of each page	All
V	Section I Enrollment Type , I-A, I-B	All
	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All
	Section III Primary Practice location – Be sure to use Addendum A for additional locations	All
V	Section IV Pay To information	All
	Section V Correspondence Address	All
✓	Section VI Specialty/Subspecialty	FAO & Atypical Agency only
\Box	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
1	Section XI Add Taxonomy	All
V	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement One of these Agreements must be signed and accompany all applications	All
$\overline{\Box}$	Appendix A – Additional Service Locations	All
П	Appendix B – Associate Billing Provider/Other Associations	All
	Appendix C - Additional License/Certification/Other	All
	Appendix D - Additional Owner(s)	All
一	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	□Yes ■No			
Enrollment Date? If Yes, enter the requested date in				
the comment field to be considered.				
Do you wish to end date your enrollment? If yes,	□Yes ■No			
enter date in comment field.				
Are you currently excluded from any Arizona or	□Yes ■No			
other state program? If yes, provide state of) —		
exclusion and program in comment field.				
Are you currently excluded from any federal	□Yes ■No			
program? If yes, provide the program and date in				
comment field.				
Have you ever had a criminal or healthcare program-	□Yes ■No			
related conviction? If yes, provide type of conviction		1) 0		
and date in comment field.				
Have you ever had a judgment under any false claims	□Yes ■No			
act? If yes, list judgment and date in comments field.				
Have you been enrolled by another State's Medicaid	□Yes ■No			
Program. If yes, provide each state and effective date				
of enrollment in comments field.				
Have you ever had a program exclusion/debarment?	□Yes ■No			
If yes, provide program and date in comments field.				
Have you ever had civil monetary penalty? If yes,	□Yes ■No			
provide penalty type and date. If yes, please specify				
federal or state in comments field.				
Are you trying to reactivate a provider previously	□Yes ■No			
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.				
Do you have 5% or more ownership interest in other	□Yes ■No			
entities reimbursable by Medicaid and/or Medicare?				
If Yes, provide details in "Add Ownership Details"				
step.				
Have you had any malpractice settlement, judgment,	□Yes □No	?		
or agreement? If yes, provide dollar amount and		,		
dates in comments field.				
Are you applying as a Private Duty Nurse (LPN/RN)	□Yes ■No			
for private duty services?				
If this enrollment is for a change of ownership	□Yes ■No			
(CHOW) for an existing provider with a new name,				
NPI, or Tax ID, please add the previous information				
in the comment box.				





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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
С	Corporation

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

Mail: Fax:

AHCCCS Provider Enrollment

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

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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		
V	Add SSN/EIN/TIN to the bottom of each page	All		
	National Provider Identification (NPI)	Group, FAO, Individual		
	AHCCCS ID (if applicable)	All		
V	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		
1	Practice address details & hours of operation	All		
V	Pay to details	All		
V	Correspondence address	All		
1	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		
V	Controlling interest/ownership details, managing employee, and owner relationship	All		
1	Owners Adverse action(s) information	All		
V	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 \boxtimes 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 \boxtimes .
- If you select the enrollment type, Contractor/MCO or Atypical, you <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I							
Select One _Applicable Req	uest Type.*						
■ New Enrollment □ Revalidation □ Provider Modification *List section numbers modified							
Complete only if you are	currently registered and h	ave a Provider Number or Provider AHCCCS ID. *					
Provider Number/AHCC	CCS ID:	□N/A					
If you do not have an NF	PI, select the N/A box ⊠ an	d select Atypical Agency for the enrollment type.					
NPI: 1487876991		□N/A					
Select One Enrollment	Type (and Subtype if applic	cable) from either section I-A or I-B.					
SECTION I-A							
□Individual/Sole	☐ Rendering Servicin	g					
Proprietor	Provider	Individual (Driver, Home Help/Personal Care, Carpenter, etc.)					
SECTION I-B							
☐ Group Practice	Facility/Agency	☐ Atypical (non-medical) provider					
(Corporation,	Organization (FAO-Hospi	tal, Agency (Child Care Institution, Home					
Partnership, LLC, etc.)	Nursing Facility, Various	Help/Personal Care Agency, Transportation					
	Entities)	Company, Local Education Agency etc.)					
□Contractor/ MCO	Sub Type:						
	☐ Correctional Facilities	☐ Department of Economic Security					
	■Tribal Behavioral Heal	th Managed Care Organization					

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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.

First Name*A	Middle Initial □N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A ммррууу	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Navajo Regional Behavioral Health (
Home Address*A	City*A	State*A
PINON & COTTONWOOD DR BL	Shiprock	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	Profit Type*A&B	Tribal Type *A&B
Tribal 638	□501(C)(3) NON-PROFIT □For Profit Closely Held	□ N/A □ Indian Health Service
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other <u>Tribal 638</u> ☐ N/A – The individual only practices as part of a group	□ Privately Owned on Tribal Land ■ Tribally Owned on Tribal Land

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 PINON & COTTONWOOD DR		End Date*A&B ммррүүүү 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.

Enter th	n Specific	s hours									sed.	Select A	M or PM	1
where a	pplicable		,											
	Sun	day	Мо	onday	Tu	esday	Wed	nesday	Thu	ırsday	Fr	iday	Satur	rday
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	■ A M
Language(s) Spoken ■ English □ Spanish □ Arabic □ Cantonese □ Chinese □ Native American □ Mandarin □ Korean □ French □ French														
Other(s)	(specify)):									□На	ndicap .	Accessi	ble

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 \boxtimes .

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice	Location	End Date ммррүүү
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.
- ullet If the "Correspondence" address is the same as the primary practice location, select this option \boxtimes .
- 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 Adda ☐ Same as Primary Pr		Phone Number*/ (928)871-6235	Fax Number (928)871-6456 End Date ммрруууу Current	
Method of Communic Only select 1 option ■ Email	ation*A&B Standard Mail	Email Address*A		
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	À	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
В	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	
1. Bit outputent clime (77)	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	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*		
Start Date ммрруучу:*	Start Date MMDDYYYY:*	
End Date ммррүүү:*	End Date MMDDYYYY:*	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:	
End Date ммррүүүү:*	End Date MMDDYYYY:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*		,
Start Date ммррүүүү:*	Start Date ммрруучу:*	
End Date ммрруучу:*	End Date ммрручуч:*	

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 Nu	mber:	
Issuing Agency:	Effective Date: ммрруучу	Expiration Date: ммррүүү	
AHCCCS Provider Registration	License/Certification Number:		
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: ммррүүү	
AHCCCS Provider Registration	License/Certification Number:		
Issuing Agency:	Effective Date: ммррүүүү	Expiration Date: ммррүүү	

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
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 ммррүүү	End Date ммрруууу
Home address for Individual or business addre	ess 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
С	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-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

No
Self, Spouse If yes, list names and relationship.

SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc
	Director	Self	Employee
	SSN/EIN/TIN	SSN/EIN/TIN Type	Type Relation to (name)



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			
	Response: 1g.	☐ Yes	■No
Owner Name Jonathan Nez	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
	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
If additional space is needed see Appendit actions.	x E. Supporting documentation	n is requi	red for all adverse



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: ммррүүү			

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.

	TION XII	om r rouse do not man in eneck payments a				
	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.			
	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:				

Provider SSN/EIN/TIN: 86-0092335

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



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, 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 recordkeeping 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 noncompliance 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.



DATE

Provider Enrollment Form

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)



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 informatio	n.				
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.*								
	e business hours oplicable.	of operation.	State "close	d" on days the b	ousiness is clo	sed. Select A	M or PM	
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM	
	□РМ	□РМ	\Box PM	□РМ	□РМ	\Box PM	\Box PM	
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM	
	□РМ	□РМ	\Box PM	□PM	□РМ	□PM	□PM	
Languag	Language(s) Spoken □ English □ Spanish □ Arabic □ Cantonese □ Chinese □ Navajo □ Farsi							
	□Native American □Mandarin □Korean □French							
Other(s)	Other(s) (specify):							



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	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммррүүүү	Start Date: ммррууу	
End Date: ммррүүүү	End Date: ммррууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: ммррууу	
End Date: ммррууу	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date:ммррууу	Start Date: ммddyyyy	
End Date: ммрруууу	End Date: ммррууу	





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	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n 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	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n Number:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification	n 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.

SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner
	SSN/EIN/TIN		





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.
SSN/EIN/TIN	Response: 2. ☐ Yes ☐ No
	Response: 3.
	Response: 4.
O N	Response: 1g.
Owner Name	
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
33.1/21.1/	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.





Appendix F

Type Identifier (NPI)		Enrollment Fee	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
В3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
В6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
В7	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 (FOHC)	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

Provider Type			Enrollment Fee	ent Site Visi	
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

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





	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	





SPECIALTY CODES MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08) AND D.O.'S (PT 31)			
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





072 OTHER MICROBIOLOGY 441 SI 073 OTHER IMMUNOHEMATOLOGY 450 M 074 HISTOPATHOLOGY 460 P 077 HOMEOPATHIC 464 B 078 ELECTROPHYSIOLOGY 490 II 093 REPRODUCTIVE ENDOCRINOLOGIST 524 U	DESCRIPTION SURGERY - OPTHALMOLOGICAL MYCOLOGY PARASITOLOGY BLOOD GROUPING/RH TYPING MMUNOHEMATOLOGY JRINALYSIS HISTOCOMPATABILITY PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS AUDIOLOGIST
072 OTHER MICROBIOLOGY 441 St 073 OTHER IMMUNOHEMATOLOGY 450 M 074 HISTOPATHOLOGY 460 P 077 HOMEOPATHIC 464 B 078 ELECTROPHYSIOLOGY 490 II 093 REPRODUCTIVE ENDOCRINOLOGIST 524 U	SURGERY - OPTHALMOLOGICAL MYCOLOGY PARASITOLOGY BLOOD GROUPING/RH TYPING MMUNOHEMATOLOGY JRINALYSIS HISTOCOMPATABILITY PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS
073 OTHER IMMUNOHEMATOLOGY 450 M 074 HISTOPATHOLOGY 460 P 077 HOMEOPATHIC 464 B 078 ELECTROPHYSIOLOGY 490 II 093 REPRODUCTIVE ENDOCRINOLOGIST 524 U	MYCOLOGY PARASITOLOGY BLOOD GROUPING/RH TYPING MMUNOHEMATOLOGY JRINALYSIS HISTOCOMPATABILITY PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS
074 HISTOPATHOLOGY 460 P 077 HOMEOPATHIC 464 B 078 ELECTROPHYSIOLOGY 490 IN 093 REPRODUCTIVE ENDOCRINOLOGIST 524 U	PARASITOLOGY BLOOD GROUPING/RH TYPING MMUNOHEMATOLOGY JRINALYSIS HISTOCOMPATABILITY PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS
077HOMEOPATHIC464B078ELECTROPHYSIOLOGY490II093REPRODUCTIVE ENDOCRINOLOGIST524U	BLOOD GROUPING/RH TYPING MMUNOHEMATOLOGY JRINALYSIS HISTOCOMPATABILITY PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS
078ELECTROPHYSIOLOGY490II093REPRODUCTIVE ENDOCRINOLOGIST524U	MMUNOHEMATOLOGY JRINALYSIS HISTOCOMPATABILITY PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS
093 REPRODUCTIVE ENDOCRINOLOGIST 524 U	JRINALYSIS HISTOCOMPATABILITY PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS
	HISTOCOMPATABILITY PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS
122 LARYNGOLOGIST 574 H	PEDIATRIC- BEHAVIORAL/DEVELOPMENTAL DIALYSIS
122 Distributed of the state	BEHAVIORAL/DEVELOPMENTAL DIALYSIS
124 OTOLOGIST 880 P	DIALYSIS
В	
	AUDIOLOGIST
	PEDIATRIC ORTHOPEDIST
	ADDICTION MEDICINE
	ANATOMIC PATHOLOGY
157 PEDIATRIC ALLERGIST 953 B	BRONCHO-ESOPHAGOLOGY
158 RADIOLOGY PEDIATRIC 954 C	CHEMICAL DEPENDENCY
176 ADOLESCENT MEDICINE 955 C	CHEMICAL PATHOLOGY
	DIABETES
	DIAGNOSTIC LABORATORY MMUNOLOGY
183 OCCUPATIONAL MEDICINE 958 G	GYNECOLOGICAL ONCOLOGY
187 NUTRITIONIST 959 IN	MMUNOPATHOLOGY
188 PHARMACOLOGIST 960 L	LEGAL MEDICINE
189 PSYCHOSOMATIC MEDICINE 961 N	NEOPLASTIC DISEASES
	PEDIATRIC HEMATOLOGY-
	DNCOLOGY RETIRED
216 SURGERY-TRAUMA 968 R	RADIOLOGY, ONCOLOGY
400 MICROBIOLOGY 976 St	SCLEROTHERAPY
410 BACTERIOLOGY 999 O	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)		





	SPECIALTY CODES - REGISTERED	NURSE PR	ACTITIONER 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	REGISTERE	ED NURSE CATEGORIES
	NURSE -MIDWIFE (PT 09)	CERTIF	IED REGISTERED NURSE ANESTHETIST (PT 12)
CODE	DESCRIPTION	CODE	DESCRIPTION
094	REGISTERED NURSE MIDWIFE	020	ANESTHESIOLOGIST
	PODIATRIST CODES (PT 10)	1 7	DENTISTRY CODES (PT 07)
CODE	DESCRIPTION	CODE	DESCRIPTION
650	PODIATRIST	484	SURGERY
	DENTISTR	Y 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-PHYSI	CIAN CATEGORIES
	LABORATORY SP	ECIALTY CO	DDES (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	RHTITERS
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)



	SPECIALTY CODES FOR NO	N-PHYSI	ICIAN 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	Y SPECIA	LIST			
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 CO	OUNT IN	FORMATION			
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

Ø	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
1	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
1	Section XI Add Taxonomy	All
1	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
П	Appendix B – Associate Billing Provider/Other Associations	AII
	Appendix C - Additional License/Certification/Other	All
	Appendix D - Additional Owner(s)	All
	Appendix E - Additional Adverse Actions	All
\Box	Appendix F – Provider Type Codes	All
П	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									





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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
С	Corporation

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

Mail: Fax:

AHCCCS Provider Enrollment

P.O. Box 25520, Mail Drop 8100 Attn: AHCCCS Provider
Phoenix, AZ 85002 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: <u>86-0092335</u>
Be sure to include this identification at the bottom of each page



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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
\checkmark	Add SSN/EIN/TIN to the bottom of each page	All
1	National Provider Identification (NPI)	Group, FAO, Individual
П	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
V	Pay to details	All
V	Correspondence address	All
V	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
1	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 \boxtimes .
- If you select the enrollment type, Contractor/MCO or Atypical, you <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I		
Select One _Applicable Req	uest Type.*	
New Enrollment		r Modification
Complete only if you are	currently registered and have	a Provider Number or Provider AHCCCS ID. *
Provider Number/AHCC	CCS ID:	□N/A
If you do not have an NF	PI, select the N/A box $oxtimes$ and sel	ect 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	☐ Rendering Servicing	☐ Atypical (non-medical) provider
Proprietor	Provider	Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
SECTION I-B		
☐Group Practice	■ Facility/Agency	☐ Atypical (non-medical) provider
(Corporation,	Organization (FAO-Hospital,	Agency (Child Care Institution, Home
Partnership, LLC, etc.)	Nursing Facility, Various	Help/Personal Care Agency, Transportation
	Entities)	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
В	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 or First Name*A	n enrollment type, using the Category Middle Initial N/A	Last Name*A
Trist Name 11	Middle inicial Ellym	East Name 11
Suffix*A	Gender*A	SSN*A
Date of Birth*A ммрруууу	Legal Entity Name*A&B	Entity Business Name (Doing Business
	Navajo Nation/DBMHS	As)*A&B Newland Outpatient Treatment Center
Home Address*A	City*A	State*A
EIN/TIN*A&B	Requested enrollment effective begin date *A&B MMDDYYYY	Zip Code*A
86-0092335	7/1/2020	
W-9 Entity Type*A&B	Profit Type*A&B	Tribal Type *A&B
- H 1 500	\square 501(C)(3) NON-PROFIT	□N/A
Tribal 638	☐For Profit Closely Held	□Indian Health Service
	☐ For Profit, Publicly Traded	□Privately Owned on Tribal
You must also attach completed	Other Tribal 638	Land
W-9 form. This can be found at IRS.GOV	□N/A – The individual only practices as part of a group	■Tribally Owned on Tribal Land

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 1/4 Miles South of Sanders Hig	*A&B gh School, Shondiin Street Bldg #6909	End Date*A&B ммрруууу 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.

	e busines		of op	eration.	Stat	e "close	d" on c	lays the l	busine	ess is clo	sed.	Select A	M or PM
	Sun	day	Мо	onday	Tu	esday	Wed	nesday	Thu	ırsday	Fr	riday	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
Languag	e(s) Spol		Engli:	sh 🗆 S ve Amer	pani ican		rabic ndarin	□ Canto		□ Chii □ Frei		■Nav	ajo □Farsi
Other(s)	(specify)):									□На	ndicap	Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	End Date ммррууу	
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 \boxtimes .
- 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 ммррүүү Current
Address Line 1*A&B PO Box 709	Address Line 2 = N/A	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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	
1. Bit outputent chine (77)	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	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммррүүү:*	Start Date MMDDYYYY:*	
End Date ммррүүүү:*	End Date MMDDYYYY:*	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:	
End Date ммррүүүү:*	End Date ммррүүүү:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date ммррүүүү:*	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: ммррүүү	Expiration Date: ммррүүү	
AHCCCS Provider Registration	License/Certification Number:		
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: ммррүүүү	
AHCCCS Provider Registration	License/Certification Number:		
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: ммррүүү	

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*1&C 86-0092335	EIN/TIN*C 86-0092335		
Legal Entity Name Navajo Nation	Entity Business Name Navajo Division of Behavioral and		
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 ммррууу	End Date MMDDYYYY		
Home address for Individual or business address	ss 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	
l	Individual	
С	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-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

Response: 1g.	☐ Yes	■No
Response: 2.	☐ Yes	■No
Response: 3.	☐ Yes	■No
Response: 4.	☐ Yes	■No
Response: 1g.	☐ Yes	■No
Response: 2.	☐ Yes	■No
Response: 3.	☐ Yes	■No
Response: 4.	☐ Yes	■No
	Response: 2. Response: 3. Response: 4. Response: 1g. Response: 2. Response: 3.	Response: 2.



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: ммррүүү

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.

SEC	TION XII			
	Options	Description		
√	Pay Fee	Select this option in order to pay fee to Al received via correspondence or if there is pay the fee in the payment gateway using https://www.azahcccs.gov/PlansProviders/Confirmation #	an existing AHCCCS Provider ID, please the following link:	
	Fee Paid to Medicare	Select this option if you have paid the enr Services This is subject to federal and state Confirmation #		
	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			
	AHCCCS Prior Payment	Select this option if you have paid the fee from the current date for a related provid Confirmation #		



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 opportunabide by all the terms and conditions set forth in this A	•
 ■ The undersigned attests that he/she is an authority to sign and submit this agreement and ha indicated below. □ I affirm under penalty of law that the information complete to the best of my knowledge. □ I understand that I must notify AHCCCS, Provide arrangements 30 days in advance. Notification must in □ I have read, understand, and agree to abide by all the 	s entered into an agreement effective on the date. I have provided on this form is true, accurate and referred the Registration of any changes to the group billing acclude the effective date of change.
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 recordkeeping 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.



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- 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 noncompliance 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)

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

Location	Specific Inform	nation for Pri	imary Pract	ice Location is	required.*		
	business hours pplicable.	of operation.	State "close	d" on days the b	ousiness is clo	sed. Select Al	M or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	\square PM	□РМ	\square PM	□РМ	\Box PM
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	\Box PM	□РМ	□PM	□PM	□PM
Languag	e(s) Spoken 🗆	English 🗆 S	panish \square A	rabic 🗆 Canto	nese 🗆 Chir	nese 🗆 Nava	ajo □Farsi
		Native Amer	ican \square Ma	ndarin \square Kor	ean □Frer	nch	
Other(s)	(specify):					☐ Handicap A	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	□AHCCCS ID or □NPI	
ID	ID	
D. II. N	D M	
Provider Name:		
Start Date: ммррууу	Start Date: MMDDYYYY	
End Date: ммрруууу	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: MMDDYYYY	
End Date: ммрруууу	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:		
Start Date: MMDDYYYY	Start Date: MMDDYYYY	
End Date: ммрруууу	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 Nur	mber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	mber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	mber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	nber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	nber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	nber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	nber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	nber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	mber:
Issuing agency:	Effective Date:	Expiration Date:
AHCCCS Provider Registration	License/Certification Nur	nber:
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.

SSN*	
Last Name*	
DOB*	-
Email	
End Date	
Address Line 2	
City/Town*	
County*	
Zip Code*	
	Last Name* DOB* Email End Date Address Line 2 City/Town* County*

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





Appendix F

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
В3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
В6	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

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

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				





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		





	SPE	CIALTY CODI	ES	
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-	
			BEHAVIORAL/DEVELOPMENTAL	
136	FORENSIC PATHOLOGY	913	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	DESCRIPTION			
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY		
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)		





	SPECIALTY CODES - REGISTERED	NURSE PR	ACTITIONER 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	REGISTER	ED NURSE CATEGORIES
	NURSE -MIDWIFE (PT 09)	CERTIF	IED 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
	DENTISTR	Y 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-PHYSI	CIAN CATEGORIES
-	LABORATORY SPI	ECIALTY CO	DES (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)



	SPECIALTY CODES FOR NO	N-PHYSI	CIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
	PATHOLOGY	Y SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	DUNT INI	FORMATION
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 Description	Enrollment Type		
1	SSN/EIN/TIN is at the bottom of each page	this applies to All		
	Section I Enrollment Type , I-A, I-B	All		
H	Section II Basic Provider information – Be sure to Attach W-9 Form from IRS	All		
H	Section III Primary Practice location - Be sure to use Addendum A for additional locations	All		
V	Section IV Pay To information	All		
1	Section V Correspondence Address	All		
V	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		
V	Section XI Add Taxonomy	All		
V	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		
Ħ	Appendix C - Additional License/Certification/Other	All		
	Appendix D - Additional Owner(s)	All		
Ħ	Appendix E - Additional Adverse Actions	All		
	Appendix F - Provider Type Codes	All		
	Appendix G – Provider Type Specialty Codes			

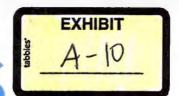
Provider SSN/EIN/TIN: 86-0092335
Be sure to include this identification at the bottom of each page

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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			





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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description	
I	Individual	
С	Corporation	

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

Mail: Fax:

AHCCCS Provider Enrollment

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

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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
\checkmark	Add SSN/EIN/TIN to the bottom of each page	All
V	National Provider Identification (NPI)	Group, FAO, Individual
П	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
1	Practice address details & hours of operation	All
V	Pay to details	All
√	Correspondence address	All
1	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)
П	Bed unit information, if applicable.	FAO and Atypical Agency only
V	Controlling interest/ownership details, managing employee, and owner relationship	All
1	Owners Adverse action(s) information	All
V	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 <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I	50-10-			
Select One _Applicable Req	uest Type.*			
New Enrollment	□ Revalidation □ Provider Modification *List section numbers modified			
Complete only if you are	currently registere	d and have a	a Provider Number or Provider AHCCCS ID. *	
Provider Number/AHCC	CCS ID:		□N/A	
If you do not have an NF	PI, select the N/A bo	x 🛭 and sel	ect Atypical Agency for the enrollment type.	
NPI: 1588925788	* · · · · · · · · · · · · · · · · · · ·		□N/A	
Select One Enrollment	Type (and Subtype	f applicable) from either section I-A or I-B.	
SECTION I-A				
□Individual/Sole	☐ Rendering S	Servicing	☐ Atypical (non-medical) provider	
Proprietor	Provider		Individual (Driver, Home Help/Personal	
			Care, Carpenter, etc.)	
SECTION I-B				
☐ Group Practice	Facility/Agency	,	☐ Atypical (non-medical) provider	
(Corporation,	Organization (FAO-Hospital,		Agency (Child Care Institution, Home	
Partnership, LLC, etc.)	Nursing Facility, V	arious	Help/Personal Care Agency, Transportation	
	Entities)		Company, Local Education Agency etc.)	
□Contractor/MCO	Sub Type:			
	☐ Correctional Fa		☐ Department of Economic Security	
	Tribal Behavior	al Health	☐ Managed Care Organization	

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ммррууу	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Gallup Outpatient Treatment Center
Home Address*A	City*A	State*A
300 WEST NIZHONI BLVD.SUITI	Gallup	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	Profit Type*A&B □501(C)(3) NON-PROFIT	Tribal Type *A&B ■N/A
Tribal 638	□For Profit Closely Held	□Indian Health Service
You must also attach completed W-9 form. This can be found at IRS.GOV	□For Profit, Publicly Traded ■Other <u>Tribal 638</u> □N/A – The individual only practices as part of a group	□ Privately Owned on Tribal Land □ Tribally Owned on Tribal Land

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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& 300 WEST NIZHONI BLVD.SUITE	B A	End Date*A&B ммррүүүү 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.*													
	e busines oplicable		of op	eration.	Stat	e "close	d" on c	lays the l	ousine	ess is clo	sed.	Select A	M or PM
	Sun	day	Мо	onday	Tu	esday	Wed	nesday	Thu	ırsday	Fr	riday	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)):				100					□На	ndicap	Accessible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ммррүүү
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 Add ☐ Same as Primary		Phone Number* (928)871-6235	Fax Number (928)871-6456	
Method of Communic Only select 1 option ■Email	ation*A&B Standard Mail	Email Address*A&B arceniocharleston@navajo-nsn.gov		End Date ммррүүүү Current
Address Line 1*A&B PO Box 709	Address Line 2 = N/A	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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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	
1. 211 Cuspation Chino (11)	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	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммрруучу:*	Start Date MMDDYYYY:*	
End Date MMDDYYYY:*	End Date ммррүүүү:*	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммррүүүү:*	Start Date ммрруууу:	
End Date ммррүүүү:*	End Date MMDDYYYY:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*		
Start Date ммррүүүү:*	Start Date MMDDYYYY:*	
End 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 Nu	mber:	
Issuing Agency:	Effective Date: ммррүүүү	Expiration Date: ммррүүү	
AHCCCS Provider Registration	License/Certification Number:		
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: ммррүүү	
AHCCCS Provider Registration	License/Certification Nur	mber:	
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: ммррүүү	

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			
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 ммррууу	End Date ммррүүү			
Home address for Individual or business addre	ss 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		
С	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.

SSN*
Last Name* Brandser
DOB*
Email mbrandser@navajo-nsn.gov
End Date
Address Line 2
City/Town* Window Rock
County* Apache
Zip Code* 86515

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, 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			
	Response: 1g.	☐ Yes	■No
Owner Name Jonathan Nez	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
	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
If additional space is needed see Append actions.	ix E. Supporting documentation	on is requi	red for all adverse



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: ммррүүү			

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.

SEC	TION XII	ioni i rouse de not man in encen payments a			
	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 W A "Hardship Letter" must be written and s continue submitting the enrollment applicable subject to federal and state approval.			
	AHCCCS Prior Payment	Select this option if you have paid the fee from the current date for a related provid Confirmation #			



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, 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 opportuabide by all the terms and conditions set forth in this	nity to review this Agreement with counsel, agree to Agreement.
authority to sign and submit this agreement and hindicated below. ☐ I affirm under penalty of law that the information complete to the best of my knowledge. ☐ I understand that I must notify AHCCCS, Provide arrangements 30 days in advance. Notification must	thorized representative of the enrolling entity, has as entered into an agreement effective on the date on I have provided on this form is true, accurate and ler Registration of any changes to the group billing include the effective date of change. 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 recordkeeping 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 noncompliance 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.
\Box 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.
\square 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 informatio	n.				
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	□AM	□AM	□АМ	□AM	□AM	□AM		
-	□РМ	□РМ	□РМ	\Box PM	□РМ	□РМ	□PM		
Close	□AM	□АМ	□AM	□АМ	□AM	□AM	□AM		
	□РМ	□РМ	□РМ	□РМ	\Box PM	□РМ	□РМ		
Language(s) Spoken □ English □ Spanish □ Arabic □ Cantonese □ Chinese □ Navajo □ Farsi									
□ Native American □ Mandarin □ Korean □ French									
Other(s) (specify):									





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	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммррууу	Start Date: ммррууу	
End Date: ммррүүү	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: ммрруууу	
End Date: ммрруууу	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date:ммрруууу	Start Date: ммрруууу	
End Date: ммррүүү	End Date: ммрруууу	





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
	Response: 2.	□ Yes	□No
SSN/EIN/TIN	Response: 3.	□ Yes	□No
	Response: 4.	□ Yes	□No
	1		
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

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
В3	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	BC BOARD CERTIFIED BEHAVIOR ANALYST (BCBA) Y		N	N
C2	FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
C4	C4 SPECIALTY PER DIEM HOSPITAL Y		N	N
C5	638 FEDERALLY QUALIFIED HEALTH CENTER (FQHC)	Y	Y	N
El	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

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			N	N
22			Y	N
23	HOME HEALTH AGENCY	Y	Y	Y
25	GROUP HOME (DEVELOPMENTAL	N	N	N
27	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

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 78 MENTAL HEALTH RESIDENTIAL TREATMENT Y CENTER		Y	Y	Y
		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





	SPEC	IALTY CODI	ES	
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	





	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		





	SPE	CIALTY CODI	ES
	MEDICAL SPECIAL	TY CODES FO	R 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-
			BEHAVIORAL/DEVELOPMENTAL
136	FORENSIC PATHOLOGY	913	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)		





	SPECIALTY CODES - REGISTER	ED NURSE PR	ACTITIONER 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 - OTH	ER REGISTERE	ED NURSE CATEGORIES
NURSE -MIDWIFE (PT 09)			IED 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
	DENTIS	TRY 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 FO	OR NON-PHYSI	CIAN CATEGORIES
	LABORATORY	SPECIALTY CO	DES (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)



	SPECIALTY CODES FOR NO	N-PHYSI	CIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
	PATHOLOGY	Y SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	OUNT INI	FORMATION
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
V	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

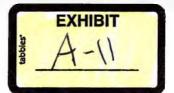
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Enrollment Checklist/Questionnaire			
Question	Answer	Comments	
Do you need to request a Retroactive or Future	□Yes ■No		
Enrollment Date? If Yes, enter the requested date in			
the comment field to be considered.			
Do you wish to end date your enrollment? If yes,	□Yes ■No		
enter date in comment field.			
Are you currently excluded from any Arizona or	□Yes ■No		
other state program? If yes, provide state of			
exclusion and program in comment field.			
Are you currently excluded from any federal	□Yes ■No		
program? If yes, provide the program and date in			
comment field.		***	
Have you ever had a criminal or healthcare program-	□Yes ■No		
related conviction? If yes, provide type of conviction			
and date in comment field.			
Have you ever had a judgment under any false claims	□Yes ■ No		
act? If yes, list judgment and date in comments field.			
Have you been enrolled by another State's Medicaid	□Yes ■No		
Program. If yes, provide each state and effective date			
of enrollment in comments field.			
Have you ever had a program exclusion/debarment?	□Yes ■No		
If yes, provide program and date in comments field.			
Have you ever had civil monetary penalty? If yes,	□Yes ■No		
provide penalty type and date. If yes, please specify			
federal or state in comments field.			
Are you trying to reactivate a provider previously	□Yes ■No		
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.			
Do you have 5% or more ownership interest in other	□Yes ■No		
entities reimbursable by Medicaid and/or Medicare?			
If Yes, provide details in "Add Ownership Details"			
step.			
Have you had any malpractice settlement, judgment,	□Yes □No	?	
or agreement? If yes, provide dollar amount and			
dates in comments field.	□Yes ■No		
Are you applying as a Private Duty Nurse (LPN/RN)	□ res ■No		
for private duty services? If this enrollment is for a change of ownership	□Yes ■No		
(CHOW) for an existing provider with a new name,	□ IE2 ■ NO		
NPI, or Tax ID, please add the previous information			
in the comment box.			

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





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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
С	Corporation

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

Mail: Fax:

AHCCCS Provider Enrollment

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



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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		
\checkmark	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		
V	Practice address details & hours of operation	All		
✓	Pay to details	All		
V	Correspondence address	All		
V	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)		
П	Bed unit information, if applicable.	FAO and Atypical Agency only		
V	Controlling interest/ownership details, managing employee, and owner relationship	All		
V	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 \boxtimes .
- If you select the enrollment type, Contractor/MCO or Atypical, you <u>must also select one subcategory</u> from the list below these enrollment types.

*List section rently registered and have ID: elect the N/A box 🗵 and se	er Modification n numbers modified a Provider Number or Provider AHCCCS ID. * □N/A lect Atypical Agency for the enrollment type. □N/A
*List section rently registered and have ID: elect the N/A box 🗵 and se	a Provider Number or Provider AHCCCS ID. * □N/A lect Atypical Agency for the enrollment type.
ID:elect the N/A box ⊠ and se	□ N/A lect Atypical Agency for the enrollment type.
elect the N/A box ⊠ and se	lect Atypical Agency for the enrollment type.
A-C-0	□N/A
e (and Subtype if applicable	e) from either section I-A or I-B.
☐ Rendering Servicing	☐Atypical (non-medical) provider
Provider	Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
Facility/Agency	☐ Atypical (non-medical) provider
	Agency (Child Care Institution, Home
	Help/Personal Care Agency, Transportation
ntities)	Company, Local Education Agency etc.)
ıb Type:	
Correctional Facilities	☐ Department of Economic Security
Tribal Behavioral Health	☐ Managed Care Organization
	Rendering Servicing Provider Facility/Agency rganization (FAO-Hospital, ursing Facility, Various ntities) b Type: Correctional Facilities

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ммддүүү	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Chinle Adult Residential Treatment
Home Address*A	City*A	State*A
PO BOX 777	Chinle	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	Profit Type*A&B □501(C)(3) NON-PROFIT	Tribal Type *A&B □N/A
Tribal 638	☐For Profit Closely Held	□Indian Health Service
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other <u>Tribal 638</u> ☐ N/A – The individual only practices as part of a group	□Privately Owned on Tribal Land ■Tribally Owned on Tribal Land

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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&I NAVAJO ROUTE 7, DUPLEX UNIT		End Date*A&B ммрруууу 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.

Locatio	on Specif	ic Inforn	nation	for Pr	imary Prac	tice Loc	ation is	requi	ired.*			**	
	ne busine applicable		of ope	ration.	State "close	ed" on d	ays the l	busine	ss is clo	sed. S	elect A	M or P	M
	Sur	nday	Moi	nday	Tuesday	Wedr	esday	Thu	rsday	Fri	day	Satu	ırday
Open	12:00	■AM □PM	12:00	■AM □PM	12:0(■AM	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	11:55 □ AM	11:59	□AM ■PM	11:59	□AM ■PM	11:59	□AM ■PM	11:59	□AM ■PM
Langua	ge(s) Spo		Englis Nativ	h □ S e Amer		Arabic Indarin	□ Canto		□ Chi		■Nav	ajo [∃Farsi
Other(s	s) (specify	/):					-		_	□На	ndicap	Access	ible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ммрруууу 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 \boxtimes .
- 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 Addı □Same as Primary Pı		Phone Number*A (928)871-6235	Fax Number (928)871-6456 End Date ммрруууу Current	
Method of Communic Only select 1 option ■Email	ation*A&B Standard Mail	Email Address*A&B arceniocharleston@navajo-nsn.gov		
Address Line 1*A&B PO Box 709	Address Line 2 N/A	À	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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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
Residential Treatment Center - 1	1	
1. Teordoniai Trodunon Contor 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	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date MMDDYYYY:*	End Date ммрруучу:*	
□AHCCCS ID or □NPl	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:	
End Date ммррүүүү:*	End Date MMDDYYYY:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date ммрруучу:*	End Date ммррүүү:*	

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 Nu	mber:	
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: ммррүүү	
AHCCCS Provider Registration	License/Certification Number:		
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: ммррүүүү	
AHCCCS Provider Registration	License/Certification Nu	mber:	
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: ммррүүү	

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	
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 ммррууу	End Date MMDDYYYY	
Home address for Individual or business addre	ss 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	Key Description	
I	Individual	
С	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-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

AHCCCS Arizona Health Care Cost Containment System

Provider Enrollment Form

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			
0	Response: 1g.	☐ Yes	■No
Owner Name Jonathan Nez	Response: 2.	☐ Yes	■No
CONTENT OF THE PROPERTY OF THE	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
O	Response: 1g.	☐ Yes	■No
Owner Name Myron Lizer	Response: 2.	☐ Yes	■No
	Response: 3.	☐ Yes	■No
SSN/EIN/TIN 86-0092335	Response: 4.	☐ Yes	■No
If additional space is needed see Appendi actions.	x E. Supporting documentation	n is requi	red for all adverse



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: Substa	nce Abuse Rehabilitation Facil	Description: BHRF - Non secured	
Start Date: ммрруучу*	10/19/2020	End Date: ммррууу	

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.

SEC	TION 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: Confirmation #	Date: 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:		

Provider SSN/EIN/TIN: 86-0092335

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



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, 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 recordkeeping 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 noncompliance 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.

Provider SSN/EIN/TIN: 86-0092335

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



DATE

Provider Enrollment Form

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)



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								
(*) are required information	n.							
	End Date							
Address Line 2	Address Line 3							
State/Province*	County*							
Zip Code*								
	Address Line 2 State/Province*	Address Line 2 Address Line 3 State/Province* County*						

Location Specific Information for Primary Practice Location is required.*									
	e business hours opplicable.	of operation.	State "close	d" on days the b	ousiness is clo	sed. Select A	M or PM		
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday		
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM		
	□РМ	□РМ	\square PM	□PM	□PM	□PM	□PM		
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM		
	□РМ	□РМ	□РМ	□РМ	□PM	□PM	□PM		
Language(s) Spoken □ English □ Spanish □ Arabic □ Cantonese □ Chinese □ Navajo □ Farsi									
		Native Amer	ican \square Ma	ndarin \square Kor	ean \square Fren	nch			
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	□AHCCCS ID or □NPI	
ID	ID	
	D	
Provider Name:		
Start Date: ммррүүүү	Start Date: ммррууу	
End Date: ммррүүүү	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: ммррууч	
End Date: MMDDYYYY	End Date: MMDDYYYY	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date:ммрруууу	Start Date: MMDDYYYY	
End Date: ммррүүү	End Date: ммррүүү	





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	n 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	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)?

 \square No \square 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.
	Response: 3. □ Yes □ No
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
	Response: 2.
SSN/EIN/TIN	Response: 3.
	Response: 4.
	Response: 4. 🗆 1es 🗀 No
Owner Name	Response: 1g. □ Yes □No
SSN/EIN/TIN	Response: 2.
2011/2111/111	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

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
В3	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

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

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



	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		





	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		





SPECIALTY CODES MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)				
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-	
			BEHAVIORAL/DEVELOPMENTAL	
136	FORENSIC PATHOLOGY	913	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)		





	SPECIALTY CODES - REGISTERI	ED NURSE PR	ACTITIONER 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 - OTHE	R REGISTER	ED NURSE CATEGORIES
	NURSE -MIDWIFE (PT 09)	CERTIF	IED 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
	DENTIST	RY 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 FO	R NON-PHYSI	CIAN CATEGORIES
	LABORATORY S	PECIALTY CO	DES (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)



	SPECIALTY CODES FOR NO	N-PHYSI	CIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
	PATHOLOG	Y SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	DUNT INI	FORMATION
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

	Passintian	Enrollment Type
	Description	this applies to
\checkmark	SSN/EIN/TIN is at the bottom of each page	All
\checkmark	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
V	Section V Correspondence Address	All
V	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
V	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
1	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

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



Enrollment Checklis	st/Questionnai	re
Question	Answer	Comments
Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in	□Yes ■No	
the comment field to be considered.		
Do you wish to end date your enrollment? If yes,	□Yes ■No	
enter date in comment field.	les ENO	
Are you currently excluded from any Arizona or	□Yes ■No	
other state program? If yes, provide state of		
exclusion and program in comment field.		
Are you currently excluded from any federal	□Yes ■No	
program? If yes, provide the program and date in comment field.		
Have you ever had a criminal or healthcare program-	□Yes ■No	
related conviction? If yes, provide type of conviction		
and date in comment field.		
Have you ever had a judgment under any false claims	□Yes ■No	
act? If yes, list judgment and date in comments field.		
Have you been enrolled by another State's Medicaid	□Yes ■No	
Program. If yes, provide each state and effective date		
of enrollment in comments field.		
Have you ever had a program exclusion/debarment?	□Yes ■No	
If yes, provide program and date in comments field.		
Have you ever had civil monetary penalty? If yes,	□Yes ■No	
provide penalty type and date. If yes, please specify		
federal or state in comments field.		
Are you trying to reactivate a provider previously	□Yes ■No	
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.		
Do you have 5% or more ownership interest in other	□Yes ■No	10
entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details"		
Have you had any malpractice settlement, judgment,	□Yes □No	_
or agreement? If yes, provide dollar amount and	Lies Livo	?
dates in comments field.		
Are you applying as a Private Duty Nurse (LPN/RN)	□Yes ■No	
for private duty services?		
If this enrollment is for a change of ownership	□Yes ■No	
(CHOW) for an existing provider with a new name,		
NPI, or Tax ID, please add the previous information		
in the comment box.		





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
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
С	Corporation

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

Mail: Fax:

AHCCCS Provider Enrollment

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

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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
V	Add SSN/EIN/TIN to the bottom of each page	All
V	National Provider Identification (NPI)	Group, FAO, Individual
	AHCCCS ID (if applicable)	All
V	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
V	Practice address details & hours of operation	All
V	Pay to details	All
V	Correspondence address	All
1	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)
П	Bed unit information, if applicable.	FAO and Atypical Agency only
V	Controlling interest/ownership details, managing employee, and owner relationship	All
1	Owners Adverse action(s) information	All
V	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

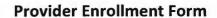


Enrollment Type

- 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 \boxtimes .
- If you select the enrollment type, Contractor/MCO or Atypical, you <u>must also select one subcategory</u> from the list below these enrollment types.

SECTION I	-	_			
Select One _Applicable Requ	uest Type.*				
■New Enrollment	☐ Revalidation ☐ Provider Modification *List section numbers modified				
Complete only if you are	currently registered an	d have a	Provider Number or Provider AHCCCS ID. *		
Provider Number/AHCC	CS ID:		□N/A		
If you do not have an NP	I, select the N/A box 🗵	and sele	ect Atypical Agency for the enrollment type.		
NPI: 1366040818		[□N/A		
Select One Enrollment 7	Type (and Subtype if ap	plicable)	from either section I-A or I-B.		
SECTION I-A					
□Individual/Sole	☐ Rendering Servi	icing	☐Atypical (non-medical) provider		
Proprietor	Provider		Individual (Driver, Home Help/Personal Care, Carpenter, etc.)		
SECTION I-B					
☐ Group Practice	■Facility/Agency		☐ Atypical (non-medical) provider		
(Corporation,	Organization (FAO-Ho	spital,	Agency (Child Care Institution, Home		
Partnership, LLC, etc.)	Nursing Facility, Vario	us	Help/Personal Care Agency, Transportation		
	Entities)		Company, Local Education Agency etc.)		
□Contractor/MCO	Sub Type:				
	☐ Correctional Faciliti	ies	☐ Department of Economic Security		
	■Tribal Behavioral H	ealth	☐ Managed Care Organization		

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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.

First Name*A	n enrollment type, using the Category Middle Initial N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A ммррууч	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Navajo Regional Behavioral Health (
Home Address*A	City*A	State*A
PO Box 1830	Shiprock	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	Profit Type*A&B	Tribal Type *A&B
Tribal 638	□501(C)(3) NON-PROFIT □For Profit Closely Held	□N/A □Indian Health Service
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit, Publicly Traded ☐ Other <u>Tribal 638</u> ☐ N/A – The individual only practices as part of a group	□ Privately Owned on Tribal Land ■ Tribally Owned on Tribal Land

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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' PINON & COTTONWOOD DR		End Date*A&B ммррүүүү 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.

Locatio	on Specifi	ic Inforn	nation fo	r Prima	ry Prac	tice Loc	ation is	requi	red.*				
	ne busine applicable		of operat	ion. Sta	te "close	ed" on da	ays the l	busine	ss is clo	sed. S	elect A	M or F	M
	Sur	nday	Monda	y Tı	ıesday	Wedn	esday	Thu	rsday	Fri	day	Sati	urday
Open	12:00	■AM □PM	12:00	117.0	AM □PM	12:00	■AM □PM	12:00	■AM □PM	12:00	■AM □PM	12:00	■AM □PM
Close	11:59	□AM ■ PM	111.59	AM PM 11:	S □ AM ■ PM	11:59	□AM ■PM	11:59	□AM ■PM	11:59	□AM ■ PM	11:59	□AM ■PM
Langua	ge(s) Spo		English Native A	□ Span merican		Arabic Indarin	□Canto		□Chii □Frei		■Nav	ajo [□Farsi
Other(s	(specify	r):								□Hai	ndicap .	Access	sible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 \boxtimes .

SECTION IV		
Pay To Address*A&B ☐ Same as Primary Practice	Location	End Date ммррүүү
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 \boxtimes .
- 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 Addı □Same as Primary Pı		Phone Number*A8 (928)871-6235	Fax Number (928)871-6456 End Date ммрруууу Current	
Method of Communic Only select 1 option ■Email	ation*A&B Standard Mail	Email Address*A&B arceniocharleston@navajo-nsn.gov		
Address Line 1*A&B PO Box 709	Address Line 2 ■N/A	À	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
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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. Adult Substance Use RTC	
1. Residential Treatment Center 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	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммрруучу:*	Start Date MMDDYYYY:*	
End Date ммррүүүү:*	End Date ммрруучу:*	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммрруучу:*	Start Date MMDDYYYY:	
End Date ммрруучу:*	End Date mmddyyyy:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*		
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date ммрруучу:*	End Date MMDDYYYY:*	

Provider SSN/EIN/TIN: <u>86-0092335</u>
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 Nur	mber:
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: мморуууу
AHCCCS Provider Registration	License/Certification Nur	mber:
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: ммррүүү
AHCCCS Provider Registration	License/Certification Nur	mber:
Issuing Agency:	Effective Date: ммррүүү	Expiration Date: мморуууу

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
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 ммррууу	End Date ммррүүү
Home address for Individual or business address	ss 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
С	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.

SSN*	
Last Name* Brandser	
DOB*	
Email mbrandser@navajo-nsn.gov	
End Date	
Address Line 2	
City/Town* Window Rock	
County* Apache	
Zip Code* 86515	

Add Owners Relationship

Do any of the Owners have the following relationship (Daughter, Daughter-In Law, 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

AHCCCS Arizona Health Care Cost Containment System

Provider Enrollment Form

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;
 - 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

Response: 1g. Response: 2. Response: 3. Response: 4.	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes	■No ■No ■No
Response: 3.	☐ Yes	■No
Response: 4.	☐ Yes	■ No
Response: 1g.	☐ Yes	■No
Response: 2.	☐ Yes	■No
Response: 3.	☐ Yes	■No
Response: 4.	☐ Yes	■No
-1	Response: 2. Response: 3. Response: 4.	Response: 2. ☐ Yes Response: 3. ☐ Yes



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: Substa	nce Abuse Rehabilitation Facil	Description: BHRF - Non secured	
Start Date: ммррүүүү*	10/19/2020	End Date: ммррууу	

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.

SEC	TION 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:		

Provider SSN/EIN/TIN: 86-0092335

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



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 recordkeeping 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 noncompliance 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.



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.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to

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

Location	n Specific Inform	ation for Pri	imary Pract	ice Location is	required.*		
	e business hours oplicable.	of operation.	State "close	d" on days the b	ousiness is clo	sed. Select A	M or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM
-	□РМ	□РМ	\square PM	□РМ	□PM	□PM	□РМ
Close	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	\square PM	□РМ	□PM	□PM	□PM
Languag	e(s) Spoken 🗆 1	English \square S	panish \square A	rabic Canto	nese Chir	nese 🗆 Nav	ajo □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	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: ммрруууу	
End Date: ммррүүүү	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: ммрруууу	
End Date: ммррүүүү	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date:ммрруууу	Start Date: ммррууу	
End Date: ммррүүүү	End Date: ммрруууу	



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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	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	n Number:	
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification Number:		
Issuing agency:	Effective Date:	Expiration Date:	
AHCCCS Provider Registration	License/Certification	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)?

 \square No \square 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.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2. □ Yes □No
	Response: 3. □ Yes □No
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
SSIV BIN TIN	Response: 3. \(\subseteq \text{Yes} \text{No} \)
	Response: 4.
Owner Name	Response: 1g. □ Yes □No
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3. □ Yes □No
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4. \square Yes \square No





Appendix F

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
В3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
В6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
В7	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

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

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





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			





	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				





	SPE	CIALTY CODI	ES	
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-	
			BEHAVIORAL/DEVELOPMENTAL	
136	FORENSIC PATHOLOGY	913	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	
192 DIAGNOSTIC LABORATORY		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)					
081	NUCLEAR PHYSICS	161	OSTEOPATHIC MANIPULATIVE THERAPY		
973	PROCTOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)		





	SPECIALTY CODES - REGISTER			
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 - OTHI	ER REGISTERE	ED NURSE CATEGORIES	
	NURSE -MIDWIFE (PT 09)	CERTIF	ED 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	
	DENTIS	TRY 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 FO	OR NON-PHYSI	CIAN CATEGORIES	
	LABORATORY	SPECIALTY CO	DES (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		
511	ROUTINE CHEMISTRY	524		
550	RADIOBIOASSAY	574	HISTOCOMPATABILITY	
585	OTHER CLINICAL CHEMISTRY	900	PROCEDURES-ANY CERTIFIED LAB	
913	DIALYSIS	962	NUCLEAR RADIOLOGY	
968	RADIOLOGY, ONCOLOGY	975	ROENTGENOLOGY (DIAGNOSTIC)	



	SPECIALTY CODES FOR NO	N-PHYS	ICIAN 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
	RADIOLOGIS	T SPECIA	ALIST
CODE	DESCRIPTION	CODE	DESCRIPTION
080	NUCLEAR	200	RADIOLOGY
201	RADIOLOGY-DIAGNOSTIC	158	RADIOLOGY PEDIATRIC
205	RADIOLOGY-THERAPEUTIC		
	PATHOLOGY	Y SPECIA	LIST
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		
	MISCELLANEO	US SPEC	IALTIES
CODE	DESCRIPTION	CODE	DESCRIPTION
799	NO SPECIALTY REQUIRED	901	EMERGENCY ROOM PHYSICIANS
077	HOMEOPATHIC	714	EYE (LOW VISION SPECIALIST)
	SPECIALTY: BED CO	OUNT INI	FORMATION
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
V	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
V	Section IV Pay To information	All
1	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
1	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
V	Section XI Add Taxonomy	All
V	Section XII Fees	All
	Provider Participation Agreement or Group Biller Participation Agreement One of these Agreements must be signed and accompany all applications	All
一	Appendix A – Additional Service Locations	All
一	Appendix B - Associate Billing Provider/Other Associations	All
Ħ	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: <u>86-0092335</u>
Be sure to include this identification at the bottom of each page



Enrollment Checklis	st/Questionna	ire
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	





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
В	Group Practice, Contractor/MCO, Facility/Agency Organization(FAO), Atypical Agency

Category Key	Description
I	Individual
С	Corporation

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

Mail: Fax:

AHCCCS Provider Enrollment

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



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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
\checkmark	National Provider Identification (NPI)	Group, FAO, Individual
П	AHCCCS ID (if applicable)	All
V	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
V	Practice address details & hours of operation	All
V	Pay to details	All
V	Correspondence address	All
V	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
V	Controlling interest/ownership details, managing employee, and owner relationship	All
V	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 \boxtimes 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 \boxtimes .
- 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 Req	uest Type.*			
New Enrollment	☐ Revalidation ☐ Provider Modification *List section numbers modified			
Complete only if you are	currently registered a	ind have a	Provider Number or Provider AHCCCS ID. *	
Provider Number/AHCC	CS ID:		□N/A	
If you do not have an NF	PI, select the N/A box	☑ and sel	ect Atypical Agency for the enrollment type.	
NPI: 1073711693			□N/A	
Select One Enrollment	Гуре (and Subtype if a	pplicable) from either section I-A or I-B.	
SECTION I-A				
□Individual/Sole	☐ Rendering Ser	vicing	☐Atypical (non-medical) provider	
Proprietor Provider			Individual (Driver, Home Help/Personal Care, Carpenter, etc.)	
SECTION I-B				
☐Group Practice	Facility/Agency		□Atypical (non-medical) provider	
(Corporation,	Organization (FAO-H	lospital,	Agency (Child Care Institution, Home	
Partnership, LLC, etc.)	Nursing Facility, Var	ious	Help/Personal Care Agency, Transportation	
	Entities)		Company, Local Education Agency etc.)	
□Contractor/MCO	Sub Type:			
	☐Correctional Facili	ties	☐ Department of Economic Security	
	Tribal Behavioral	Health	☐ Managed Care Organization	
L.,				

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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.

First Name*A	Middle Initial □N/A	Last Name*A
Suffix*A	Gender*A	SSN*A
Date of Birth*A ммррууу	Legal Entity Name*A&B Navajo Nation/DBMHS	Entity Business Name (Doing Business As)*A&B Navajo Regional Behavioral Health (
Home Address*A	City*A	State*A
PO Box 1830	Shiprock	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	Profit Type*A&B □501(C)(3) NON-PROFIT □501 Classic Held	Tribal Type *A&B □N/A
You must also attach completed W-9 form. This can be found at IRS.GOV	☐ For Profit Closely Held ☐ For Profit, Publicly Traded ☐ Other <u>Tribal 638</u> ☐ N/A – The individual only practices as part of a group	□ Indian Health Service □ Privately Owned on Tribal Land ■ Tribally Owned on Tribal Land

Category Key	Enrollment Types
Α	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 ммррүүүү 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.

Locatio	n Specif	ic Inform	nation	for Pr	imary Pra	ctice Lo	cation is	s requ	ired.*				
	ne busine applicable		of ope	ration.	State "clos	ed" on c	lays the	busine	ss is clo	osed. S	Select A	M or l	PM
	Sur	nday	Mon	day	Tuesday	Wed	nesday	Thu	rsday	Fri	iday	Sat	urday
Open	12:00	■AM □PM	112:00	■AM □PM	12:0(PM	1 12:00	■AM □PM	12:00	■AM □PM	12:00	■AM □PM	12:00	■AM □PM
Close	11:59	□AM ■PM	111.59	□AM ■ PM	11:55 □ AM	111.79	□AM ■PM	11:59	□AM ■PM	11:59	□AM ■PM	11:59	□AM ■PM
Langua	ge(s) Spo		English Native		•	Arabic andarin	□Canto		□ Chi		■Nav	ajo	□Farsi
Other(s) (specify	v):								□На	ndicap	Acces	sible

Category Key	Enrollment Types
A	Individual/Sole Proprietor, Rendering/Servicing, Atypical Individual
В	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 \boxtimes .

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 \boxtimes .
- 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				
		Phone Number*A (928)871-6235	Fax Number (928)871-6456	
Method of Communic Only select 1 option ■Email	ation*A&B Standard Mail	Email Address*Adarceniocharleston(End Date MMDDYYYY Current
Address Line 1*A&B PO Box 709	Address Line 2 = N/A	À	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
В	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	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date MMDDYYYY:*	Start Date MMDDYYYY:*	
End Date MMDDYYYY:*	End Date MMDDYYYY:*	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммрруучу:*	Start Date MMDDYYYY:	
End Date ммррүүүү:*	End Date ммррүүүү:	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID*	ID*	
Provider Name:*	Provider Name:*	
Start Date ммрруууу:*	Start Date ммррүүү:*	
End Date ммррүүүү:*	End Date ммррүүү:*	

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 Num	mber:		
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: ммррүүү		
AHCCCS Provider Registration	License/Certification Number:			
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: ммррүүүү		
AHCCCS Provider Registration	License/Certification Nu	mber:		
Issuing Agency:	Effective Date: ммррууч	Expiration Date: ммррүүүү		
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: M		

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



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 SSN/EIN/TIN: 86-0092335

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





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	
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 ммррууч	End Date ммррууу	
Home address for Individual or business addre	ss 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
С	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		
SSN*		
Last Name* Brandser		
DOB*		
Email mbrandser@navajo-nsn.gov		
End Date		
Address Line 2		
City/Town* Window Rock		
County* Apache		
Zip Code* 86515		

Add Owners Relationship

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

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

SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Assoc. Owner
	Director	Self	Employee
	SSN/EIN/TIN	SSN/EIN/TIN Type	Type Relation to (name)

AHCCCS Arizona Health Care Cost Containment System

Provider Enrollment Form

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;
 - 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

Response: 1g.	☐ Yes	■No
Response: 2.	☐ Yes	■No
Response: 3.	☐ Yes	■No
Response: 4.	☐ Yes	■No
Response: 1g.	☐ Yes	■No
Response: 2.	☐ Yes	■No
Response: 3.	☐ Yes	■No
Response: 4.	☐ Yes	■No
_	Response: 2. Response: 3. Response: 4. Response: 1g. Response: 2. Response: 3.	Response: 2.



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: Substa	nce Abuse Rehabilitation Facili	Description: BHRF - Non secured
Start Date: ммррүүүү*	10/19/2020	End Date: ммррүүү

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.

SEC	TION 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:		

Provider SSN/EIN/TIN: 86-0092335

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



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 data indicated below. □ I affirm under penalty of law that the information I have provided on this form is true, accurate an 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 recordkeeping 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 noncompliance 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)

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

Location	n Specific Inform	nation for Pr	imary Prac	tice Location is	required.*		
	e business hours opplicable.	of operation.	State "close	d" on days the b	ousiness is clo	sed. Select A	M or PM
	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open	□AM	□AM	□AM	□AM	□AM	□AM	□AM
	□РМ	□РМ	\Box PM	□РМ	□PM	□РМ	□РМ
Close	□AM	□AM	\Box AM	□AM	□AM	□AM	□AM
	□РМ	\square PM	\Box PM	□PM	\Box PM	□РМ	□РМ
Languag	Language(s) Spoken □ English □ Spanish □ Arabic □ Cantonese □ Chinese □ Navajo □ Farsi						
		Native Amer	ican \square Ma	ndarin \square Kor	rean 🗆 Free	nch	
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	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: ммрруууу	Start Date: ммррууу	
End Date: ммррүүүү	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date: мморуууу	Start Date: ммррууу	
End Date: ммррүүүү	End Date: ммрруууу	
□AHCCCS ID or □NPI	□AHCCCS ID or □NPI	
ID	ID	
Provider Name:	Provider Name:	
Start Date:ммрруууу	Start Date: ммрруууу	
End Date: ммррүүүү	End Date: ммрруууу	





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.).

License/Certification N	umber:
Effective Date:	Expiration Date:
License/Certification No	umber:
Effective Date:	Expiration Date:
License/Certification N	umber:
Effective Date:	Expiration Date:
License/Certification No	umber:
Effective Date:	Expiration Date:
License/Certification Number:	
Effective Date:	Expiration Date:
License/Certification Number:	
Effective Date:	Expiration Date:
License/Certification No	umber:
Effective Date:	Expiration Date:
License/Certification N	umber:
Effective Date:	Expiration Date:
License/Certification Number:	
Effective Date:	Expiration Date:
License/Certification N	umber:
Effective Date:	Expiration Date:
	Effective Date: License/Certification Note Effective 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-In Law, Mother, Mother-In Law, Sibling, Son, Son-In Law, Self, Spouse)?

 \square No \square Yes If yes, list names and relationship.

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.
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
5511/ 1111/ 1111	Response: 3.
	Response: 4. Yes No
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2.
	Response: 3. ☐ Yes ☐ No
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2. Yes No
	Response: 3.
	Response: 4.
Owner Name	Response: 1g.
SSN/EIN/TIN	Response: 2. Yes No
33H/ LH4/ 11H	Response: 3.
	Response: 4. Yes No





Appendix F

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
В3	RESIDENTIAL TREATMENT CENTER-NON-SECURE	Y	Y	N
B5	SUBACUTE FACILITY (1-16 BEDS)	Y	Y	N
В6	SUBACUTE FACILITY (17+BEDS)	Y	Y	N
В7	CRISIS SERVICES PROVIDER	Y	Y	N
В8	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

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

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



	SPEC	IALTY CODI	ES			
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			





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	



SPECIALTY CODES MEDICAL SPECIALTY CODES FOR M.D.'S (PT 08)				
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-	
			BEHAVIORAL/DEVELOPMENTAL	
136	FORENSIC PATHOLOGY	913	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)	





	SPECIALTY CODES - REGISTERE	D NURSE PR	ACTITIONER 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	ED NURSE CATEGORIES			
	NURSE -MIDWIFE (PT 09)	CERTIF	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		
	DENTIST	RY 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 SI	PECIALTY CO	DES (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)		



	SPECIALTY CODES FOR NO	N-PHYS	ICIAN 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		
	RADIOLOGIS	T SPECIA	ALIST		
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				
	MISCELLANEO	US SPEC	IALTIES		
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
$\overline{\mathbf{V}}$	SSN/EIN/TIN is at the bottom of each page	All
1	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
V	Section IV Pay To information	All
V	Section V Correspondence Address	All
1	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
V	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
1	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

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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			

972

Navajo Nation Council 2022 Winter Session

02:30:11 PM

1/26/2022

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 Begay, K Begay, P Brown

Freeland, M Halona, P Henio, J James, V Nez, R

Smith Stewart, W Tso

Tso, E Walker, T Wauneka, E

Charles-Newton

Tso, C Tso, D Yazzie Yellowhair

Daniels

Slater, C

Nay: 0

Excused: 1

Crotty

Not Voting: 0

Presiding Speaker: Damon