Credentialing Alliance

ORGANIZATIONAL/FACILITY APPLICATION

This form is also used for facilities that DON'T require credentialing. The information is necessary to add into the Provider Directory and payment system for claims processing.

Initial Credentialing—Failure to legibly complete all sections of this application and submit current copies of all required documentation may result in processing delays. If a question does not apply, please put N/A in that section to ensure a complete application.

Recredentialing—Submission of recredentialing information is a contractual obligation. Failure to complete all sections of this application and submit current copies of all required documentation in a timely manner will be considered a request to terminate the facility's participation in our network. If a question does not apply, please put N/A in that section to ensure a complete application.

PLEASE NOTE: FOR EVERY ORGANIZATION/FACILITY TYPE, A SEPARATE APPLICATION MUST BE COMPLETED.

- New organizational providers will receive written confirmation of their effective date with the health plan.
  - Members may not be seen until written confirmation has been received and AHCCCS registration has been completed. You cannot receive payment for services provided without AHCCCS registration.
- Please use the Organizational/Facility Supplemental form (last page) for additional addresses. Each of the location must have the same AHCCCS ID#, License #'s and NPI. If not, complete a new application.

INSTRUCTIONS:

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING PROVIDING ANY ATTACHMENTS, TO PREVENT DELAYS IN PROCESSING YOUR REQUEST. PLEASE SUBMIT ALL PAGES.

Include the following items for each location with your completed and signed application:

- Current State License and business license for each location (if applicable)
- Medicare Certification letter (if applicable)
- Certifications and/or Accreditation Certificates (e.g. TJC,CHAP, etc), if applicable
- CLIA Certificate (if applicable)
- Current *Professional Malpractice, Comprehensive General Liability and Workers Comp* Insurance Policies
- IRS form 941 voucher or accurate W9
- Maintenance vehicle schedule (Transportation only)
- Documentation of age-appropriate car seats (Transportation only)
- **Behavioral Health Facilities Only**—if you employ Behavioral Health Technicians (BHTs) and/or Paraprofessionals (BHPP), please **provide your Policies and Procedures** that outlines your process for monitoring/supervision of the BHTs and BHPPs'.
- **Electronic Visit Verification (EVV) Training and Office Contact Name**—see page 5
- **EVV Attestation**—further instructions can be found on pages 15-18. Attestation on page 17

If you have any questions, please contact the Provider Network/Operations Department of the Health Plan (s) you are applying to (see page 14).

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ORGANIZATIONAL/FACILITY APPLICATION

Each health plan will provide instruction as to where the completed application and required documents should be submitted.

SUBMISSION DATE:				
1099 Registered Name (Required):			Tax ID#:	
Organizational/Facility Name/DBA (if applicable):			Effective Date with TIN:	
Lines of Business: ☐ Medicaid ☐ Medicare ☐ Commercial	License #		State	Exp Date:
AHCCCS ID #	AHCCCS Provider Type	Organization NPI#	CLIA# Expiration Date	
Is Facility a Medicare participating provider? ☐ YES ☐ NO	Medicare # (PTAN):			

ORGANIZATIONAL/FACILITY TYPE AS LISTED ON LICENSE OR ACCREDITATION: Check all that apply		
☐ Acute Rehab	☐ Habilitation Providers	☐ Pharmacy
☐ Ambulatory Surgery Center	☐ Home Health Agency	☐ PT/ST
☐ Attendant Care Agency	☐ Hospice	☐ Radiology—locations only
☐ Assisted Living Center**Indicate Specialties below	☐ Hospital	☐ Skilled Nursing Facility ** Indicate Specialties below
☐ Assisted Living Home ** Indicate Specialties below	☐ Infusion Agency	☐ Transportation
☐ Behavioral Health	☐ Intensive Outpatient Treatment (BH)	☐ Transportation—Air and Non-Emergency
☐ Behavioral Health Residential Facility (BHRF)	☐ Laboratory	☐ Behavioral Health Therapeutic Home
☐ Dialysis	☐ Medical/Dental Schools	☐ Therapeutic Foster Home
☐ DME/Enteral	☐ Orthotics & Prosthetics	☐ Urgent Care
☐ FQHC/RHC	☐ Outpatient Medical Rehab Center	☐ Other

ORGANIZATIONAL/ FACILITY TYPE SPECIALTIES—HSD SPECIALTY CODE AND SPECIALTY NAME: Check all that apply		
☐ 040 Acute Inpatient Hospitals	☐ 046 Skilled Nursing Facilities	☐ 050 Occupational Therapy
☐ 041 Cardiac Surgery Program	☐ 047 Diagnostic Radiology	☐ 051 Speech Therapy
☐ 042 Cardiac Catheterization Services	☐ 048 Mammography	☐ 052 Inpatient Psychiatric Facility Services
☐ 043 Critical Care Services -Intensive Care Units (ICU)	☐ 049 Physical Therapy	☐ 057 Outpatient Infusion/Chemotherapy
☐ 045 Surgical Services (Outpatient or ASC)		

ASSISTED LIVING FACILITY/SNF TYPE SPECIALTIES—SPECIALTY NAME: Check all that apply		
☐ Dementia or related disorders	☐ Traumatic Brain Injury	☐ Addiction/Substance Abuse Disorders
☐ Persistent aggressive behaviors	☐ None of the above	

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ORGANIZATIONAL/FACILITY APPLICATION

ACCREDITING AUTHORITIES: Please indicate if this location has been reviewed by any of the accrediting authorities listed below and provide a copy of the most recent accreditation report for each location.	
☐ Accreditation Commission for Health Care, INC.	☐ Commission on Office Laboratory Accreditation
☐ American Association for Accreditation of Ambulatory Surgery Facilities	☐ Community Health Accreditation
☐ American Association for Ambulatory Health Care	☐ Det Norske Veritas National Integrated Accreditation for Healthcare Organizations
☐ American College of Radiology	☐ Healthcare Facilities Accreditation Program
☐ American Osteopathic Association	☐ Joint Commission
☐ Commission on Accreditation of Rehabilitation Facilities	☐ Other:

PRIMARY ADDRESS: Physical location where services are performed. Complete a supplemental form for each additional location							
Address			City		State:	Zip Code	
Appointment Phone (will be listed in directory)		Fax		County	Location NPI (can't be processed without a valid 10 digit NPI) if applicable		
Modalities			List Address in Directories ☐ YES ☐ NO				
Office Hours ☐ Check if 24hrs	**DAY**	**Open**	**Closed**	**DAY**	**Open**	**Closed**	Special Considerations: (i.e., closed for lunch etc.)
	Mon			Fri			
	Tues			Sat			
	Wed			Sun			
	Thurs						
Languages spoken fluently by Provider when communicating about medical care:							
Languages spoken fluently by Office Staff:							

ORGANIZATIONAL/FACILITY CONTACT			
Contact Name/Title:	Phone:	Fax:	
Org/Facility Email:	Organizational/Facility Website Address:		
Mailing Address:	City:	State:	Zip Code:

Credentialing Alliance

ORGANIZATIONAL/FACILITY APPLICATION

BILLING SERVICE			
Name of Service:		Contact Name:	
Address:		Phone:	
City:	State:	Zip Code:	

PAY TO ADDRESS			
Name:		Contact:	
Address:	City:	State:	Zip Code:
Phone:	Fax:		

CREDENTIALING CONTACT			
Name:			
Address:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

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

If appropriate, has EVV training been completed through Sandata (See pages 15-18 for more information. **List of facilities required to complete this information is on page 16**) ☐ YES ☐ NO		
EVV Office Contact (*Primary contact for EVV. This person will receive primary communications and notices from Sandata and AHCCCS and the health plans:*	Phone:	Email

Organizational/Facility Assessment of Cognitive and Physical Disabilities Accommodations

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

Organizational/Facility Location Address: _____

Accommodation	YES	NO	NA	Comments
Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities				
Provider/Staff trained to assist individuals with a physical disability, i.e., mobility limitations or wheelchair bound				
Flexible appointment times available—sick appointments, same day appts—please specify				
Extended appointment times—before 8 am, after 5pm, Sat and/or Sunday—please specify				
Assistance available to members to fill out forms				
Waiting and Examinations rooms are routinely cleaned (MED 3A factor 3)*				
Waiting room space contains seating sufficient for all scheduled appointments (MED 3A factor 4)*				
Medical/treatment of members is fully documented (MED 3A Factor 5)*				
Records are securely maintained in a confidential and orderly manner (MED 3 factor 5)*				
Records are in compliance with HIPAA requirements (MED 3 factor 5)*				
In-home and/or community services				
Large print materials				
Materials in electronic format				
Augmentative/Alternative communication devices				
TDD capabilities				
American Sign Language translator				
Signage with Braille and raised tactile text characters at office, elevator, stairwells and restroom doors mounted 60in from floor				
Visible & Audible alarms – emergency systems				
Dimmable Lights				

Accommodation	YES	NO	NA	Comments
Ramps have non-slip surface material				
Railings between 30 & 38in high. On both sides.				
Paths are at least 36in wide and free of protruding objects				
Cane detectible objects on ground as a warning barrier				
Widened doorways (at least 32in clearance)				
Offset (swing-clear) hinges				
Power assisted or automatic door openers				
Door handles no higher than 48in				
Lever or loop handles vs knobs				
5ft circle or T-shaped space for turning a wheelchair completely				
A clear floor space, 30" x 48" minimum, adjacent to the exam table and adjoining accessible route make it possible to do a side transfer				
Adjustable height exam table or chair (lowers to 17-19in from floor)				
Positioning and support aids, such as wedges, rolled up blankets, straps and rails				
Ceiling or floor based patient lift				
Gurneys and/or stretchers				
Wheelchair accessible scales				
Adjustable height radiologic equipment				
Handicap parking				
Handicap accessible restroom				
Access ramps				
Accessible by bus				
Accessible by Valley Metro Rail				
Accessible by Taxi or similar options i.e., Uber/Lyft				
Provider/Staff has completed cultural competence training				
Do you provide Field Clinic services? (A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty Interdisciplinary Clinics (MSICs) to provide a specific set of services including evaluation, monitoring, and treatment for CRS-related conditions on a periodic basis)				
Do you provide Virtual Clinic services? (Integrated services provided in community settings through the use of innovative strategies for care coordination such as telemedicine, integrated medical records, and virtual interdisciplinary treatment team meetings)				

*NCQA Requirements

DISCLOSURE QUESTIONS

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

Organizational/Facility Attestation, Consent & Release Form

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

**Must be signed within 180 days of submission to the Plan

AHCCCS INSURANCE CHECKLIST

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

Use this checklist as a tool to address all insurance requirements

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

Commercial General Liability—policy should include bodily injury, property damage, personal and advertising injury, and broad form contractual liability coverage.	
General Aggregate $2,000,000 Products Ops Aggregate $1,000,000 Personal & Adv. Injury $1,000,000 Damage to Rented Premises $ 50,000 Each Occurrence $1,000,000	Policy Number: EFF Date: ☐ Attached ☐ NA

Requirements:

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

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

☐ **Sexual Abuse and Molestation coverage (SAM)**—If direct services are provided to children and/or vulnerable adults as defined by A.R.S. 46-451(A)(9), the policy shall include coverage for SAM. This SAM coverage may be sub-limited to no less than $500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits.

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

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

Business Automobile Liability-Bodily injury and property damage for any owned, hired, and/or non-owned vehicles used in the performance of the services under contract.
(*required only if you provide transportation to members)*

Combined Single Limit $1,000,000	Policy Number: EFF Date: ☐ Attached ☐ NA

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

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

Workers' Compensation Liability

Each Accident	$1,000,000	Policy Number: EFF Date: ☐ Attached ☐NA
Disease—Each Employee	$1,000,000	
Disease—Policy Limit	$1,000,000	

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

Professional Liability (if applicable)

Each Claim	$1,000,000	Policy Number: EFF Date: ☐ Attached ☐NA
Annual Aggregate	$2,000,000	

☐ **Sexual Abuse and Molestation coverage (SAM)**—If direct services are provided to children and/or vulnerable adults as defined by A.R.S. 46-451(A)(9), the policy shall include coverage for SAM. This SAM coverage may be sub-limited to no less than $500,000. The limits may be included within the General Liability limit, provided by separate endorsement with its own limits.

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

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

Credentialing Alliance

ORGANIZATIONAL/FACILITY APPLICATION

SUPPLEMENTAL FORM FOR ADDITIONAL ADDRESSES/LOCATIONS

☐ **Secondary** ☐ **Tertiary**

For each additional address that has the same AHCCCS ID and license, copy and complete this Supplemental form. A Provider Assessment of Cognitive and Physical Disabilities Accommodations must be completed for each location unless accommodations are the same at each location. (Please note: if a different AHCCCS ID and license the entire application must be completed)

Location Name:

Street Address:

City:	**State:**	**Zip Code:**	**Location NPI:**

Appointment Phone #:	**Fax #:**

Office Hours:

☐ **Check if 24 hrs**

DAY	**Open**	**Closed**	**DAY**	**Open**	**Closed**
Mon			Fri		
Tues			Sat		
Wed			Sun		
Thurs					

Special Considerations: (i.e., closed for lunch)

List Location in Provider Directory: ☐ **YES** ☐ **NO**

Languages spoken fluently by Provider when communicating about medical care:

Languages spoken fluently by Office Staff:

Accreditation:

Does this site have the same accrediting agency as the primary address? (as listed on page 3)

☐ **Yes**

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

SUPPLEMENTAL FORM FOR ADDITIONAL ADDRESSES/LOCATIONS

☐ **Secondary** ☐ **Tertiary**

For each additional address that has the same AHCCCS ID and license, copy and complete this Supplemental form. A Provider Assessment of Cognitive and Physical Disabilities Accommodations must be completed for each location unless accommodations are the same at each location. (Please note: if a different AHCCCS ID and license the entire application must be completed)

Location Name:

Street Address:

City:	**State:**	**Zip Code:**	**Location NPI:**

Appointment Phone #:	**Fax #:**

Office Hours:

☐ **Check if 24 hours**

DAY	Open	Closed	DAY	Open	Closed
Mon			Fri		
Tues			Sat		
Wed			Sun		
Thurs					

Special Considerations: (i.e., closed for lunch)

List Location in Provider Directory: ☐ **YES** ☐ **NO**

Languages spoken fluently by Provider when communicating about medical care:

Languages spoken fluently by Office Staff:

Accreditation:

Does this site have the same accrediting agency as the primary address? (as listed on page 3)

☐ **Yes**

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

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

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

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

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

Sandata—Electronic Visit Verification

As of January 1, 2021 and in response to a federal mandate known as the 21st Century Cures Act, the AHCCCS program will begin using an Electronic Visit Verification (EVV) system for selected home and community-based services. The legislation outlines key data points that must be collected and electronically verified, but states create their own systems and decide how to gather and report data, as well as whether to include additional compliance rules.

AHCCCS is using EVV to help ensure, track and monitor timely service delivery and access to care for members. AHCCCS is also using EVV to help reduce provider administrative burden associated with scheduling and hard coy timesheet processing. This means AHCCCS wants to use EVV to make sure members get the service that they need when they need them. AHCCCS' contracted vendor, Sandata Technologies LLC, will deliver the EVV system and associated devices, as well as provide system orientation and training to providers.

Many agency providers will use the EVV system provided by Sandata. However, some agency providers may choose to use an alternate EVV system, which is permissible if they meet the business requirements as an alternate data collection specifications found on the AHCCCS webpage.

Next page includes a list of the Provider types, services and places of service subject to EVV.

Resource:

Electronic Visit Verification (EVV) Website (azahcccs.gov)

Reference Materials and Technical Assistance

- AHCCCS EVV Webpage (www.azahcccs.gov/EVV)
  - Session PowerPoint and Recording
  - Link to the companion guide
- General EVV Questions (EVV@azahcccs.gov)

NOTE:

- Please identify who will serve as the primary EVV Office Contact on page 4 of this application. This person will be responsible for receiving communications and notices from AHCCCS and Sandata.
- The Electronic Visit Verification (EVV) Compliance Attestation on page 14, MUST be signed by the Organizational/Facility Chief Executive.

Provider types, services, and places of service subject to EVV:

Provider Description	Provider Type	Provider Description	Provider Type
Attendant Care Agency	PT 40	Home Health Agency	PT 23
Behavioral Outpatient Clinic	PT 77	Integrated Clinic	PT IC
Community Service Agency	PT A3	Non-Medicare Certified Home Health Agency	PT 95
Fiscal Intermediary	PT F1		
Habilitation Provider	PT 39	Private Nurse	PT 46

Service	HCPCS Service Code	DDD Focus Codes
Attendant Care	S5125	ATC
Companion Care	S5135	
Habilitation	T2017	HAH, HAI
Home Health Services (aide, therapy, and part-time/intermittent nursing services		
Nursing	G0299 and G0300	
Home Health Aide	T1021	
Physical Therapy	G1051 and S9131	
Occupational Therapy	G0152 and S9129	
Respiratory Therapy	S5181	
Speech Therapy	G0153 and S9128	
Private Duty Nursing (continuous nursing services)	S9123 and S9124	HN1, HNR
Homemaker	S5130	HSK
Personal Care	T1019	
Respite	S5150 and S5151	RSP, RSD

Place of Service Description	POS Code
Home	12
Assisted Living	13
Other	99

Electronic Visit Verification (EVV) Compliance Attestation

As the Chief Executive of a provider agency that provides services to AHCCCS members subject to Electronic Visit Verification (EVV), I attest to the following:

1. My agency will utilize an EVV system for all EVV applicable services as outlined on the AHCCCS website. I understand that my agency can choose to use the AHCCCS supplied state-wide system with Sandata Technologies or an alternate EVV system that my agency procures.

2. I understand my agency cannot onboard with EVV until we have an AHCCCS Provider ID number. We will not be able to bill for services until after we have completed credentialing and have our EVV system in place (i.e. access to the system, people trained, devices deployed, etc.) and record visits.

3. For EVV services that don't require prior authorization, my agency will input/upload required information including updates and changes into the AHCCCS Service Confirmation Portal to inform AHCCCS and Managed Care Organizations (MCOs) of the following information to support monitoring access to care through the EVV system

- Service codes, units and modifiers
- Beginning and end date of the services
- Medical necessity determination date

4. I understand and will adhere to the AHCCCS Medical Policy Manual (AMPM) Electronic Visit Verification policy (540).

Please verify the name and contact information (page 4 of application) for the administrative representative within your organization who will be responsible for serving as the primary contact for EVV. This person will receive primary communications and notices from Sandata and AHCCCS.

Chief Executive Name:	
Title:	
Direct email	
Signature	

If the organization has multiple AHCCCS Provider Registration IDs that may be subject to EVV, please list all relevant Provider IDs.

AHCCCS Provider IDs	