NON-DELEGATED GROUP ROSTER **PLEASE TALK WITH YOUR PROVIDER RELATIONS REP AT THE HEALTH PLAN IF THIS ROSTER CAN BE USED**

TYPE (add/term/change/or other reason)	CAQH #	PRACTITIONER'S LAST NAME	PRACTITIONER'S FIRST NAME	PRACTITIONER'S MIDDLE INTIAL	DEGREE/TITLE	EFF DATE W/PRACTICE	END DATE W/PRACTICE	REASON	INDIVIDUAL NPI#	DOB	PROVIDER GENDER (See Help tab)	DEA #	DEA STATE	DEA EXPIRATION DATE	HOSPITAL BASED (Yes or No)	TYPE OF VISIT (Telemedicine, In Person, Both)

Revised 2024

IS PROVIDER A MEDICATION ASSISTED TREATMENT (MAT) PRESCRIBER? (Yes or No)	XDEA# (if provider is a MAT prescriber)	XDEA State: (if provider is an MAT prescriber)	XDEA Expiration Date: (if provider is an MAT prescriber)	LINE OF BUSINESS-MEDICAID/ MEDICARE/COMMERCIAL (ADD Medicaid only, Medicaid/Medicare, Medicaid/Medicare/Commercial, Medicare only, Commercial only)	AZ MEDICARE PARTICIPATING PROVIDER (Yes or No)	PRACTITIONER PTAN#	LICENSE#	LICENSE STATE	LICENSE EXPIRATION DATE	MALPRACTICE POLICY #	SSN#	AHCCCS ID #	PRACTITIONER TYPE (PCP, OBGYN, SPECIALIST, BH, DENTIST, OTHER (explain))

GROUP TYPE (FQHC/RHC, IC, MULTI SPECIALIST, OTHER (explain))	PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN NAME OR DOCUMENT COLLABORATIVE PA	DENTAL HYGIENIST AFFLIATED DENTIST NAME	NEW DENTIST GRADUATE WITHIN LAST 6 MONTHS (Yes or No)	GRADUATION/COMPLETION DATE (If new grad provide date)	PRIMARY SPECIALTY	PRIMARY SPECIALTY BOARD CERTIFIED (Yes or No)	DATE OF EXAM	SECONDARY SPECIALTY	SECONDARY SPECIALTY BOARD CERTIFIED (Yes or No)	DATE OF EXAM	CONTRACT AS PCP (Yes or No)	ACCEPTING NEW PATIENTS? (Yes or No)

ANY PANEL RESTRICTIONS-- PLEASE EXPLAIN --SUCH AS ONLY REFERRALS, ETC.	PATIENT AGE RANGE (i.e. 0-99)	PATIENT GENDER (See Help tab)	DO YOU E-PRESCRIBE? (Yes or No)	DO YOU PROVIDE SERVICES TO INDIVIDUALS W/PHYSICAL SPECIAL NEEDS/ CHRONIC CONDITIONS? (Yes or No)	DO YOU PROVIDE SERVICES TO INDIVIDUALS W/DEVELOPMENTA L SPECIALNEEDS/ CHRONIC CONDITIONS? (Yes or No)	DO YOU PROVIDE SERVICES TO INDIVIDUALS W/BEHAVIORAL SPECIALNEEDS/ CHRONIC CONDITIONS? (Yes or No)	DO YOU PROVIDE SERVICES TO INDIVIDUALS W/EMOTIONAL SPECIALNEEDS/ CHRONIC CONDITIONS? (Yes or No)	DO YOU PROVIDE SERVICES TO INDIVIDUALS WHO HAVE DIFFICULTY COMMUNICATION OR COOPERATING (i.e. autism or intellectual disabilities? (Yes or No)	DO YOU PROVIDE SERVICES TO INDIVIDUALS WITH MOBILITY LIMITATIONS? (i.e.Wheelchair bound) (Yes or No)	DO YOU TREAT ANXIETY? (Yes or No)	DO YOU TREAT ADHD? (Yes or No)	DO YOU TREAT DEPRESSION? (Yes or No)	DO YOU TREAT AUTISM SPECTRUM DISORDER?	DO YOU TREAT HIV? (Yes or No)	DO YOU TREAT ADDICTION/ SUBSTANCE ABUSE? (Yes or No)	ARE YOU TRAINED IN THE USE AND SCORING OF THE DEVELOPMENTAL SCREENING TOOLS AS INDICATED BY THE AAP? (Yes or No)

DO YOU HAVE SPECIALIZED TRAINING/CERTIFICATIONS IN ANY OF THE FOLLOWING (SEE THE HELP TAB0	PCPs & OBs ONLY DO YOU PROVIDE EPSDT SERVICES? (Yes or No)	PCPs DO YOU PROVIDE OB SERVICES? (Yes or No)	DO YOU PARTICIPATE IN VFC (Vaccine for Children) (PCPs seeing AHCCCS members 18 & < MUST participate) (Yes or No)	VFC PIN CODE	HOSPITAL AND AMBULATORY SURGERY CENTER PRIVILEGES (List)	NAMES OF PRACTITIONERS IN CALL GROUP (Must be contracted with plan)	PRACTITIONERS LANGUAGES (Other than Engish)	PRACTITIONERS RACE (See Help tab)	PRACTITIONER ENTHICITY (See Help tab)	OFFICE STAFF LANGUAGES (Other than English)	OTHER NAMES POSSIBLE IN RECORDS	1099 REGISTERED NAME (Legal name that TIN was issued to)	GROUP PRACTICE NAME (DBA)	TAX ID #

ORGANIZATIONAL NPI#	BILLING SERVICE NAME	ADDRESS	SUITE #	CITY	STATE	ZIP	PHONE #	FAX #	BILLING CONTACT NAME	EMAIL	PAY TO (REMIT) ADDRESS	SUITE #	CITY

STATE	ZIP	PHONE #	FAX #	INDICATE IF PRIMARY, SECONDARY OR ADDITIONAL LOCATION	PRIMARY LOCATION ADDRESS (WHERE SERVICES ARE RENDERED) ADD ADDITIONAL LOCATIONS/ADDRESSES ON A SEPARATE LINE	SUITE#	CITY	STATE	ZIP	COUNTY (Apache, Cochise, Coconino Gila, Graham, Greenlee, LaPaz, Maricopa, Mohave, Navajo, Pima, Pinal, SantaCruz, Yavapai, Yuma)	APPOINTMENT PHONE #	FAX #

OFFICE HOURS ON SUNDAY Example: 8-4pm or closed	OFFICE HOURS ON MONDAY Example: 8-4pm or closed	OFFICE HOURS ON TUESDAY Example: 8-4pm or closed	OFFICE HOURS ON WEDNESDAY Example: 8-4pm or closed	OFFICE HOURS ON THURSDAY Example: 8-4pm or closed	OFFICE HOURS ON FRIDAY Example: 8-4pm or closed	OFFICE HOURS ON SATURDAY Example: 8-4pm or closed	IS OFFICE ACCESSIBLE TO PERSONS WITH DISABILITIES? (Yes or No)	PRACTITIONER IN DIRECTORY? (Yes or No)	PRACTICE CONTACT NAME/TITLE	EMAIL ADDRESS

WEBSITE ADDRESS	MAILING ADDRESS	SUITE #	CITY	STATE	ZIP	PHONE #	FAX #	CREDENTIALING CONTACT (Name)	ADDRESS	SUITE #	CITY	STATE

ZIP	PHONE #	FAX#	EMAIL	DESCRIBE MEDICAL RECORD KEEPING SYSTEM (i.e. EMR, Paper, etc.)	DESCRIBE COST RECORD KEEPING SYSTEM (i.e. Billing or A/R system)	ELECTRONIC CLAIMS SUBMISSION? (Yes or No)	INTERNET ACCESS? (Yes or No)	MINORITY OR FEMALE OWNED BUSINESS? (Yes or No)

Facility Assessment Checklist

ASSESSMENT OF COGNITIVE AND PHYSICAL DISABILITIES ACCOMMODATIONS

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

Facility Location Address:

Accommodation	YES	NO	Comments
Provider/Staff trained to assist individuals with a cognitive disability, i.e., autism or intellectual disabilities			
Provider/Staff trained to assist individuals with a physical disability i.e., mobility limitations or wheelchair bound			
Flexible appointment times --sick appointments, same day appts-- please specify			
Extended appointment times--before 8 am, after 5 pm, 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 3 factor 5)*			
Records are securely maintained in a confidential and orderly manner (Med 3 factor 5)*			
Records are in compliance with HIPAA requirements (MED 3A factor 5)*			
In-home and/or community services			
Large print materials			
Materials in electronc format			
Augmentative /Alternative comunication devices			
TDD capabilities			
American Sign Language translator			
Signage with Braille and raised tactile text characters at office, elevator, stairwells and restrooms doors mounted 60in from floor			
Visible & Audible alarms--emergency systems			
Dimmable Lights			
Ramps have non-slip surface material			
Railings between 30 and 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 Taxis or similar options (Uber/Lyft)			
Accessible by Valley Metro Rail			
Provider/Staff has completed cultural competence training			
Do you provide Field Clinic services? (A "clinic" consisting of single specialty health care providers who travel to health care delivery settings closer to members and their families than the Multi-Specialty to members and their families than the Multi-Specialty Interdisciplinary (MSIC) to provide a specific set of Interdisciplinary Clinics (ICs) to provide a specific set of services including evaluation, monitory, 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 Requirement

Health Plan Contact List

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.BannerUCF.com www.BannerUHP.com
Care1st Health Plan Arizona	(602) 778-1800 (options in order 5, 7)	(602) 778-1875 SM_AZ_PNO@care1stAZ.com	www.care1staz.com
DentaQuest	(800) 233-1468	credenrollment@greatdentalplans.com (262)241-7401	www.dentaquest.com/state-plans/regions/arizona/az-dentist-page
BCBSAZ Health Choice Arizona	(800) 322-8670 (options in order 4, 7)	Preferred: E-apply through the Health Choice Az Provider Portal Alternate: Request to participate/Contract: hchcontracting@azblue.com Request to credential/Already Contracted: hchcredentialing@azblue.com	www.healthchoiceaz .com www.healthchoicepathway.com
Molina Complete Care 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

Help

Gender Options for both Provider and Members
F=Female
M=Male
NB=Non-binary
TF=Transgender female
TM=Transgender male
ND=Does not wish to disclose
A=All

RACE
B=Black or African American
H=Hispanic or Latino
W=White
AI=American Indian or Alaska Native
NH=Native Hawaiian or other Pacific Islander
ME=Middle Eastern or North African
PND=Prefer not to disclose
Other-please spcecify

ETHNICITY
H=Hispanic or Latino
NH=Not Hispanic or Not Latino
PND=Perfer not to disclose

Specialized Training/Certifications
HE=Health Equity
D=Diversity
E=Equity
I=Inclusion
TIC=Trauma Informed Care