Credentialing Alliance

PRACTITIONER DATA FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST. New providers receive written confirmation of their effective date with the health plan. Members may not be seen until the provider receives written confirmation that a request or change is approved and completed (this includes approval by the Credentialing Committee if applicable). **Please Type or Print Clearly.**

To:	Return To:
Fax #: Phone #:	Fax #: Phone #:

DIRECTIONS:

- Please type or print this form clearly and return the completed form with attachments
- CAQH Registration is required
- Certification in your requested specialty or documentation of your examination date is required in order to successfully complete the contracting process

Attach the following:

☐ IRS 941 coupon or accurate W9
☐ Documentation of board certification or scheduled exam date
☐ General Anesthesia Permit, Conscious Sedation Permit and/or Oral Conscious Sedation Permit (*Dental providers only*)

CAQH Registered?

☐ Yes CAQH # ____________________ *Please ensure your application is up to date and that each health plan you are requesting participation in is authorized to access your data.*
☐ No

Practitioner's Name & Degree: (Last) (First) (M.I.) (Degree)	☐ Female ☐ Male DOB:	Practitioner's Effective Date w/Practice:
1099 Registered Name (Required):		Tax ID #:
Group Practice Name (DBA): (If applicable)		
Are you associated with any of the following: ☐ IPA ☐ PHO ☐ N/A If IPA or PHO marked please provide Name:	Group Type (*check all that apply*): ☐ PCP ☐ OBGYN ☐ Dentist ☐ Specialist	

Lines of Business: ☐ Medicaid ☐ Medicare ☐ Commercial	Individual NPI#:	Organizational NPI#:	Malpractice Policy #
SSN:	DEA #: State: Exp. Date:	License #: State: Exp. Date:	

Is provider a Medicare participating provider? ☐ Yes ☐ No	AHCCCS I.D.#:

Primary Specialty:	Board Certification: ☐ Yes ☐ No	Date of Exam:
Secondary Specialty:	Board Certification: ☐ Yes ☐ No	Date of Exam:
Want Contract as PCP? ☐ Yes ☐ No	Accepting New Patients? ☐ Yes ☐ No	Patient Age Range:
Do you provide services to individuals with special needs/chronic conditions (*check all that apply*)? ☐ Physical ☐ Developmental ☐ Behavioral ☐ Emotional ☐ None		Physician Assistant Supervising Physician Name:
Do you provide services to individuals who have difficulty communicating or cooperating (i.e. those with autism or intellectual disabilities)? ☐ Yes ☐ No		Do you provide services to individuals with mobility limitations (i.e. wheelchair bound)? ☐ Yes ☐ No

Do you treat any of the following diagnoses (*check all that apply*)? ☐ Anxiety ☐ ADHD ☐ Depression ☐ HIV ☐ None

PCPs & OBs ONLY: Do you provide any of the following services (*check all that apply*)? ☐ EPSDT ☐ OB ☐ None

Do you participate in VFC (Vaccines for Children)? ☐ Yes ☐ No (*PCPs seeing AHCCCS members 18 < must participate*)	VFC PIN Code:
Are You a Baby Arizona Provider? ☐ Yes ☐ No	Is Practice/Clinic an FQHC or RHC? ☐ FQHC ☐ RHC ☐ N/A

Hospitals & Ambulatory Surgery Center(s) where practitioner has privileges:

Names of Practitioners in Call Group *(Must be contracted with plan)*:

 SEE PAGE 3 FOR FAX AND PHONE INFORMATION

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BILLING SERVICE (If applicable)	Name:			
	Address:			Phone:
	City:	State:	Zip Code:	Fax:

PAY TO ADDRESS (All payments sent to this address)	Address:		City:	State:
	Billing Phone #:	Billing Fax #:		Zip Code:

PRIMARY ADDRESS (Physical location where services are performed)	Address:		City:	Zip Code:
	Phone #:	Fax #:		County:
	Office Hours:	Office Contact (*All Other*):		

ADDITIONAL OFFICE: (Indicate other additional offices on an separate sheet)	Address:		City:	Zip Code:
	Phone #:	Fax #:		County:
	Office Hours:			

MAILING ADDRESS: (All correspondence will be sent to this address)	Address:	City:	Zip Code:
	E-mail Address:		County:

CREDENTIALING CONTACT:	Name:	E-mail Address:		
	Address:			Phone:
	City:	State:	Zip Code:	Fax:

Languages other than English spoken by PRACTITIONER:	☐ N/A
Languages other than English spoken by OFFICE STAFF:	☐ N/A
Any other Name(s) Possible in Records?	☐ N/A

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	Internet Access? ☐ Yes ☐ No	Is this a minority or female owned business? ☐ Yes ☐ No
Electronic Funds Transfer? ☐ Yes ☐ No		

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

<u>If your intent is to apply for participation in a Health Plan network</u>, 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.

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

HEALTH PLAN	PHONE	FAX	WEBSITE
Bridgeway Health Soloutions	(866) 475-3129	(866) 687-0514	www.bridgewayhs.com
Care1st Health Plan Arizona	(602) 778-1800 (options in order 5, 7)	(602) 778-1875	www.care1st.com/az
Comprehensive Medical and Dental Program (CMDP)	(602) 351-2245 or (800) 201-1795 (options in order 1, 2, 3)	(602) 264-3801	www.azdes.gov/cmdp
Health Choice Arizona	(800) 322-8670 (options in order 4, 7)	Maricopa/Pima/Gila/Pinal: (480) 760-4975 Apache/Navajo/Mohave/Coconino: (480) 760-4709	www.healthchoiceaz.com
Health Net Access	(800) 289-2818	Apache/Coconino/Gila/LaPaz/ Maricopa/Mohave/Navajo/ Yavapai: (602) 794-1803 Cochise/Graham/Greenlee/Pima/ Pinal/Santa Cruz/Yuma: (520)258-5172	www.healthnet.com
Mercy Care Plan	(602) 263-3000 (Express Code 631)	(860) 975-3201	www.mercycareplan.com
Phoenix Health Plan	(602) 824-3720	(602) 674-6670	www.phoenixhealthplan.com
UnitedHealthcare Community Plan	(877) 842-3210	(612) 234-0211	www.uhccommunityplan.com
The University of Arizona Health Plans	(520) 874-5290 or (800) 582-8686	(520) 874-7142	www.ufcaz.com www.mhpaz.com www.universitycareadvantage.com www.universityhealthcaregroup.com

Each plan retains the right to make their own contracting decisions (whether or not to add practitioners to their network) and also will make their own credentialing committee decisions (review of the primary source verification information obtained by OptumInsight™ resulting in approval/denial by the plan's committee). You will receive separate communication from each plan regarding the effective date of your credentialing and the effective date of your contract.

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