AZ AHP

Credentialing Alliance
PRACTITIONER DATA FORM

Directions for completion of the Practitioner Data Form (PDF)

1. Ensure your CAQH application and attestation is up to date and that each health plan you are requesting participation in is authorized to access your data.

2. **PLEASE TYPE OR PRINT CLEARLY & COMPLETE PAGES 2-6 IN ITS ENTIRETY**
   a. Please use a separate sheet if necessary, to include all hospital and ambulatory surgery centers where you have privileges
   b. Please use a separate sheet if necessary, to include all Practitioners in Call Group—must be contracted with the plan
   c. Additional Offices—Page 3 has space for one additional location. Please indicate any additional locations/offices on a separate sheet

3. Please complete the Provider Assessment of Cognitive and Physical Disabilities Accommodations assessment (Pages 4-5). A separate assessment must be completed for each location.

4. **The following ATTACHMENTS are required to be submitted with the PDF SO YOUR REQUEST MAY BE PROCESSED TIMELY**
   a. Copy of your Board Certification (if applicable) or CMEs in your specialty
   b. Copy of W-9
   c. Copy of your Certificates of Insurance information that include the minimum requirements (Commercial General Liability, Business Automobile Liability, Workers' Compensation Liability and Professional Liability--see pages 6-7)
   d. The following endorsements, waiver of subrogation and/or SAM language as applicable must be submitted with the certificates. Use of the Insurance Checklist to make sure all coverage levels, endorsement and waivers have been addressed.
      i. Endorsement—Required for Commercial General and Business Auto Liability
         a. This policy contains an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the actives performed by the Subcontractor or on behalf of the Subcontractor or Contractor
      ii. Waiver of Subrogation—Required for all
         a. This policy contains a waiver of subrogation endorsement 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 the Subcontractor or on behalf of the Subcontractor or Contractor.
      iii. **Sexual Abuse and Molestation (SAM)--Required for Commercial General Liability or Professional Liability when providing services to children and/or vulnerable adults
         a. Insurance Certificate(s) must provide the following statement "Sexual Abuse and Molestation coverage is included" or "Sexual Abuse and Molestation coverage is not excluded".
         b. If you are unable to obtain SAM coverage under your General Liability because the insurance market will not support it, it should be included with the Professional Liability.
         ***Please check with health plan if SAM coverage is required for your specific provider type*
      iv. NOTE: Please see the Certificate of Liability Insurance samples at the end of this document (pages 9-10)
   d. If a practicing OB/GYN and you are performing Detailed Anatomic Fetal Ultrasound, provide documentation of 30 hours of CME in fetal anatomic ultrasound (30 hours of CMEs every 3 years)

5. 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 and signed contract, if applicable).

AZ AHP

Credentialing Alliance
PRACTITIONER DATA FORM

PLEASE TYPE OR PRINT CLEARLY & COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST.

This form includes Personally Identifiable Information (PII) such as practitioner name, date of birth and SSN and should be sent in a secure manner.

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

DIRECTIONS:

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

Post the following items (as applicable) to CAQH - Check box to indicate items posted:

- ☐ IRS 941 coupon or accurate W9
- ☐ Documentation of board certification or scheduled exam date
- ☐ Medicaid required insurance certificates as applicable (*see page 3 for requirements*)
- ☐ Fluoride Varnish Application Training Certificate *(PCPs only)*
- ☐ Developmental Screening Tool Training Certificate-PEDS/ASQ/M-CHAT *(PCPs only)*
- ☐ General Anesthesia Permit, Conscious Sedation Permit and/or Oral Conscious Sedation Permit (*Dental providers only*)

CAQH Registration is required (http://www.caqh.org - for assistance please contact CAQH HELP DESK 1-888-599-1771)

CAQH # _____ *Please ensure your application and attestation is up to date and that each health plan you are requesting participation in is authorized to access your data.*

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*): ☐ FQHC ☐ RHC ☐ BH ☐ PCP ☐ OBGYN ☐ Dentist ☐ Specialist ☐ MAT	
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 Practicing Specialty:	Board Certification: ☐ Yes ☐ No Date of Exam:	**New Graduate: ☐ Yes ☐ No** **Graduation/Completion Date:**
Secondary Practicing Specialty:	Board Certification: ☐ Yes ☐ No Date of Exam:	Dental Hygienist Affiliated Dentist Name:
Check any that apply to the practice/practitioner: ☐ FQHC ☐ RHC ☐ MAT prescriber ☐ Dental ☐ Behavioral Health		**If MAT Prescriber XDEA #:** **State: Exp. Date:**
Want Contract as PCP? ☐ Yes ☐ No	Accepting New Patients? ☐ Yes ☐ No	Patient Age Range: / Patient Gender: ☐ M ☐ F ☐ B
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/accommodations 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 ☐ Substance Use ☐ None		
PCPs & OBs ONLY: Do you provide any of the following services (*check all that apply*)? ☐ EPSDT ☐ OB ☐ None **OBs ONLY**: Do you perform Detailed Anatomic Fetal Ultrasound? ☐ Yes ☐ No - if yes, please provide documentation of 30 hours of Fetal anatomic u/s CMEs		
Do you participate in VFC (Vaccines for Children)? ☐ Yes ☐ No (*PCPs seeing AHCCCS members 18 & < must participate*)		VFC PIN Code:
Names of Practitioners in Call Group *(Must be contracted with plan)*:	Do you E-Prescribe? ☐ Yes ☐ No Hospitals & Ambulatory Surgery Center(s) where practitioner has privileges:	

[1] ***licensed to practice medicine or dentistry for the first time in your career and or completed post-graduate training for the first time within the last 6 months***

PLEASE TYPE OR PRINT CLEARLY & COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST.

This form includes Personally Identifiable Information (PII) such as practitioner name, date of birth and SSN and should be sent in a secure manner.

New providers will 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).

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

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

PRIMARY ADDRESS (Physical location where services are performed)	Address:	City:	Zip Code:
	Phone:	Fax:	County:
	Office Hours:	Is Office Accessible to Persons with Disabilities? ☐ Yes ☐ No	
	List Practitioner in Directories at this Address? ☐ Yes ☐ No		

ADDITIONAL OFFICE: (Indicate other additional offices on a separate sheet)	Address:	City:	Zip Code:
	Phone:	Fax:	County:
	Office Hours:	Is Office Accessible to Persons with Disabilities? ☐ Yes ☐ No	
	List Practitioner in Directories at this Address? ☐ Yes ☐ No		

PRACTICE CONTACT/ MAILING ADDRESS:	Contact Name/Title:	Phone:	Fax:
	E-mail Address:	Website Address:	
	Address:	City:	Zip Code:

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 system, 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		

Provider Assessment of Cognitive and Physical Disabilities Accommodations

Please identify what accommodations you provide at **each of your practice 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.

Practice 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 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			
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			
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			

Accommodation	YES	NO	Comments
Handicap parking			
Handicap accessible restroom			
Access ramps			
Accessible by bus			
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 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)			

Prior to submitting your insurance information complete this checklist, use it as a tool to address everything that's required and send it on top of your insurance document(s).

Commercial General Liability	Professional Liability
☐ ATTACHED	☐ ATTACHED ☐ N/A
☐ 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	☐ Each Claim $1,000,000 ☐ Annual Aggregate $2,000,000
Business Automobile Liability	**Workers' Compensation Liability**
☐ ATTACHED ☐ N/A	☐ ATTACHED ☐ N/A
☐ Combined Single Limit $1,000,000	☐ Each Accident $1,000,000 ☐ Disease – Each Employee $1,000,000 ☐ Disease – Policy Limit $1,000,000

Your Certificates of Insurance must include the minimum requirements outlined in the tables above and the following endorsement, waiver of subrogation and/or SAM language as applicable.

☐ **Endorsement – Required for Commercial General and Business Auto Liability**
This policy contains an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ **Waiver of Subrogation – Required for all**
This policy contains a waiver of subrogation endorsement 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 the Subcontractor or on behalf of the Subcontractor or Contractor.

☐ **Sexual Abuse and Molestation (SAM) – Required for Commercial General Liability or Professional Liability when providing services to children and/or vulnerable adults**
Insurance Certificate(s) must provide the following statement "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 be included with the Professional Liability.

AHCCCS Insurance Requirements

This communication outlines the additional insurance requirements and provides examples to assist you.

AHCCCS Insurance Requirements
The AHCCCS insurance requirements include Commercial General Liability, Business Automobile Liability and Worker's Compensation and Employers' Liability.

Your commercial general liability policy and your business automobile policy (if applicable), need to include an endorsement (see letter a. below under Commercial General Liability and letter a. below under Business Automobile Liability) and a waiver of subrogation (see letter b. below under Commercial General Liability and letter b. below under Business Automobile Liability) in the Description field of your policy.

Your worker's compensation and employers' liability policy requires only the waiver of subrogation language.

Outlined below are the minimum requirements. Policy examples follow.

Commercial General Liability – Occurrence Form
Policy should include bodily injury, property damage, personal and advertising injury and broad form contractual liability coverage. The amounts below are the minimum requirements.

- General Aggregate $2,000,000
- Products – Completed Operations Aggregate $1,000,000
- Personal and Advertising Injury $1,000,000
- Damage to Rented Premises $50,000
- Each Occurrence $1,000,000

a. The policy shall be endorsed (**Blanket Endorsements are not acceptable**) to include the following additional 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."*** 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.

b. 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.

c. 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 Sexual Abuse and Molestation (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 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.

d. 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."

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. The amount below is the minimum required.

- Combined Single Limit (CSL) $1,000,000

a. The policy shall be endorsed (**Blanket Endorsements are not acceptable**) to include the following additional 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.

b. 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.

Worker's Compensation and Employers' Liability

- Workers' Compensation Statutory
- Employers' Liability
  - Each Accident $500,000
  - Disease – Each Employee $500,000
  - Disease – Policy Limit $1,000,000

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."

Two examples for your reference are included on pages 9-10:

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

We are required to verify your adherence to these insurance requirements. We appreciate you submitting Certificates of Liability with required coverage levels, endorsements and waivers along with the attached checklist

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/01/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Insurance Company Name
License Number
Mailing Address
City, AZ Zip Code

CONTACT NAME: Agent Name
PHONE (A/C, No, Ext): 602-555-5555 FAX (A/C, No): 602-555-1111
E-MAIL ADDRESS: agent@insco.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ABC Insurance Company	
INSURER B : DEF Insurance Company	
INSURER C : XYZ Insurance Company	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Provider's Group Name
Address
Suite #
City AZ Zip Code

COVERAGES **CERTIFICATE NUMBER:** 123456789 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC OTHER:	X		123-ABC-456	09/01/2017	08/31/2018	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50,000 $ $ 1,000,000 $ 2,000,000 $ 1,000,000
B	AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS	X		99-000-AB1111	09/01/2017	08/31/2018	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y / N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $ $ $
D	Professional Liability	X		12345678	09/01/2017	08/31/2018	$1,000,000 Per Claim/ $2,000,000 per Agg	

AHCCCS minimum coverage limits

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
This policy contains an endorsement that includes the State of Arizona, and its departments, agencies, boards, commissions, universities, officers, officials, agents, and employees as additional insureds with respect to liability arising out of the activities performed by the Subcontractor, or on behalf of the Subcontractor or Contractor. This policy contains a waiver of subrogation endorsement 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 the Subcontractor, or on behalf of the Subcontractor or Contractor. Sexual Abuse and Molestation coverage is included.

AHCCCS required endorsement language and waiver of subrogation language.
NEW – Added Sexual Abuse and Molestation language

CERTIFICATE HOLDER
Arizona Health Care Cost Containment System
Attn: Contracts
700 E. Jefferson St. MD 5700
Phoenix AZ 85034

Add AHCCCS as the Certificate Holder

CANCELLATION
SHOULD ANY OF THE
THE EXPIRATION D
NTATIVE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 10/01/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Agent Name
Insurance Company Name License Number Mailing Address City, AZ Zip Code	PHONE (A/C, No, Ext): 602-555-5555 FAX (A/C, No): 602-555-1111 E-MAIL ADDRESS: agent@insco.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : SCF Casualty Insurance	13210
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED: Provider's Group Name, Address, City, AZ Zip Code

COVERAGES CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB ☐ CLAIMS-MADE							$
	DED ☐ RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N ☐ N / A If yes, describe under DESCRIPTION OF OPERATIONS below			C12345			STH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 1,000,000 $ 1,000,000 $ 1,000,000

UPDATED – limits to $1,000,000

AHCCCS minimum coverage limits

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

This policy contains a waiver of subrogation endorsement in favor of the State of Arizona, and its departments, agencies, boards, commissions universities, officials, agents, and employees for losses arising from work performed by the Subcontractor or on behalf of the Subcontractor or Contractor.

Only Waiver of Subrogation language is required for Worker's Comp policy

CERTIFICATE HOLDER

Arizona Health Care Cost Containment System
Attn: Contracts
700 E. Jefferson St. MD 5700
Phoenix, AZ 85034

Add AHCCCS as the Certificate Holder

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

ITATIVE

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.BannerUCF.com www.BannerUHP.com
Care1st Health Plan Arizona – A WellCare Company	(602) 778-1800 (options in order 5, 7)	(602) 778-1875 SM_AZ_PNO@care1stAZ.com	www.care1staz.com
Comprehensive Medical and Dental Program (CMDP)	(602) 351-2245 or (800) 201-1795 (options in order 1, 2, 3)	(602) 264-3801 CMDPProviderServices@azdcs.gov	https://dcs.az.gov.cmdp
DentaQuest	(800) 233-1468	initialproviderenrollment@dentaquest.com 262-241-7401	http://www.dentaquest.com/state-plans/regions/arizona/az-dentist-page
Magellan Complete Care Arizona	(800) 424-5891	888-656-0369 MCCAZProvider@MagellanHealth.com	www.mccofaz.com
Mercy Care	(602) 263-3000	Contracting: contractingdepartment@mercycareaz.org If contracted already, email completed forms to Provider Relations at: Providerrelations@mercycareaz.org Or fax to: (860) 975-3201	www.mercycareaz.org
Health Choice Arizona	(800) 322-8670 (options in order 4, 7)	Contracting: hchcontracting@steward.org If contracted already, email your provider representative (480) 760-4975	https://www.healthchoiceaz .com
United Healthcare Community Plan	(877) 842-3210	(855) 523-9998 Cred_applications@uhc.com	www.uhcprovider.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 Aperture Credentialing, LLC 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.