Practitioner/Practice Change Form

Practitioner/Group Name_____

NPI#_____ **CAQH#**_____

SUBMIT CHANGES AT LEAST 90 DAYS PRIOR TO CHANGE OR AS SOON AS POSSIBLE
NOTE: This form can only be used if the group is currently contracted with the health plan—change to an existing provider. Provider must be in the network already.
Please add Practitioner and/or Group Name, NPI # and CAQH # on the above lines. Only complete the appropriate change type requested. NOT ALL SECTIONS NEED TO BE COMPLETED. Fax/email this form and any required documentation to each of the health plans you are contracted with. **Be sure to update CAQH, licensing board, AHCCCS etc as appropriate.**

PLEASE UPDATE THE FOLLOWING. PAYMENT SYSTEMS CANNOT BE UPDATED UNTIL THESE AGENCIES HAVE BEEN NOTIFIED.
☐ AHCCCS ☐ CAQH ☐ Licensing Board ☐ NA

Request Type: (Must Complete)	☐ Service Address ☐ Termination ☐ Name Change ☐ Billing Contact ☐ Billing Name/Address ☐ Credentialing Contact ☐ Specialty ☐ Practitioner Type ☐ Panel Change ☐ Other (AHCCCS Reg #, NPI# etc)

Practitioner/Group Information: (Must Complete)	Practitioner's Name:		Group Name:
	Practitioner's NPI#	**CAQH #**	Practitioner's AHCCCS#
	Group Federal Tax ID#		Group NPI#

Service Address Change:

*****NOTE: If adding a new location, please complete the Assessment form (last 2 pages)**

☐ **PRIMARY LOCATION** ☐ **SECONDARY LOCATION** ☐ **ADDITIONAL LOCATION**

Address 1 ☐ **Add** ☐ **Delete** **EFFECTIVE DATE:**

Street: Suite #:

City: State: Zip Code:

Telephone: Fax: Email:

Office Hours:	**Day**	**Open**	**Closed**	**Day**	**Open**	**Closed**	**Special Considerations: (i.e., closed for lunch, etc)**
	Mon			Fri			
	Tues			Sat			
	Wed			Sun			
	Thurs						

List Practitioner in Directories at this address: ☐ Yes ☐ No

Language spoken fluently by Provider/Office Staff when communicating about medical care. ☐ N/A

Location NPI: Handicap accessible ☐ Yes ☐ NO

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Service Address Change: *****NOTE: If adding a new location, please complete the Assessment form (last 2 pages)**	☐ **PRIMARY LOCATION** ☐ **SECONDARY LOCATION** ☐ **ADDITIONAL LOCATION**							
	Address 1 ☐ **Add** ☐ **Delete**				**EFFECTIVE DATE:**			
	Street:						Suite #:	
	City:		State:		Zip Code:			
	Telephone:		Fax:		Email:			
	Office Hours:	**Day**	**Open**	**Closed**	**Day**	**Open**	**Closed**	**Special Considerations: (i.e., closed for lunch, etc)**
		Mon			Fri			
		Tues			Sat			
		Wed			Sun			
		Thurs						
	List Practitioner in Directories at this address: ☐ Yes ☐ No							
	Language spoken fluently by Provider/Office Staff when communicating about medical care. ☐ N/A							
	Location NPI:				Handicap accessible ☐ Yes ☐ NO			

Practitioner Location Change: (Practitioner is remaining with the practice but changing locations)	PCP Member Reassignment? (Will members remain at previous location?) ☐ Yes ☐ No	Effective Date of Change to New Location:
	Reassigned Practitioner Name:	Reassigned Practitioner NPI:

Practitioner Termination Request: (Practitioner is leaving the practice/group for any reason)	PCP Member Reassignment? ☐ Yes ☐ No	Effective Date of Term:
	Reassigned Practitioner Name:	Reassigned Practitioner NPI:
	Reason for Term: ☐ Leaving practice/group ☐ Retired ☐ Death ☐ Other (Explain):	

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Practitioner Name Change:	Previous Last, First, and Middle Name:	New Last, First, and Middle Name:
	Effective Date:	
Required Documentation	*For any name changes, a copy of Practitioner's current license reflecting the change is required to be submitted with this form and/or AHCCCS Registration, NPI #*	

Billing/Remit Address:	Legal Name:	Previous Legal name	
	Street:	Suite #:	
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		
Required Documentation	*A W 9 must be submitted*		

Billing Contact Change:	Name:	Title:	
	Street:	Suite #:	
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		

Credentialing Contact Change	Name:	Title:	
	Street:	Suite #:	
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		

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Practitioner/Group Name_____

NPI#_____ **CAQH#**_____

Practitioner Specialty or Provider Type Change:	Previous Practitioner Specialty/Provider Type:	
	New Practitioner Specialty/Provider Type:	Effective Date:
Required Documentation	***Any change in this section may require a credentialing event. If changing your NPI# and/or AHCCCS Registration you MUST complete the Practitioner or Organizational/Facility Application as appropriate.*** *Please confirm with your Practitioner Rep at the health plans for what is required.* *For any change in Specialty, documentation that supports the change in specialty needs to be submitted with this form, i.e., education, certification, etc. update with AHCCCS prior to submitting,*	

Panel Change: (Complete for any change to panel—open and closed, number of members assigned, change in ages of members with effective date of change)	Panel ☐ OPEN ☐ CLOSE ☐ MAX PANEL LIMIT ☐ AGES	
	If change in max panel limit or age range of member, please provide an explanation:	
	Provide specific instructions for any member moves, if applicable.	
	Effective Date:	

Other Changes (any other change being requested)	☐ AHCCCS Registration # ☐ NPI# ☐ DEA # ☐ TIN # ☐ Other (Describe i.e., change in languages spoken, hospital privileges etc.):	
	Previous #	Current #
	Effective Date:	
Required Documentation	***Any change in this section may require a credentialing event. If changing your NPI# and/or AHCCCS Registration you MUST complete the Practitioner or Organizational/Facility Application as appropriate.*** *Please confirm with your Practitioner Rep at the health plans for what is required.* *For any change in AHCCCS Registration, NPI, DEA or TIN, updating with AHCCCS is required*	

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Additional Comments or Explanation/Changes	

Request Submitted by	Name:	Title:
	Date:	
	Phone:	Email:

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Practitioner/Group Name_____

NPI#_____ **CAQH#**_____

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	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				
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				

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Accommodation	YES	NO	NA	Comments
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 other 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 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

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

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HEALTH PLAN	PHONE	FAX/EMAIL	WEBSITE
Arizona Complete Health - Complete Care Plan	(888)788-4408	(866)687-0514 AzCHProviderData@azcompletehealth.com New contract: AzCHPotentialProvider@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
Blue Cross Blue Shield of Arizona Health Choice (ACC plan) Health Choice Pathway (DSNP)	480-760-4651	Request Credentialing-E-apply: https://www.azblue.com/medicaid/providers/provider-portal Request Participation/New Contract E-apply: https://www.azblue.com/medicaid/providers/provider-portal OR Email Credentialing Forms to: hchcredentialing@azblue.com Email Request to Participate to: hchcontracting@azblue.com	https://www.azblue.com/medicaid (ACC) https://www.azblue.com/health-choice-pathway (DSNP)
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 MCCAZProvider@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	866-842-3278, option 1	NA	United Healthcare provider portal access using your One Healthcare ID. Don't have a One Healthcare ID? Register now.

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.