Atypical Individual Enrollment
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This guide explains how to complete the enrollment process for providers when the provider being enrolled:

- Is an individual or sole proprietor operating his/her own health care services; AND
- Does NOT have a National Provider Identifier (NPI).

These providers include:

- Homemaker
- Some Habilitation Providers (Independent Providers)
- Registered Dietician
- Nutritionist
- School-based Attendant Care

Beginning an Application

To begin an application, select the “Atypical-Individual” option, then select “Submit.”

Enrollment Overview

Each provider must complete steps 1 through 11 to submit the application.

- Status column: This column will change from “Incomplete” to “Complete” as steps are completed.
- Step Remark column: This column will alert you to any problems in completing the step.
- Blue font: indicates a hyperlink.
- Steps display in blue font when the step is ready for data entry.
- * An asterisk indicates required fields. Required fields must be completed to proceed forward.
- In order to skip steps, you must first complete steps 1 through 4 in numberical order to make remainder of steps available.
NOTE: It is important to ensure all data entered is accurate and valid.

**Step 1: Provider Basic Information**

1. Step 1: “Provider Basic Information.”

2. Basic Information: Enter the provider’s basic information.
   - Applicant Type:
     - Rendering/Servicing Only: Select this option if a billing provider is billing on your behalf.
     - Individual/Sole Proprietor: Select this option if you are a sole proprietor and own the tax ID number.
     - Tribal Type: select this option if the provider is tribally-affiliated. Leave the question blank if not applicable.

3. W9 Information: IRS W-9 information provided must match IRS reports.
   - W-9 Entity type: For most individuals, “Sole Proprietor” will apply.
   - Profit Type: Non-Profit, For-Profit and Closely Held are the most common profit status codes.
4. Home Address: Enter the home address of the Provider.

Note: Most addresses are validated through USPS. The Address Submission only requires Address Line 1 and Zip Code. When you click the “Validate Address” button, the remaining address fields will be populated.

- Begin with updating the address within the “Address Line 1” field and enter Zip Code; Click the “VALIDATE ADDRESS” option and when the message “Address is validated” displays, the County, City and State fields will be populated.

5. Once complete select, “Finish,” to proceed forward.

6. Once the Basic Information is complete, an Application ID will be provided. You will need this Application ID later if you choose to complete the application at a later time. Once an application has been started, you will have 30 calendar days to complete and submit the application.

TIP: Write down your Application ID and keep it in a safe place. If you misplace the Application ID, check your email account used during the User Registration process to retrieve the email containing the Application ID. If you are unable to locate the email containing the Application ID, please contact the AHCCCS Provider Enrollment team.
7. To continue with the application, select “OK”. By selecting “OK”, this will take you to “Step 2: Add Locations”. This step is required prior to submission of the application.

8. Once the application has been established, you will be brought to the “Business Process Wizard or BPW.” This page breaks down the full application into multiple steps. Step 1, Provider Basic Information, has already been completed which will be indicated in the “Status” column.

- The “Required” column tells you which of the steps are “required” and which are “optional” to submit the application.

Note: To complete the next step, “Click” the blue hyperlink. Currently, only Step 2 has a hyper link. However, once you complete Step 4, every step will display a hyper link, allowing you to complete the steps in any order.
Step 2: Add Locations

1. Select “Step 2: Add Locations.”

2. Select “Add” to open up the details page to add a Primary Practice Location and a Pay-To-Address for the location(s). Adding additional servicing locations are optional.

Note: If you are already registered with AHCCCS, you will see a list of your locations under the “Locations List.” For a new enrollment, this list will be empty.
3. Select: Primary Practice Location” in the drop down menu. Complete all required fields then select “Validate Address” and “OK” to proceed forward.

Note: Enter your street address on Address line 1 and your five-digit zip code, then “Click,” “Validate Address.” The remainder of the address fields will automatically populated and validated by the information from the U.S. Postal Service.

4. Every “Primary Practice Location,” requires hours of operation. Fill in these fields as appropriate.

5. Select, “OK,” when complete.

6. Select the “Primary Practice location” link to Add Pay-To Address. The link will display in Blue font under the “Location Type” field.

Note: A message at the top will indicate a “Pay to Address is required for the Primary Practice Location. To Add/Modify Pay to Address, click on the Primary Practice Location hyperlink.”
7. Select “Add Address.”

8. Type of Address: Select “Pay To Address” in the drop-down menu. Carefully enter, review and “Validate Address” the address. When complete, select “OK” to proceed forward.

Note: If the “Pay to Address” is the same as the Primary Practice Location, Click the “Location Address: radio button Copy this Location Address” to copy the address then click “OK.”
9. The provider address will now display in the Address List. To continue without adding another service location, select “save” and then select “Close” to proceed forward.

10. To add another service location, select “Add Address” and repeat steps 1 though 9. To continue without adding another service location, select “Close” to proceed forward.
Step 3: Add Correspondence Address

1. Select “Step 3: Add Correspondence Address.”
2. Select “Add.”

3. In the “Communication Preference” field, select “Standard Mail” or “Email.”

   NOTE: Only one option may be selected. All notices will go to the mailing address or email address entered on this screen.

4. Carefully enter, review and “Validate Address” the address. When complete, select “OK” to proceed forward.
5. Select “Close” to proceed forward.

Step 4: Add Provider Type/Specialties/Subspecialties

1. Select “Step 4: Add Provider Type/Specialties/Subspecialties.”
2. Select “Add.”

3. Complete the “Add Provider Type/Specialty” and “Add Subspecialty” fields as appropriate.

4. Select, appropriate “Provider Type” in the drop-down option.

5. Select, the “Speciality” in the drop-down option, or “No Specialty” if applicable.

6. Add “Subspecialty”:
   - Select, “Associated Subspecialty”: “No Subspecialty”

Note: For new enrollments, the “Add Provider Type/Specialty & Add Subspecialty” fields will display empty.
7. When complete, select “OK” to proceed forward.

![Image of completed provider type]

8. The image below is an example of a completed provider type.

![Image of example provider type]

Note: Once Step 4 is completed, the rest of the enrollment steps become available and may be completed in any order.

**Step 5: Associate Billing Provider/Other Associations**

Complete Step 5 if another provider will be billing on behalf of the provider. If this step does not apply, skip to Step 6.

Note: To associate, all providers must be or have been approved by the state in new APEP system.
To complete Step 5:

1. Select “Step 5: Associate Billing Provider/Other Associations.”

2. Select “Add.”
3. Enter the AHCCCS ID or NPI of the billing provider. Select “Confirm Provider.” Once the provider is confirmed, select “OK” to complete the association.

Note: If your provider is known to AHCCCS, the Provider Name field is auto-populated.

Step 6: Add License/Certification/Other

1. Select “Step 6: Add License/Certification/Other.”

2. Select “Add”.

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3. Carefully enter the License/Certification/Other List information. Once complete, select “Confirm License/Certification” then select “OK.” Repeat for each available License/Certification.

NOTE: The licenses and certifications listed in the drop-down menu are based on the specialty you indicated in Step 4: Add Provider Type Speciality/Sub-Specialities.

Step 7: Add Provider Controlling Interest/Ownership Details

Note: It's important that all information notated on this page is carefully read

1. Select “Step 7: Add Provider Controlling Interest/Ownership Details.”

2. Clicking the link takes you to a page that describes who exactly should provide details of ownership or controlling interest.

Provider Ownership and Control Disclosures

Provider Enrollment Information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

Required Disclosure Information

Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, recertification, and renewal.

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location and P.O. Box address.
- Date of birth and Social Security Number in the case of an individual.
- Other Tax Identification Number in the case of a corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child, or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employee.

Required Owners

- Managing Employee is mandatory for all enrollment types.
- There must be at least one other ownership type in addition to Managing Employee.
- If any of the following 11 owner types are selected: Corporate/Charitable 501(c)(3), Corporate/Non Charitable, Corporate/Not-For-Profit, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign Nonresident Alien for the Employer tax ID, and then at least 1 of the following 5 owner types must also be selected in addition: Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer.
- If you select any of the following ownership types: Managing Employee, Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Officer, you must add at least 1 additional ownership type that is not from among that list.
- For the Contractor/MCO Enrollment Type, 3 ownership records must be added:
  1. (3) Managing Employee
  2. (2) Board of Directors, Chief Executive Officer, Chief Information Officer, Chief Operating Office
  3. (1) Managing Employee

3. Select “Actions” then select “Add Owner” to add ownership information. Repeat this step if there are multiple owners.
Note: The “Actions” drop-down menu offers you the option to Add an Owner, Import Owner, specify Owner Relationships, and provide details about Owners Adverse Action (if applicable).


5. Carefully enter the Provider/Controlling Interest/Ownership fields for each provider. When complete, select “OK.”
6. Select “Owner’s Relationships.” This option requires an action to proceed forward. Select “Actions,” then select “Owners Relationship” to disclose and establish if Owner’s Relationships.

7. Complete the drop-down fields to describe the relationship between provider owners.

Note: The Managing Employee can be the owner, if an Individual Sole Proprietor was selected.
8. When all information has been entered, select “Save.”

9. For each provider owner, you must disclose any adverse actions taken. Select “Actions,” then select “Owners Adverse Action.”
10. For each owner, indicate if any adverse actions have been taken by answering “Yes” or “No.”
This is an example of a completed Provider Controlling Interest/Owners Detail page.

Note: The “Relationship Status” and Adverse Action” columns reflect as “Completed” for all disclosed Owner Types allowing you to proceed forward.
Step 8: Add Taxonomy Details

This step is related to the providers’ National Provider Identifier (NPI) number and is optional.

Note: Taxonomy codes are reflective on the NPPES NPI Registry website; visit https://npiregistry.cms.hhs.gov/

1. Select “Step 8: Add Taxonomy Details.”
2. Select “Add.”

3. Enter your taxonomy code and start date. A Taxonomy list is available for reference by selecting, “Arrow” link next to the Taxonomy Code field.
4. Click, “Confirm Taxonomy.”
5. Click, “OK.”
6. Select “Close” to proceed forward.

Step 9: Upload Documents
Providers must upload an electronic copy of all applicable licenses, certifications and W-9 forms in this step.

1. Select “Step 9: Upload Documents.”
2. Select “Add.”

3. Select the applicable Document Type and Document Name. Select “Browse” to find the document on your machine.

4. Select a “Start Date” and “End Date” for each uploaded document.

Note: The “Start Date” is the license/certificate date of issuance. If the license/certificate has a renewal date, this date will serve as the “End Date.” If the license/certificate does not have a renewal date, the “End Date” can be left blank.

Note: Document types that may be uploaded include PDF, Word, Excel, and photo formats such as PNG and JPEG.
5. Select, “OK.”

6. Once “Upload Documents” has been completed, each Uploaded Document will display with document name and start/end dates. Select “Close.”

Note: Document types that may be uploaded include PDF, Word, Excel, and photo formats such as PNG and JPEG.
Step 10: Complete Enrollment Checklist

1. Select “Step 10: Complete Enrollment Checklist.”

2. Answer each question and provide any additional information in the Comments field. After reviewing the information, select “Save” and then select “Close.”

Note: Specific questions could result in additional information needed, resulting in potential completed steps requiring review and an action taken by the provider prior to submission.
Step 11: Submit Enrollment Application for Approval

1. Select “Step 11: Submit Enrollment Application for Approval.”

Note: If a step is displaying “Incomplete” in the Status column, Please return to that step and complete all required fields.

2. Once you have reviewed all of your answers in the prior steps, you may submit your application by Selection “Next.”
3. Carefully review the Provider Participation Agreement.

Note: The image below is an example of a Provider Participation Agreement. Prior to submitting, each provider must review the Medicaid Provider Participation Agreement in its entirety.

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**A. PURPOSE:**

This Agreement is made and entered into as of the date executed below by and between the Arizona Health Care Cost Containment System (“AHCCCS” or the “Administration”) and the Provider, as identified above, pursuant to Title XXI and Title XXII of the Social Security Act and A.R.S. §36-2901 et seq. to govern: (1) the registration of, and payment to, the Provider for the health care services provided by the Provider to fee-for-service eligible persons who are not enrolled with a Contractor who is providing member services under contract with AHCCCS (Contractor) or who receive emergency services only; (2) the registration of and for the Provider to participate and deliver health care services to eligible persons who are enrolled with a Contractor; and (3) the registration of the Provider who wishes to participate and qualify under the one-time only waiver option.

Therefore, for and in consideration of the mutual covenants, promises, representations and assurances contained in this Agreement, and for good and valuable consideration, AHCCCS and the Provider do hereby acknowledge and expressly agree as follows:

**B. GENERAL TERMS AND CONDITIONS:**

1. Pursuant to 42 C.F.R. §431.107, the Provider is prohibited from participation in the AHCCCS system unless a provider participation agreement with the Administration is in effect. The Provider may not enter into or continue any contracts for the delivery of health care services to any AHCCCS eligible person, including contracts with any Contractor, if this Agreement is terminated. Furthermore, AHCCCS will not pay the Provider for any services rendered if there is no Agreement in effect at the time the services were rendered or at the time a claim for services rendered is submitted.

2. All AHCCCS guidelines, policies and manuals, including but not limited to the AHCCCS Medical Policy Manual, AHCCCS Fee-For-Service Manual, AHCCCS Claims Guidelines and application forms, are incorporated by reference in this Agreement.

**AGREEMENT & ACKNOWLEDGEMENT:** I agree that my electronic signature is a legally binding equivalent to my handwritten signature. Whenever I execute an electronic signature, it has the same validity and meaning as my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding. Likewise, I, on behalf of the organization that I am authorized to represent, consent to do business electronically. This electronic signature will function as acknowledgement that I am authorized to represent and bind the organization for which this documentation is submitted. An electronic record will be kept of the documentation with which the electronic signature is associated. This electronic record will be retained and capable of being reproduced for future use. It is also acknowledged that this electronic signature meets the standard identified in A.R.S. § 44-7031 for uniqueness, verification, sole control, and record linkage applicable for Arizona. The undersigned attest that they have entered into an agreement effective on the date indicated below. Both parties agree that the organization submitting the enrollment form has the authority to sign and submit this electronic agreement and to maintain enrollment information through AHCCCS Provider Registration.

I have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement. Provider acknowledges that this application is being submitted during the COVID-19 Waiver period, and certain features of the application process have been waived such as fee payment, finger printing, and site visits if applicable. Provider may be required to revalidate following the COVID-19 Waiver period with these features enabled if applicable.

First Name: Veronica Last Name: Valenzuela Date: 07/18/2020
4. Select the “Check box” indicating agreement with the Provider Participation Agreement. The signer’s First, Last and Date will automatically display.

5. Select “Submit Application.”
Note: This returns you back to the BPW. A message should display letting you know your application has been successfully submitted. You can return back to APEP to track the status of your application with the Application ID number. You are also provided with your AHCCCS ID.