ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Information Needed for Completing a Provider Enrollment Application in the AHCCCS Provider Enrollment Portal (APEP)

This form is a guide to help you collect information needed for the APEP application. This form will NOT be accepted as a paper application. All provider enrollment applications must be submitted in APEP.

Provider Name: _____ Application ID: _____ Date Submitted: _____

Provider Number/AHCCCS ID (for currently registered providers):
National Provider Identifier (if applicable):

Enrollment Type (select one)

- ☐ Individual/Sole Proprietor or Rendering/Servicing Provider
- ☐ Group Biller (Provider Type 01) (An organization electing to act as a financial representative for any provider or group of providers.)
- ☐ Facility/Agency Organization (FAO-Hospital, Nursing Facility, Various Entities)
- ☐ Atypical (non-medical) provider (Choose this option if you do not have a NPI)
  - ☐ Individual (Driver, Home Help/Personal Care, Carpenter, etc.)
  - ☐ Agency (Child Care Institution, Home Help/Personal Care Agency, Transportation Company, Local Education Agency etc.)
- ☐ Referring, Ordering, Prescribing, Attending (ROPA) Medical Providers
  - ☐ Individual
  - ☐ Organization/Agency
- ☐ One-Time Enrollment for Single Case
  - ☐ Individual
  - ☐ Organization/Agency
- ☐ Contractor/ MCO
  - ☐ Managed Care Organization(MCO)
  - ☐ Correctional Facilities
  - ☐ Tribal Behavioral Health
  - ☐ Department of Economic Security(DES)

Provider Basic Information (Group Practice, Atypical Agency, or FAO)		
Legal Entity Name:		
Entity Business Name (Doing Business As):		
EIN/TIN:		
Tribal Type: ☐ N/A ☐ Indian Health Service ☐ Privately Owned on Tribal Land ☐ Tribally Owned on Tribal Land	W-9 Entity Type (from Box 3a of the IRS W-9 form): You must also attach a completed W-9 form. This can be found at IRS.GOV	Profit Status: ☐ 501(C)(3) Non Profit ☐ For Profit Closely Held ☐ For Profit, Publicly Traded ☐ Other: ☐ N/A – The individual only practices as part of a group

Provider Basic Information (Individual/Sole Proprietor, Rendering/Servicing, and Atypical Individual)		
Legal First Name:	Middle Initial: ☐ N/A	Legal Last Name:
Suffix:	Gender:	SSN:
Date of Birth: (MM/DD/YYYY)	Home Address:	
City:	State:	ZIP Code:

Locations/Primary Practice Address (required for all enrollment types)		
Primary Practice Address ☐ Same as home address		End Date: (MM/DD/YYYY)
Phone Number:	Email Address:	
Address Line 1:	Address Line 2: ☐ N/A	Address Line 3: ☐ N/A
City/Town:	State/Province:	County:
Country:	ZIP Code:	
Reason for out-of-state registration in Medicaid:		
Web Page:		

Locations/Primary Practice Information (all enrollment types)						
Enter the business hours of operation. Select AM or PM where applicable.						
Open						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Accepting New Medicaid Patients: ☐ YES ☐ NO

In Person/Telehealth: ☐ In Person ☐ Both In Person and Telehealth ☐ Telehealth Only

☐ Handicap Accessible

☐ American Sign Language (ASL)

Language(s) Spoken:

☐ English	☐ Arabic	☐ Cantonese
☐ Chinese	☐ Farsi	☐ French
☐ Korean	☐ Mandarin	☐ Native American
☐ Navajo	☐ Spanish	☐ Russian
☐ Somali	☐ Vietnamese	☐ Other(s) (specify): _____

☐ OB-Gyn Services

☐ Pediatric Services

FQH: ☐ YES ☐ NO

Hospital: ☐ YES ☐ NO

NOTE For additional service locations, use Appendix A.

Pay to Location (all enrollment types)		
Pay To Address ☐ Same as Primary Practice Location		End Date: (MM/DD/YYYY)
Address Line 1:	Address Line 2: ☐ N/A	Address Line 3: ☐ N/A
City/Town:	State/Province:	County:
Country:	ZIP Code:	

Correspondence Address (Where all correspondence will be sent)			
Correspondence Address ☐ Same as Primary Practice Location		Phone Number:	Fax Number (optional):
Communication Preference: ☐ Email ☐ Standard Mail	Select only 1 option (Selecting more than one option or not selecting any option will default to standard U.S. mail.)	Email Address:	End Date (optional): (MM/DD/YYYY)
Address Line 1:		Address Line 2: ☐ N/A	Address Line 3: ☐ N/A
City/Town:		State/Province:	County:
Country:		ZIP Code:	

Provider Type/Specialty/Subspecialties (all enrollment types)	
Provider Type:	
Specialty: (required for Physician, Dentist, Podiatrist, Osteopath, and Registered Nurse Practitioners)	1.
	2.

Associate Billing Provider/Other Associations (all enrollment types, if applicable)	
• Associate Billing Provider/Other Associations information is recommended if another provider will be billing on your behalf. • This section is required for rendering/servicing providers. • To associate, all providers must be in a pending or active status (affiliation to a terminated or suspended provider is not allowed). • Enter AHCCCS ID or NPI of Billing Provider/Other Associations	
☐ AHCCCS ID or ☐ NPI	☐ AHCCCS ID or ☐ NPI
ID Number:	ID Number:
Provider Name:	Provider Name:
Start Date: (MMDDYYYY)	Start Date: (MMDDYYYY)
End Date: (MMDDYYYY)	End Date: (MMDDYYYY)
☐ AHCCCS ID or ☐ NPI	☐ AHCCCS ID or ☐ NPI
ID Number:	ID Number:
Provider Name:	Provider Name:
Start Date: (MMDDYYYY)	Start Date: (MMDDYYYY)
End Date: (MMDDYYYY)	End Date: (MMDDYYYY)
☐ AHCCCS ID or ☐ NPI	☐ AHCCCS ID or ☐ NPI
ID Number:	ID Number:
Provider Name:	Provider Name:
Start Date: (MMDDYYYY)	Start Date: (MMDDYYYY)
End Date: (MMDDYYYY)	End Date: (MMDDYYYY)

License/Certification/Other (all enrollment types except Group)		
License/Certification Number:		
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
License/Certification Number:		
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY
License/Certification Number:		
Issuing Agency:	Effective Date: MMDDYYYY	Expiration Date: MMDDYYYY

Information for Behavioral Health Outpatient Clinic, Behavioral Health Residential Facility, and Integrated Clinics		
Add information for all behavioral health professionals working at the facility.		
Behavioral Health Professional Name First Name: Last Name:		
NPI:	SSN:	AHCCCS ID:
Credentials:		
Start Date:	End Date:	
Behavioral Health Professional Name First Name: Last Name:		
NPI:	SSN:	AHCCCS ID
Credentials:		
Start Date:	End Date:	
Behavioral Health Professional Name First Name: Last Name:		
NPI:	SSN:	AHCCCS ID:
Credentials:		
Start Date:	End Date:	

Information for FAO and Atypical Agency Enrollment Types	
Select Bed Type	Number of bed units
☐ Acute Care Bed(s)	
☐ Licensed LTC Unit(s)	
☐ Licensed Medicaid Bed(s)	
☐ Licensed Medicare Bed(s)	
☐ Licensed Medicaid/Medicare Bed(s)	
☐ Medicare Surgery Bed(s)	
☐ Obstetrics (OB/GYN) Bed(s)	
☐ Pediatrics Bed(s)	
☐ Psych Bed(s)	
☐ Rehab Bed(s)	
☐ Skilled Nursing Bed(s)	
☐ Substance Abuse Bed(s)	
☐ Swing Bed(s)	
☐ Temporarily Non Available Bed(s)	
☐ Ventilator Dependent Unit(s)	

Provider Controlling Interest/Ownership Information (Corporations. Not needed for Individuals.)	
Corporate-Charitable 501(c)3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, Chief Operating Officer	
Title:	Percentage Owned:
SSN:	EIN/TIN: (for Corporation only)
Legal Entity Name:	Entity Business Name:
Owner NPI:	
First Name:	Last Name:
Suffix:	DOB:
Phone Number:	Email:
Start Date:	End Date:
Home address for Individual or business address for Corporation	
Address Line 1:	Address Line 2:
Address Line 3:	City/Town:
State/Province:	County:
Country:	ZIP Code:

NOTE To add additional persons with controlling interest or ownership, see Appendix B.

Managing Employee (Not required for individual enrollment types)	
Managing Employee SSN:	
First Name:	Last Name:
Suffix:	DOB:
Phone Number:	Email:
Start Date:	End Date:
Managing Employee Home Address	
Address Line 1:	Address Line 2:
Address Line 3:	City/Town:
State/Province:	County:
Country:	ZIP Code:

Relationship of Owners (Not required for individual enrollment types)

Do any of the Owners have the following relationship: Daughter, Daughter-In Law, Father, Father-in Law, Mother, Mother-in Law, Sibling, Son, Son-in Law, Self, Spouse?
☐ No ☐ Yes If yes, list names and relationship.

Associate Owner	SSN/EIN/TIN	Relationship Type	Relation to (name)	Relation to Associate Owner

Adverse Actions (all enrollment types)	
This section captures information on final adverse legal actions, such as convictions, exclusions, revocations, and suspensions. All applicable final adverse actions must be reported, regardless of whether any records were expunged, or any appeals are pending. Respond to the following questions on behalf of the following Responsive Entities: the applicant, the entity that the applicant represents; all individuals and entities with an ownership or control interest; all agents, managing employees and key personnel; and any entity in which the applicant (and the entity represented by the applicant) has a 5% or more ownership interest.	
1. Have any Responsive Entities, on or after August 21, 1996, been convicted (as defined in 42 CFR 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea) of any of the following: a. A federal or state felony;	1a. ☐ Yes ☐ No
b. Any criminal offense, under federal or state law, related to the delivery of an item or service under Medicaid, Medicare, AHCCCS, or a state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program;	1b. ☐ Yes ☐ No
c. Any criminal offense, under state or federal law, related to the abuse or neglect of a patient in connection with the delivery of a health care item or service, as further explained in 42 CFR 1001.101(b);	1c. ☐ Yes ☐ No
d. Any criminal offense, under federal or state law, related to the theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service, including the performance of management or administrative services relating to the delivery of items or services under any such program;	1d. ☐ Yes ☐ No
e. Any misdemeanor conviction, under federal or state law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR 1001.101 or 1001.201;	1e. ☐ Yes ☐ No
f. Any misdemeanor conviction, under federal or state law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; or	1f. ☐ Yes ☐ No
g. Any criminal offense related to public assistance or welfare fraud.	1g. ☐ Yes ☐ No
2. Have any Responsive Entities been terminated, denied enrollment, suspended, revoked, precluded, determined ineligible, restricted by Agreement, or otherwise sanctioned by Medicare, AHCCCS, a Medicaid program in any other state, or any other governmental or private medical insurance program?	2. ☐ Yes ☐ No
3. Have any Responsive Entities had their business or professional license, certification, permit, or the licensure of an entity in which they had an ownership interest of 5% or more ever been revoked, suspended, terminated, surrendered, placed on probation, or restricted by Agreement by any licensing authority in any State?	3. ☐ Yes ☐ No

4. Is there currently any pending proceedings, such as but not limited to an indictment, pending plea, or investigation, that could result in any sanction, conviction (as defined in 42 CFR 1001.2, and including convictions that are the result of plea agreements, no contest plea, Alford plea, or nolo contendere plea), or action for any Responsive Entity?	4. ☐ Yes ☐ No
If you answered **yes** to any of the above questions, please tell us who the answer pertains to. Supporting documentation is required for all adverse actions.	
Owner Name:	SSN/EIN/TIN:
Owner Name:	SSN/EIN/TIN:

Taxonomy (not required for atypical enrollment types)	
The NUCC taxonomy code list is available to assist with locating taxonomy. The taxonomy codes are reflective on NPPES NPI registry website; visit https://npiregistry.cms.hhs.gov/.	
Taxonomy Code:	Description:
Start Date: MMDDYYYY	End Date: MMDDYYYY
Taxonomy Code:	Description:
Start Date: MMDDYYYY	End Date: MMDDYYYY
Taxonomy Code:	Description:
Start Date: MMDDYYYY	End Date: MMDDYYYY
Taxonomy Code:	Description:
Start Date: MMDDYYYY	End Date: MMDDYYYY
Taxonomy Code:	Description:
Start Date: MMDDYYYY	End Date: MMDDYYYY
Taxonomy Code:	Description:
Start Date: MMDDYYYY	End Date: MMDDYYYY

Enrollment Checklist/Questionnaire			
Question	**Answer**		**Comments**
Do you wish to end date your enrollment? If yes, enter date in comment field.	☐ Yes	☐ No	
Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field.	☐ Yes	☐ No	
Are you currently excluded from any federal program? If yes, provide the program and date in comment field.	☐ Yes	☐ No	
Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field.	☐ Yes	☐ No	
Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field.	☐ Yes	☐ No	
Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field.	☐ Yes	☐ No	
Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field.	☐ Yes	☐ No	
Have you ever had civil monetary penalty? If yes, provide penalty type and date. If yes, please specify federal or state in comments field.	☐ Yes	☐ No	
Are you trying to reactivate a provider previously active with AHCCCS whose status became inactive or lapsed for any reason? If yes, please add the previous AHCCCS ID in the comments field again.	☐ Yes	☐ No	
Do you have 5% or more ownership interest in other entities reimbursable by Medicaid and/or Medicare? If Yes, provide details in "Add Ownership Details" step.	☐ Yes	☐ No	
Have you had any malpractice settlement, judgment, or agreement? If yes, provide dollar amount and dates in comments field.	☐ Yes	☐ No	
Are you applying as a Private Duty Nurse (LPN/RN) for private duty services?	☐ Yes	☐ No	
If this enrollment is for a change of ownership (CHOW) for an existing provider with a new name, NPI, or Tax ID, please add the previous information in the comment box.	☐ Yes	☐ No	

The following pages are Appendix A and Appendix B. Appendix A is used to collect information for additional locations. Appendix B is used to collect information for additional owners. If the provider does not have additional locations to add, no further information is needed.

Appendix A

Location/Primary Practice Address (required for all enrollment types)		
Primary Practice Address ☐ Same as home address		End Date: (MM/DD/YYYY)
Phone Number:	Email Address:	
Address Line 1:	Address Line 2: ☐ N/A	Address Line 3: ☐ N/A
City/Town:	State/Province:	County:
Country:	ZIP Code:	
Reason for out-of-state registration in Medicaid:		
Web Page:		

Location/Primary Practice Information						
Enter the business hours of operation. Select AM or PM where applicable.						
Open						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM
Close						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM	☐AM ☐PM

Accepting New Medicaid Patients: ☐ YES ☐ NO

In Person/Telehealth: ☐ In Person ☐ Both In Person and Telehealth ☐ Telehealth Only

☐ Handicap Accessible

☐ American Sign Language (ASL)

Language(s) Spoken:

☐ English	☐ Arabic	☐ Cantonese
☐ Chinese	☐ Farsi	☐ French
☐ Korean	☐ Mandarin	☐ Native American
☐ Navajo	☐ Spanish	☐ Russian
☐ Somali	☐ Vietnamese	☐ Other(s) (specify): _____

☐ OB-Gyn Services

☐ Pediatric Services

FQHC: ☐ YES ☐ NO

Hospital: ☐ YES ☐ NO

Click here to return to where you left off

Appendix B

Provider Controlling Interest/Ownership Information	
Corporate-Charitable 501(c)3, Corporate-Non Charitable, Corporate-Publicly Traded, Corporate-Not Publicly Traded, Holding Company, Indirect Owner, Limited Liability Company, Subcontractor, Foreign, Nonresident Alien for the keyed Tax ID, Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, Chief Operating Officer	
Title:	Percentage Owned:
SSN:	EIN/TIN: (for Corporation only)
Legal Entity Name:	Entity Business Name:
Owner NPI:	
First Name:	Last Name:
Suffix:	DOB:
Phone Number:	Email:
Start Date:	End Date:
Home address for Individual or business address for Corporation	
Address Line 1:	Address Line 2:
Address Line 3:	City/Town:
State/Province:	County:
Country:	ZIP Code:

Click here to return to where you left off