DELEGATED ROSTER

Format 2024, 2025

Green indicates **OPTIONAL** Fields. Please leave **BLANK** if you won't be answering

TYPE (add/term/change/or other reason)	CAQH #	PRACTITIONER'S LAST NAME	PRACTITIONER'S FIRST NAME	PRACTITIONER'S MIDDLE INITIAL	DEGREE/TITLE	CURRENT ORIENTAIUING DATE/COMMITTEE DATE	NEXT RECREDENTIALING DATE	EFF DATE W/PRACTICE	END DATE W/PRACTICE	REASON FOR TERM (left group, deceased, etc)	INDIVIDUAL NPI#	DOB	PROVIDER GENDER (see help tab)	DEA #	DEA STATE	DEA EXPIRATION DATE	HOSPITAL BASED (Yes or No)	TYPE OF VISIT (Telemedicine, In-Person, Both)	IS PROVIDER A MEDICATION ASSISTED TREATMENT (MAT) PRESCRIBER? (Yes or No)	X2DEA# (If provider is a MAT prescriber)	X2DEA State: (If provider is an MAT prescriber)	X2DEA Expiration Date: (If provider is an MAT prescriber)	LINE OF BUSINESS-MEDICAID/ MEDICARE/COMMERCIAL (Medicaid only, Medicaid/Medicare, Medicaid/Medicare/Commercial, Medicare only, Commercial only)	AZ MEDICARE PARTICIPATING PROVIDER (Yes or No)	PRACTITIONER PTAN#	LICENSE#	LICENSE STATE	LICENSE EXPIRATION DATE	MALPRACTICE POLICY #	SSN#	AHCCCS ID #	PRACTITIONER TYPE (PCP, OBGYN, SPECIALIST, RHC DENTIST, OTHER (explain))	GROUP TYPE (FQHC/RHC, IC, MULTI SPECIALIST, OTHER (explain))	*PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN NAME OR DOCUMENT COLLABORATIVE PA* *OPTIONAL FOR OTHER PROVIDER TYPES--LEAVE BLANK*	*DENTAL HYGIENIST AFFILIATED DENTIST NAME* *OPTIONAL FOR OTHER PROVIDER TYPES--LEAVE BLANK*	*NEW DENTIST GRADUATE WITHIN LAST 6 MONTHS* *(Yes or No)* *OPTIONAL FOR OTHER PROVIDER TYPES--LEAVE BLANK*	*GRADUATION/COMPLETION DATE* *(if new grad provide date)* *OPTIONAL FOR OTHER PROVIDER TYPES--LEAVE BLANK*

PRIMARY SPECIALTY	PRIMARY SPECIALTY BOARD CERTIFIED (Yes or No)	*DATE OF EXAM* *OPTIONAL -LEAVE BLANK*	SECONDARY SPECIALTY	SECONDARY SPECIALTY BOARD CERTIFIED (Yes or No)	*DATE OF EXAM* *OPTIONAL -LEAVE BLANK*	CONTRACT AS PCP (Yes or No)	ACCEPTING NEW PATIENTS? (Yes or No)	ANY PANEL RESTRICTIONS-- PLEASE EXPLAIN --SUCH AS ONLY REFERRALS, ETC.	PATIENT AGE RANGE (i.e. 0-99)	PATIENT GENDER (See Help tab)	DO YOU E-PRESCRIBE? (Yes or No)	*DO YOU PROVIDE SERVICES TO INDIVIDUALS W/ PHYSICAL SPECIAL NEEDS/ CHRONIC CONDITIONS?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU PROVIDE SERVICES TO INDIVIDUALS W/ DEVELOPMENTAL SPECIALNEEDS/ CHRONIC CONDITIONS?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU PROVIDE SERVICES TO INDIVIDUALS W/ BEHAVIORAL SPECIALNEEDS/ CHRONIC CONDITIONS?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU PROVIDE SERVICES TO INDIVIDUALS W/ EMOTIONAL SPECIALNEEDS/ CHRONIC CONDITIONS?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU PROVIDE SERVICES TO INDIVIDUALS WHO HAVE DIFFICULTY COMMUNICATION OR COOPERATING* *(i.e. autism or intellectual disabilities)* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU PROVIDE SERVICES TO INDIVIDUALS WITH MOBILITY LIMITATIONS ?* *(i.e. Wheelchair bound)* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU TREAT ANXIETY ?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU TREAT ADHD ?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU TREAT DEPRESSION ?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU TREAT AUTISM SPECTRUM DISORDER?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	*DO YOU TREAT SEX ?* *(Yes or No)* *OPTIONAL*	*DO YOU TREAT ADDICTION/ SUBSTANCE ABUSE ?* *(Yes or No)* *OPTIONAL -LEAVE BLANK*	ARE YOU TRAINED IN THE USE AND SCORING OF THE DEVELOPMENTAL SCREENING TOOLS AS INDICATED BY THE AAP? (Yes or No)	DO YOU HAVE SPECIALIZED TRAINING/CERTIFICATIONS IN ANY OF THE FOLLOWING (SEE THE HELP TAB)	PCPs & OBs ONLY DO YOU PROVIDE EPSDT SERVICES? (Yes or No)	PCPs DO YOU PROVIDE OB SERVICES? (Yes or No)	DO YOU PARTICIPATE IN VFC (Vaccine for Children) (PCPs seeing AHCCCS members 18 & < MUST participate) (Yes or No)	VFC PIN CODE	HOSPITAL AND AMBULATORY SURGERY CENTER PRIVILEGES (List)	*NAMES OF PRACTITIONERS IN CALL GROUP* *(Must be contracted with plan)* *OPTIONAL-LEAVE BLANK*	PRACTITIONERS LANGUAGES (Other than English)	PRACTITIONERS RACE (See Help Tab)	PRACTITIONERS ETHNICITY (See Help tab)	OFFICE STAFF LANGUAGES (Other than English)	*OTHER NAMES POSSIBLE IN RECORDS* *OPTIONAL-LEAVE BLANK*	1099 REGISTERED NAME (Legal name that TIN was issued to)	GROUP PRACTICE NAME (DBA)	TAX ID #

ORGANIZATIONAL NPI#	BILLING SERVICE NAME	ADDRESS	SUITE #	CITY	STATE	ZIP	PHONE #	FAX #	BILLING CONTACT NAME	EMAIL	PAY TO (REMIT) ADDRESS	SUITE #	CITY	STATE	ZIP	PHONE #	FAX #	INDICATE IF PRIMARY, SECONDARY OR ADDITIONAL LOCATION	PRIMARY LOCATION ADDRESS (WHERE SERVICES ARE RENDERED) ADD ADDITIONAL LOCATIONS/ADDRESSES ON A SEPARATE LINE	SUITE#	CITY	STATE	ZIP	COUNTY (Apache, Cochise, Coconino Gila, Graham, Greenlee, Lafac, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, Yuma)	APPOINTMENT PHONE #	FAX #	OFFICE HOURS ON SUNDAY Example: 8-4pm or closed	OFFICE HOURS ON MONDAY Example: 8-4pm or closed	OFFICE HOURS ON TUESDAY Example: 8-4pm or closed	OFFICE HOURS ON WEDNESDAY Example: 8-4pm or closed	OFFICE HOURS ON THURSDAY Example: 8-4pm or closed	OFFICE HOURS ON FRIDAY Example: 8-4pm or closed	OFFICE HOURS ON SATURDAY Example: 8-4pm or closed

IS OFFICE ACCESSIBLE TO PERSONS WITH DISABILITIES? (Yes or No)	PRACTITIONER IN DIRECTORY? (Yes or No)	PRACTICE CONTACT NAME/TITLE	EMAIL ADDRESS	WEBSITE ADDRESS	MAILING ADDRESS	SUITE #	CITY	STATE	ZIP	PHONE #	FAX #	CREDENTIALING CONTACT (Name)	ADDRESS	SUITE #	CITY	STATE	ZIP	PHONE #	FAX#	EMAIL	DESCRIBE MEDICAL RECORD KEEPING SYSTEM (i.e. EMR, Paper, etc.)	DESCRIBE COST RECORD KEEPING SYSTEM (i.e. Billing or A/R system)	ELECTRONIC CLAIMS SUBMISSION? (Yes or No)	INTERNET ACCESS? (Yes or No)	MINORITY OR FEMALE OWNED BUSINESS? (Yes or No)	*MEDICAL/DENTAL SCHOOL* *OPTIONAL-LEAVE BLANK*	*GRADUATION DATE* *OPTIONAL-LEAVE BLANK*	*FOREIGN MEDICAL SCHOOL* *OPTIONAL-LEAVE BLANK*	*GRADUATION DATE* *OPTIONAL-LEAVE BLANK*	*INTERNSHIP SCHOOL* *OPTIONAL-LEAVE BLANK*	*INTERNSHIP DATE* *OPTIONAL-LEAVE BLANK*

RESIDENCY SCHOOL OPTIONAL-LEAVE BLANK	RESIDENCY START DATE OPTIONAL-LEAVE BLANK	RESIDENCY END DATE OPTIONAL-LEAVE BLANK	RESIDENCY SPECIALTY OPTIONAL-LEAVE BLANK	RESIDENCY SCHOOL2 OPTIONAL-LEAVE BLANK	RESIDENCY START DATE OPTIONAL-LEAVE BLANK	RESIDENCY END DATE OPTIONAL-LEAVE BLANK	RESIDENCY SPECIALTY OPTIONAL-LEAVE BLANK	FELLOWSHIP SCHOOL OPTIONAL-LEAVE BLANK	FELLOWSHIP START DATE OPTIONAL-LEAVE BLANK	FELLOWSHIP END DATE OPTIONAL-LEAVE BLANK	FELLOWSHIP SPECIALTY OPTIONAL-LEAVE BLANK	FELLOWSHIP SCHOOL2 OPTIONAL-LEAVE BLANK	FELLOWSHIP START DATE OPTIONAL-LEAVE BLANK	FELLOWSHIP END DATE OPTIONAL-LEAVE BLANK	FELLOWSHIP SPECIALTY OPTIONAL-LEAVE BLANK

ASSESSMENT OF COGNITIVE AND PHYSICAL DISABILITIES ACCOMMODATIONS

Please identify what accommodations you provide at each of your facility locations for members with cognitive or physical disabilities. If accommodations are the same at all locations, on Practice Location Adddress, please state ALL.
Please, complete a separate Assessment for each location if accommodations vary.

Facility 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 --sick appointments, same day appts-- please specify	☐	☐	
Extended appointment times--before 8 am, after 5 pm, 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 3 factor 5)*	☐	☐	
Records are securely maintained in a confidential and orderly manner (Med 3 factor 5)*	☐	☐	
Records are in compliance with HIPAA requirements (MED 3A factor 5)*	☐	☐	
In-home and/or community services	☐	☐	
Large print materials	☐	☐	
Materials in electronc format	☐	☐	
Augmentative /Alternative comunication devices	☐	☐	
TDD capabilities	☐	☐	
American Sign Language translator	☐	☐	
Signage with Braille and raised tactile text characters at office, elevator, stairwells and restrooms doors mounted 60in from floor	☐	☐	
Visible & Audible alarms--emergency systems	☐	☐	
Dimmable Lights	☐	☐	
Ramps have non-slip surface material	☐	☐	
Railings between 30 and 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	☐	☐	
Handicap parking	☐	☐	
Handicap accessible restroom	☐	☐	
Access ramps	☐	☐	
Accessible by bus	☐	☐	
Accessible by Taxis or 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 to members and their families than the Multi-Specialty Interdisciplinary (MSIC) to provide a specific set of Interdisciplinary Clinics (ICs) to provide a specific set of services including evaluation, monitory, 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

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
DentaQuest	(800) 233-1468	credenrollment@greatdentalplans.com (262) 241-7401	http://www.dentaquest.com/state- plans/regions/arizona/az-dentist- page
BCBSAZ Health Choice Arizona	(800) 322-8670 (options in order 4, 7)	Preferred: E-apply through the Health Choice Az Provider Portal Alternate: Request to participate/Contract: hchcontracting@azblue.com Request to credential/Already Contracted: hchcredentialing@azblue.com	www.healthchoiceaz .com www.healthchoicepathway.com
Molina Complete Care Arizona	(800) 424-5891	(888)656-0369 MCCAZ-Provider@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	For questions please email: networkhelp@uhc.com	Submission to the RFP Portal is the preferred method for accepting the pdf:UHC RFP Portal (855) 523-9998 Cred_applications@uhc.com	www.uhcprovider.com

Gender Options for both Provider and Members
F=Female
M=Male
NB=Non-binary
TF=Transgender female
TM=Transgender male
ND=Does not wish to disclose
A=All

RACE
B=Black or African American
H=Hispanic or Latino
W=White
AI=American Indian or Alaska Native
NH=Native Hawaiian or other Pacific Islander
ME=Middle Eastern or North African
PND=Prefer not to disclose
Other-please spcecify

ETHNICITY
H=Hispanic or Latino
NH=Not Hispanic or Not Latino
PND=Perfer not to disclose

Specialized Training/Certifications
HE=Health Equity
D=Diversity
E=Equity
I=Inclusion
TIC=Trauma Informed Care

DELEGATED ROSTER

	References--this may not be an all inclusive list of references	Optional fields --highlighted in green	
TYPE (add/term/change/or other reason)	Plan requirement		
CAQH #	Policy 950		
PRACTITIONER'S LAST NAME	CAQH, contracts and Policy 950		
PRACTITIONER'S FIRST NAME	CAQH, contracts and Policy 950		
PRACTITIONER'S MIDDLE INTIAL	CAQH, contracts and Policy 950		
DEGREE/TITLE	CAQH, contracts and Policy 950		
CURRENT CREDENTIALING DATE/COMMITTEE DATE	CAQH, contracts and Policy 950		
NEXT RECREDENTIALING DATE	CAQH, contracts and Policy 950		
EFF DATE W/PRACTICE	CAQH, contracts and Policy 950		
END DATE W/PRACTICE	CAQH, contracts and Policy 950		
REASON FOR TERM (Left group, deceased, etc)	Plan requirement		
INDIVIDUAL NPI#	CAQH		
DOB	CAQH		
PROVIDER GENDER (see help tab)	CAQH		
DEA #	CAQH		
DEA STATE	CAQH		
DEA EXPIRATION DATE	CAQH		
HOSPITAL BASED (Yes or No)	CAQH		
TYPE OF VISIT (Telemedicine, In-Person, Both)	CAQH/ACOM 406		
IS PROVIDER A MEDICATION ASSISTED TREATMENT (MAT) PRESCRIBER? (Yes or No)	Policy 950		
XDEA# (if provider is a MAT prescriber)	Policy 950		
XDEA State: (if provider is an MAT prescriber)	Policy 950		
XDEA Expiration Date: (if provider is an MAT prescriber)	Policy 950		
LINE OF BUSINESS-MEDICAID/ MEDICARE/COMMERCIAL (Medicaid only, Medicaid/Medicare, Medicaid/Medicare/Commercial, Medicare only, Commercial only)	required for contracts		
AZ MEDICARE PARTICIPATING PROVIDER (Yes or No)	required for contracts		
PRACTITIONER PTAN#	required for contracts		
LICENSE#	CAQH and PSV		
LICENSE STATE	CAQH and PSV		
LICENSE EXPIRATION DATE	CAQH and PSV		
MALPRACTICE POLICY #	CAQH and PSV		
SSN#	CAQH and PSV		
AHCCCS ID #	CAQH and PSV		
PRACTITIONER TYPE (PCP, OBGYN, SPECIALIST, BH, DENTIST, OTHER (explain))	CAQH and PSV		
GROUP TYPE (FQHC/RHC, IC, MULTI SPECIALIST, OTHER (explain))	CAQH and PSV		
PHYSICIAN ASSISTANT SUPERVISING PHYSICIAN NAME OR DOCUMENT COLLABORATIVE PA	CAQH	Optional for other provider types	Leave blank
DENTAL HYGIENIST AFFLIATED DENTIST NAME	Policy 950	Optional for other provider types	Leave blank
NEW DENTIST GRADUATE WITHIN LAST 6 MONTHS (Yes or No)	Policy 950	Optional for other provider types	Leave blank
GRADUATION/COMPLETION DATE (If new grad provide date)	PSV	Optional for other provider types	Leave blank
PRIMARY SPECIALTY	PSV		
PRIMARY SPECIALTY BOARD CERTIFIED (Yes or No)	PSV		
DATE OF EXAM	PSV	Optional	Leave blank
SECONDARY SPECIALTY	PSV		
SECONDARY SPECIALTY BOARD CERTIFIED (Yes or No)	PSV		
DATE OF EXAM	PSV	Optional	Leave blank
CONTRACT AS PCP (Yes or No)	Billing and directory requirements/member assignment/AHCCCS reporting		
ACCEPTING NEW PATIENTS? (Yes or No)	required for directory/member assignment/ACOM 406/AHCCCS reporting		
ANY PANEL RESTRICTIONS-- PLEASE EXPLAIN --SUCH AS ONLY REFERRALS, ETC.	required for directory/member assignment		
PATIENT AGE RANGE (i.e. 0-99)	required for directory/member assignment		
PATIENT GENDER (See Help tab)	required for directory/member assignment		
DO YOU E-PRESCRIBE? (Yes or No)	Plan requirement/AHCCCS requirement		
DO YOU PROVIDE SERVICES TO INDIVIDUALS W/PHYSICAL SPECIAL NEEDS/ CHRONIC CONDITIONS? (Yes or No)	Plan requirement and for directory/AHCCCS reporting	Optional	Leave blank
DO YOU PROVIDE SERVICES TO INDIVIDUALS W/DEVELOPMENTAL SPECIALNEEDS/ CHRONIC CONDITIONS? (Yes or No)	Plan requirement and for directory/AHCCCS reporting	Optional	Leave blank
DO YOU PROVIDE SERVICES TO INDIVIDUALS W/BEHAVIORAL SPECIALNEEDS/ CHRONIC CONDITIONS? (Yes or No)	Plan requirement and for directory/AHCCCS reporting	Optional	Leave blank
DO YOU PROVIDE SERVICES TO INDIVIDUALS W/EMOTIONAL SPECIALNEEDS/ CHRONIC CONDITIONS? (Yes or No)	Plan requirement and for directory/AHCCCS reporting	Optional	Leave blank
DO YOU PROVIDE SERVICES TO INDIVIDUALS WHO HAVE DIFFICULTY COMMUNICATION OR COOPERATING (i.e. autism or intellectual disabilities? (Yes or No)	Plan requirement and for directory/AHCCCS reporting	Optional	Leave blank
DO YOU PROVIDE SERVICES TO INDIVIDUALS WITH MOBILITY LIMITATIONS? (i.e.Wheelchair bound) (Yes or No)	Plan requirement and for directory/ACOM 406/AHCCCS reporting	Optional	Leave blank
DO YOU TREAT ANXIETY? (Yes or No)	Plan requirement and for directory	Optional	Leave blank
DO YOU TREAT ADHD? (Yes or No)	Plan requirement and for directory	Optional	Leave blank
DO YOU TREAT DEPRESSION? (Yes or No)	Plan requirement and for directory	Optional	Leave blank
DO YOU TREAT AUTISM SPECTRUM DISORDER?	Plan requirement and for directory	Optional	Leave blank
DO YOU TREAT HIV? (Yes or No)	Plan requirement and for directory	Optional	Leave blank
DO YOU TREAT ADDICTION/ SUBSTANCE ABUSE? (Yes or No)	Plan requirement and for directory	Optional	Leave blank
ARE YOU TRAINED IN THE USE AND SCORING OF THE DEVELOPMENTAL SCREENING TOOLS AS INDICATED BY THE AAP? (Yes or No)	Plan requirement and for directory and for billing		
DO YOU HAVE SPECIALIZED TRAINING/CERTIFICATIONS IN ANY OF THE FOLLOWING (SEE THE HELP TAB)	Plan requirement and for directory		
PCPs & OBs ONLY DO YOU PROVIDE EPSDT SERVICES? (Yes or No)	Plan requirement and for directory/AHCCCS reporting		
PCPs DO YOU PROVIDE OB SERVICES? (Yes or No)	Plan requirement and for directory/AHCCCS reporting		
DO YOU PARTICIPATE IN VFC (Vaccine for Children) (PCPs seeing AHCCCS members 18 & < MUST participate) (Yes or No)	Policy 950, Plan requirement/Member assignment		
VFC PIN CODE	Policy 950, Plan requirement		
HOSPITAL AND AMBULATORY SURGERY CENTER PRIVILEGES (List)	Plan requirement/ACOM 406		
NAMES OF PRACTITIONERS IN CALL GROUP (Must be contracted with plan)	Plan requirement	Optional	
PRACTITIONERS LANGUAGES (Other than Engish)	Plan requirement, Policy 950 and directory/ ACOM 406		
PRACTITIONERS RACE (See Help Tab)	Plan requirement, Policy 950 and directory, NCQA requirement		
PRACTITIONERS ETHNICITY (See Help tab)	Plan requirement, Policy 950 and directory, NCQA requirement		
OFFICE STAFF LANGUAGES (Other than English)	ACOM 406/		
OTHER NAMES POSSIBLE IN RECORDS		optional	Leave blank
1099 REGISTERED NAME (Legal name that TIN was issued to)	required for contracts and for completing billing information		
GROUP PRACTICE NAME (DBA)	required for contracts and for completing billing information		
TAX ID #	required for contracts and for completing billing information		
ORGANIZATIONAL NPI#	required for contracts and for completing billing information		
BILLING SERVICE NAME	required for payment systems		
ADDRESS	required for payment systems		
SUITE #	required for payment systems		
CITY	required for payment systems		
STATE	required for payment systems		
ZIP	required for payment systems		
PHONE #	required for payment systems		
FAX #	required for payment systems		
BILLING CONTACT NAME	required for payment systems		
EMAIL	required for payment systems		
PAY TO (REMIT) ADDRESS	required for payment systems		
SUITE #	required for payment systems		
CITY	required for payment systems		
STATE	required for payment systems		
ZIP	required for payment systems		
PHONE #	required for payment systems		
FAX #	required for payment systems		
INDICATE IF PRIMARY, SECONDARY OR ADDITIONAL LOCATION	ACOM 406/AHCCCS reporting		
PRIMARY LOCATION ADDRESS (WHERE SERVICES ARE RENDERED) ADD ADDITIONAL LOCATIONS/ADDRESSES ON A SEPARATE LINE	ACOM 406/AHCCCS reporting		
SUITE#	ACOM 406/AHCCCS reporting		
CITY	ACOM 406/AHCCCS reporting		
STATE	ACOM 406/AHCCCS reporting		
ZIP	ACOM 406/AHCCCS reporting		
COUNTY (Apache, Cochise, Coconino Gila, Graham, Greenlee, LaPaz, Maricopa, Mohave, Navajo, Pima, Pinal, SantaCruz, Yavapai, Yuma)	ACOM 406/AHCCCS reporting		
APPOINTMENT PHONE #	ACOM 406/AHCCCS reporting		
FAX #			
OFFICE HOURS ON SUNDAY Example: 8-4pm or closed	required for provider directory		
OFFICE HOURS ON MONDAY Example: 8-4pm or closed	required for provider directory		
OFFICE HOURS ON TUESDAY Example: 8-4pm or closed	required for provider directory		
OFFICE HOURS ON WEDNESDAY Example: 8-4pm or closed	required for provider directory		
OFFICE HOURS ON THURSDAY Example: 8-4pm or closed	required for provider directory		
OFFICE HOURS ON FRIDAY Example: 8-4pm or closed	required for provider directory		
OFFICE HOURS ON SATURDAY Example: 8-4pm or closed	required for provider directory		
IS OFFICE ACCESSIBLE TO PERSONS WITH DISABILITIES? (Yes or No)	required for provider directory/ACOM 406		
PRACTITIONER IN DIRECTORY? (Yes or No)	Plan requirement		
PRACTICE CONTACT NAME/TITLE	Plan requirement		
EMAIL ADDRESS	Plan requirement		
WEBSITE ADDRESS	Plan requirement		
MAILING ADDRESS	Plan requirement		
SUITE #	Plan requirement		
CITY	Plan requirement		
STATE	Plan requirement		
ZIP	Plan requirement		
PHONE #	Plan requirement		
FAX #	Plan requirement		
CREDENTIALING CONTACT (Name)	required for contracting		
ADDRESS	required for contracting		
SUITE #	required for contracting		
CITY	required for contracting		
STATE	required for contracting		
ZIP	required for contracting		
PHONE #	required for contracting		
FAX#	required for contracting		
EMAIL	required for contracting		
DESCRIBE MEDICAL RECORD KEEPING SYSTEM (i.e. EMR, Paper, etc.)	AHCCCS requirement		
DESCRIBE COST RECORD KEEPING SYSTEM (i.e. Billing or A/R system) ELECTRONIC CLAIMS SUBMISSION? (Yes or No)	AHCCCS requirement		
INTERNET ACCESS? (Yes or No)	AHCCCS requirement		
MINORITY OR FEMALE OWNED BUSINESS? (Yes or No)	AHCCCS requirement	Optional	Leave blank
MEDICAL/DENTAL SCHOOL	PSV	Optional	Leave blank
GRADUATION DATE	PSV	Optional	Leave blank
FOREIGN MEDICAL SCHOOL	PSV	Optional	Leave blank
GRADUATION DATE	PSV	Optional	Leave blank
INTERNSHIP SCHOOL	PSV	Optional	Leave blank
INTERNSHIP DATE	PSV	Optional	Leave blank
RESIDENCY SCHOOL	PSV	Optional	Leave blank
RESIDENCY START DATE	PSV	Optional	Leave blank
RESIDENCY END DATE	PSV	Optional	Leave blank
RESIDENCY SPECIALTY	PSV	Optional	Leave blank
RESIDENCY SCHOOL2	PSV	Optional	Leave blank
RESIDENCY START DATE	PSV	Optional	Leave blank
RESIDENCY END DATE	PSV	Optional	Leave blank
RESIDENCY SPECIALTY	PSV	Optional	Leave blank
FELLOWSHIP SCHOOL	PSV	Optional	Leave blank
FELLOWSHIP START DATE	PSV	Optional	Leave blank
FELLOWSHIP END DATE	PSV	Optional	Leave blank
FELLOWSHIP SPECIALTY	PSV	Optional	Leave blank
FELLOWSHIP SCHOOL2	PSV	Optional	Leave blank
FELLOWSHIP START DATE	PSV	Optional	Leave blank
FELLOWSHIP END DATE	PSV	Optional	Leave blank
FELLOWSHIP SPECIALTY	PSV	Optional	Leave blank

OTVORNE REDOVI SU TAKOVOG OBLIKA