



Group Practice Enrollment



Group Enrollment

This guide explains how to complete the enrollment process for providers when the provider being enrolled

- Is a group biller or group billing organization; AND
- Has a National Provider Identifier (NPI)

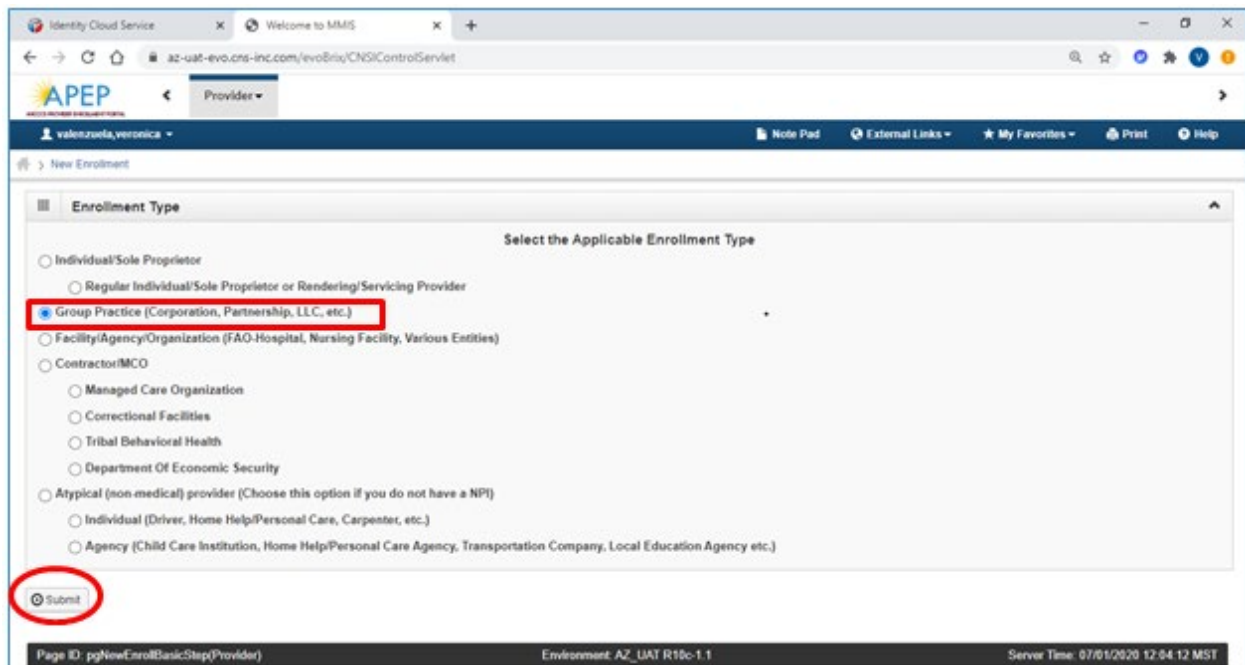
Note: if a group biller does not have an NPI, select “Atypical (non-medical) provider.”

These providers include:

- Group billers
- Group billing organizations

Beginning an Application

To begin an application, select the “Group Practice (corporation, Partnership, LLC, etc.)” option, then select “Submit.”



The screenshot shows a web browser window with the URL a2-uat-evo.cns-inc.com/evobrio/CNSIControlServlet. The page title is "New Enrollment". Under the "Enrollment Type" section, the following options are listed:

- Individual/Sole Proprietor
- Regular Individual/Sole Proprietor or Rendering/Service Provider
- Group Practice (Corporation, Partnership, LLC, etc.)
- Facility(Agency/Organization (FAO-Hospital, Nursing Facility, Various Entities)
- Contractor/MCO
 - Managed Care Organization
 - Correctional Facilities
 - Tribal Behavioral Health
 - Department Of Economic Security
- 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.)

The "Submit" button is located at the bottom left of the form area.

Enrollment Overview

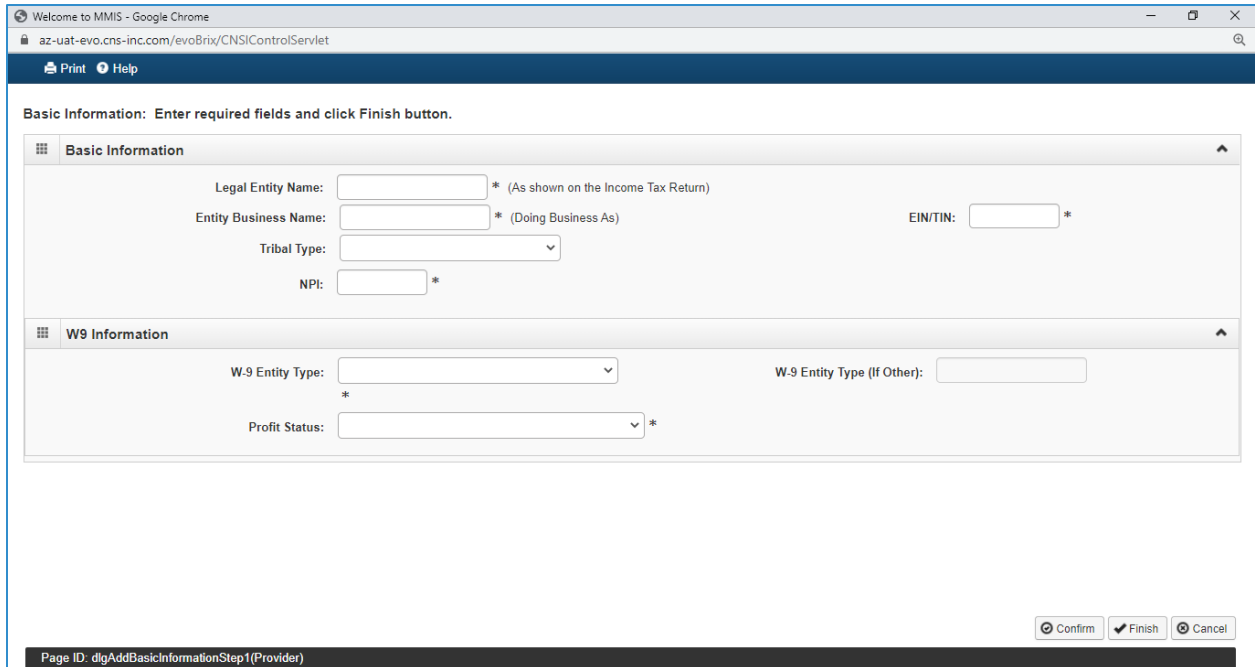
Each provider must complete steps 1 through 10 to submit the application.

- 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.
- In order to skip steps, you must first complete steps 1 through 4 in numerical order to make the remainder of steps available.
- * An asterisk indicates required fields. Required fields must be completed to advance forward.

NOTE: It is important to ensure all data entered is accurate and valid.

Step 1: Provider Basic Information

1. Select Step 1: "Provider Basic Information."



Welcome to MMIS - Google Chrome
 az-uat-evo.cns-inc.com/evoBrix/CNSIControlServlet

Print Help

Basic Information: Enter required fields and click Finish button.

Basic Information

Legal Entity Name: * (As shown on the Income Tax Return)
 Entity Business Name: * (Doing Business As) EIN/TIN: *
 Tribal Type: ▾
 NPI: *

W9 Information

W-9 Entity Type: ▾ W-9 Entity Type (If Other):
 *
 Profit Status: ▾ *

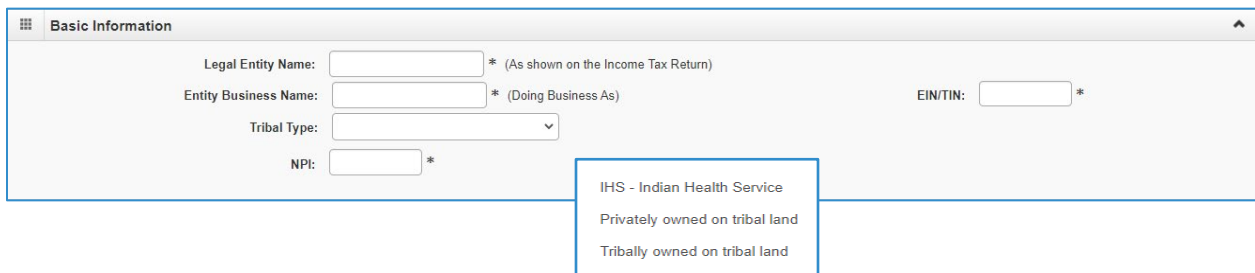
Confirm Finish Cancel

Page ID: dlgAddBasicInformationStep1(Provider)

2. Basic Information: Enter the provider's basic information.

- Legal Entity Name: As shown on the provider's Income Tax Return
- Entity Business Name: Provider's "Doing Business Name"

Note: Your 10-digit National Provider Identifier (NPI) number is required. If you do not have an NPI number, cancel the enrollment by clicking the "Cancel" button at the bottom of the page, return to the Enrollment Type page, and choose "Atypical Agency" as your enrollment type.



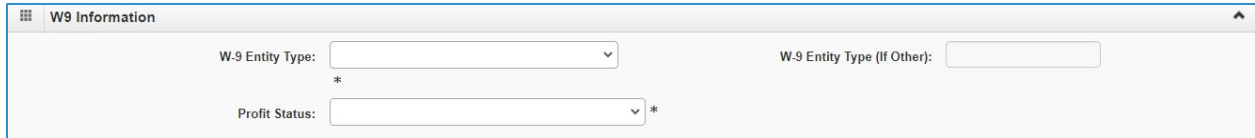
Basic Information

Legal Entity Name: * (As shown on the Income Tax Return)
 Entity Business Name: * (Doing Business As) EIN/TIN: *
 Tribal Type: ▾
 NPI: *

IHS - Indian Health Service
 Privately owned on tribal land
 Tribally owned on tribal land

3. W-9 Entity Type: IRS W-9 information provided must match IRS reports.

- Corporate-Charitable applies for non-profits
- Corporate-Non-Charitable applies for many private companies
- Profit Status: Non-Profit, For-Profit, and Closely Held are the most common Profit Status Codes that apply for non-profits and private companies.

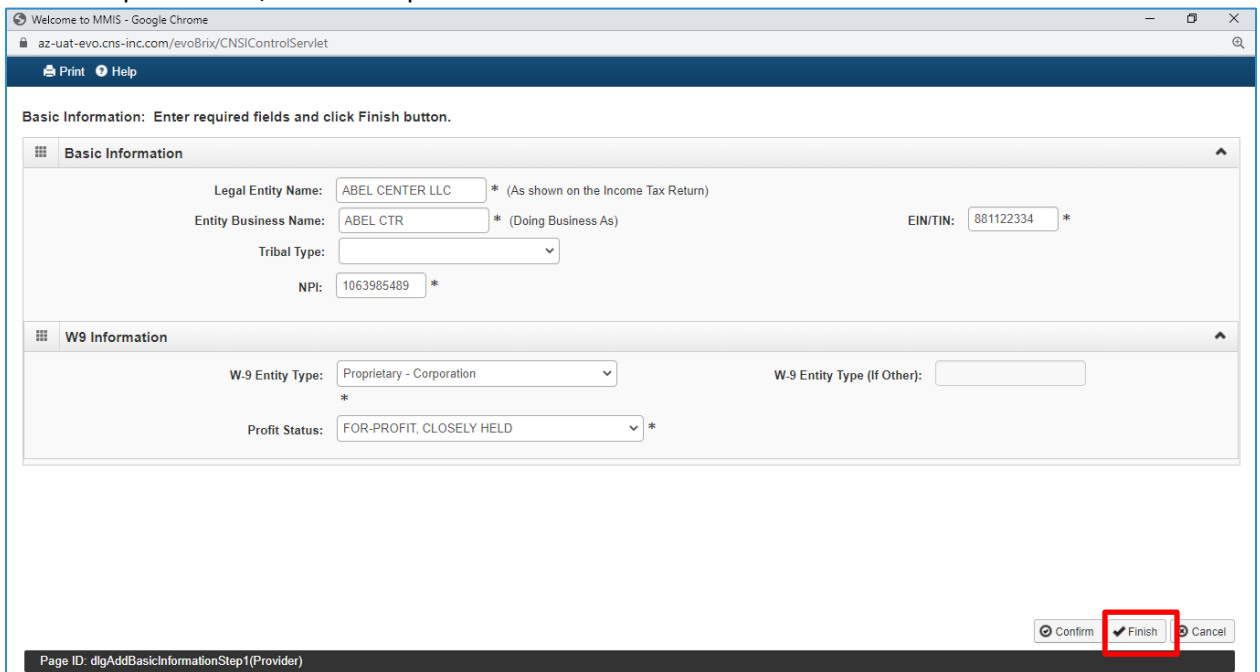


W9 Information

W-9 Entity Type: * W-9 Entity Type (If Other):

Profit Status: *

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



Welcome to MMIS - Google Chrome
az-uat-evo.cns-inc.com/evoBrix/CNSIControlServlet

Print Help

Basic Information: Enter required fields and click Finish button.

Basic Information

Legal Entity Name: ABEL CENTER LLC * (As shown on the Income Tax Return)

Entity Business Name: ABEL CTR * (Doing Business As) EIN/TIN: 881122334 *

Tribal Type:

NPI: 1063985489 *

W9 Information

W-9 Entity Type: Proprietary - Corporation * W-9 Entity Type (If Other):

Profit Status: FOR-PROFIT, CLOSELY HELD *

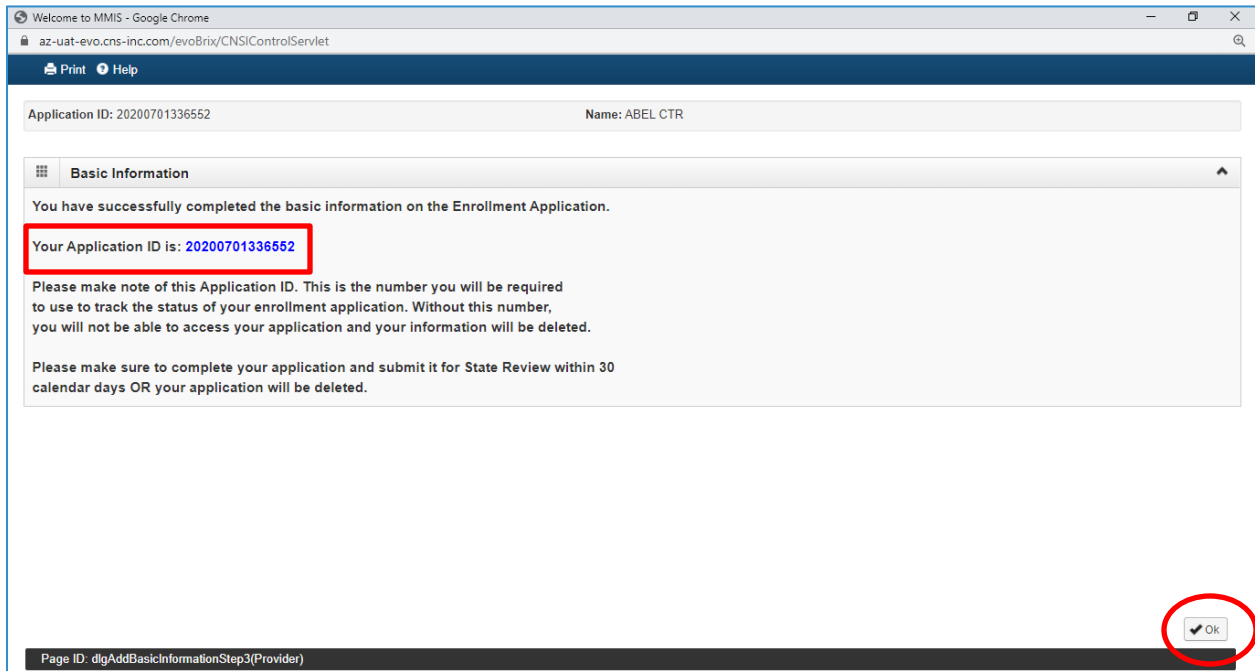
Confirm **Finish** Cancel

Page ID: dlgAddBasicInformationStep1(Provider)

5. 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.

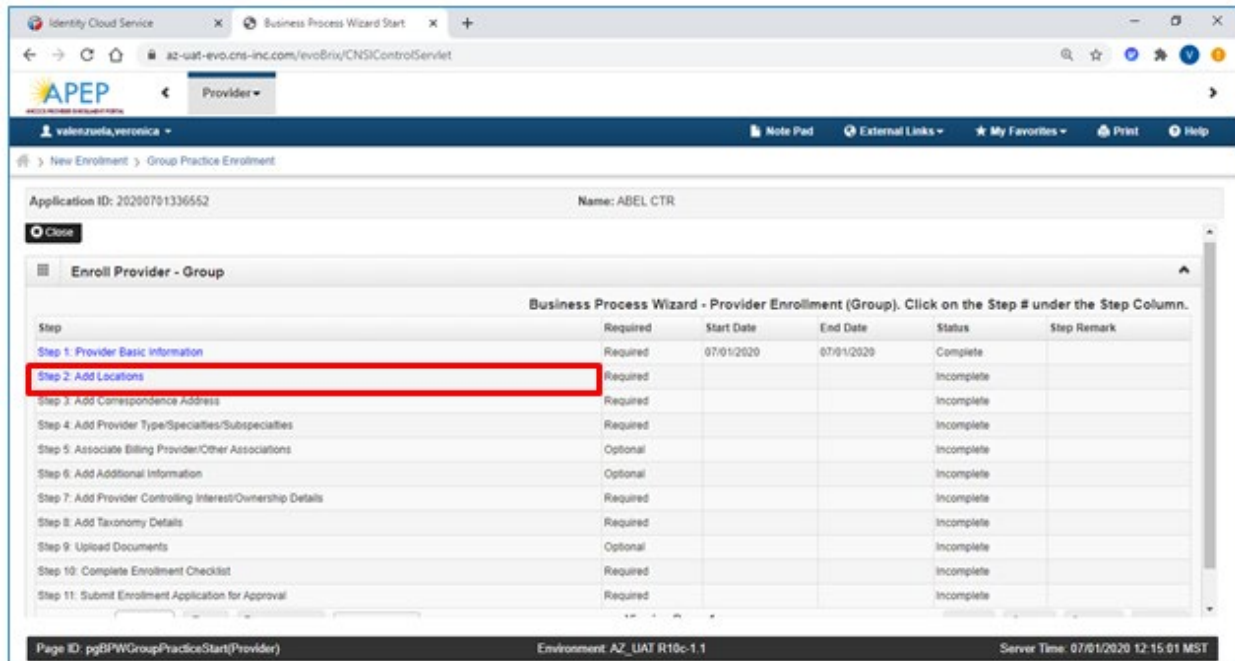
TIP: Write down your Application ID and keep it in a safe place. If you misplace the Application ID, check your email account used during the User Registration process to retrieve the email containing the Application ID. If you are unable to locate the email containing the Application ID, please contact the AHCCCS Provider Enrollment team.

6. To continue with the application, select “OK”.

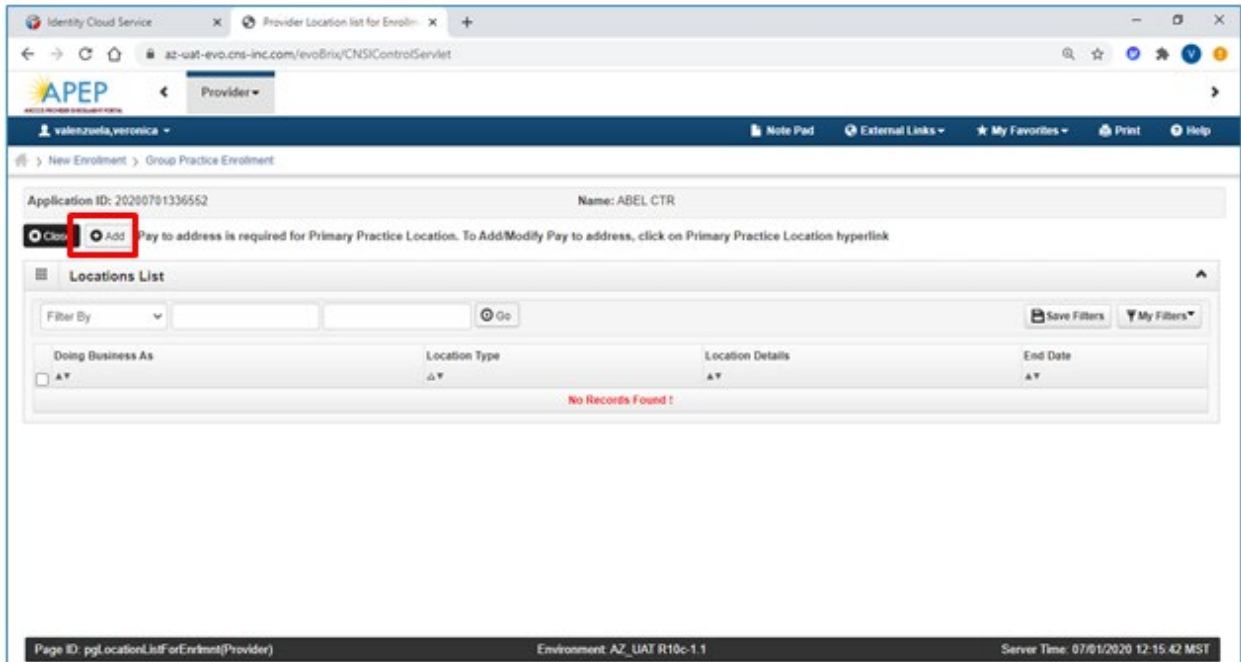


Step 2: Add Locations

1. Select “Step 2: Add Locations.”

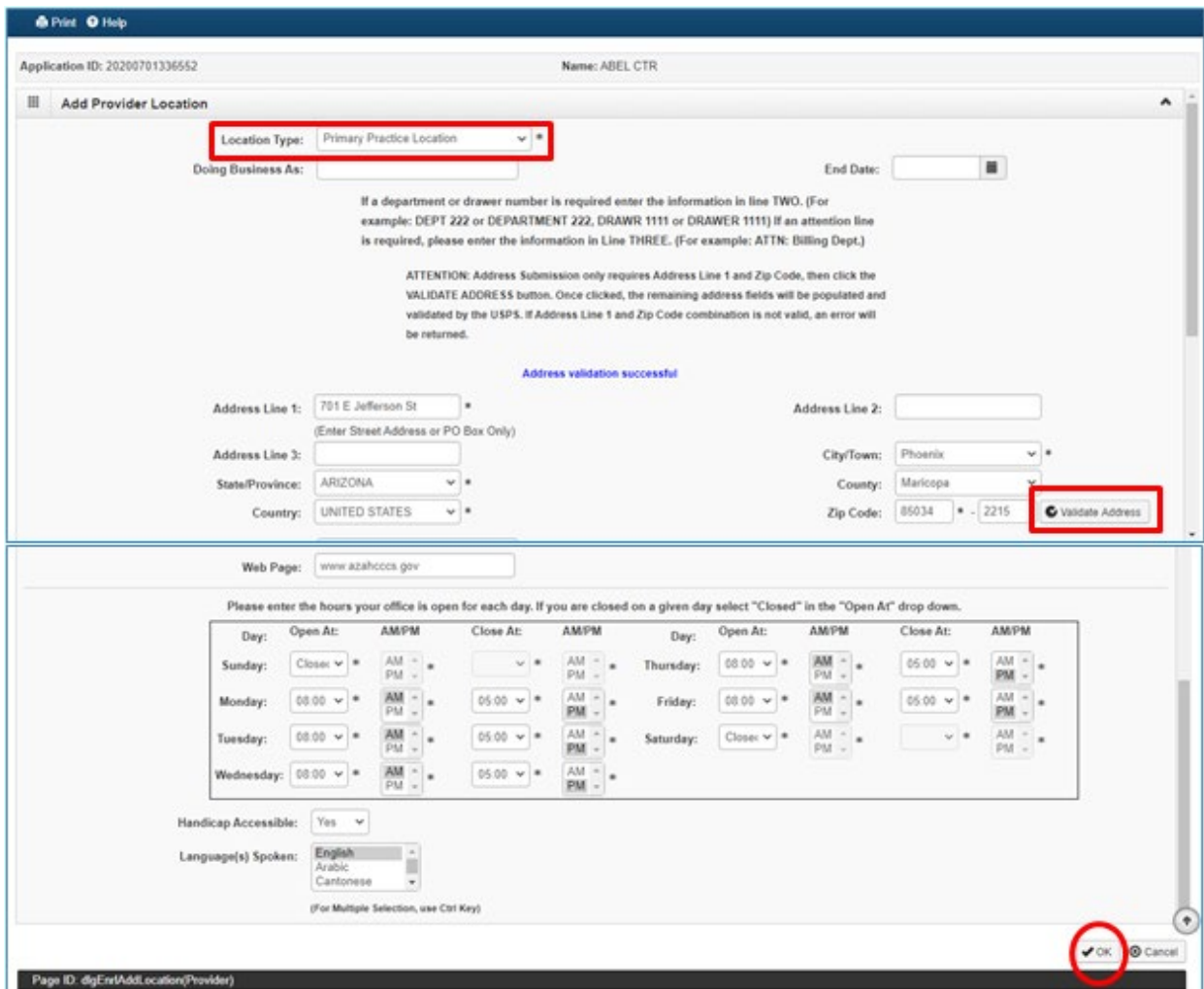


2. Select "Add" to add a Primary Practice Location and a Pay To address for the location.



3. Select: "Primary Practice Location" in the drop down menu. Complete all required fields, select "Validate Address."
4. Every "Primary Practice Location" requires hours of operation. Fill in these fields as appropriate.
5. Select, "OK," when complete.

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 populate and be validated by the information from the U.S. Postal Service.



Application ID: 20200701336552 Name: ABEL CTR

Add Provider Location

Location Type: Primary Practice Location *

Doing Business As: End Date:

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWR 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address validation successful

Address Line 1: 701 E Jefferson St *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: Phoenix *

State/Province: ARIZONA *

County: Maricopa *

Country: UNITED STATES *

Zip Code: 85034 * - 2215 **Validate Address**

Web Page:

Please enter the hours your office is open for each day. If you are closed on a given day select "Closed" in the "Open At" drop down.

| Day: | Open At: | AM/PM | Close At: | AM/PM | Day: | Open At: | AM/PM | Close At: | AM/PM |
|------------|----------|---------|----------------------|---------|-----------|----------|---------|----------------------|---------|
| Sunday: | Closed * | AM/PM * | <input type="text"/> | AM/PM * | Thursday: | 08:00 * | AM/PM * | 05:00 * | AM/PM * |
| Monday: | 08:00 * | AM/PM * | 05:00 * | AM/PM * | Friday: | 08:00 * | AM/PM * | 05:00 * | AM/PM * |
| Tuesday: | 08:00 * | AM/PM * | 05:00 * | AM/PM * | Saturday: | Closed * | AM/PM * | <input type="text"/> | AM/PM * |
| Wednesday: | 08:00 * | AM/PM * | 05:00 * | AM/PM * | | | | | |

Handicap Accessible: Yes *

Language(s) Spoken: English, Arabic, Cantonese *

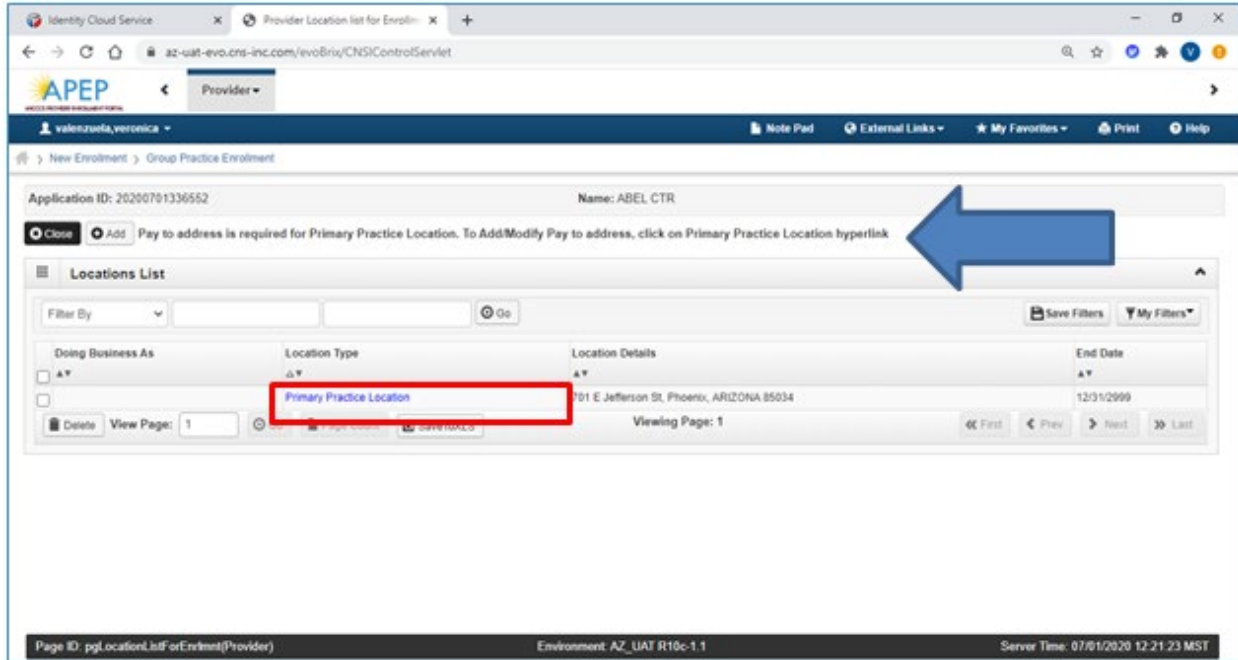
(For Multiple Selection, use Ctrl Key)

OK Cancel

Page ID: dgEntAddLocation(Provider)

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."

The screenshot shows a web browser window with the URL `az-uat-evo.crs-inc.com/evoBrix/CNSIControlServlet`. The page title is "APEP" and the user is logged in as "valenzuela,veronica". The breadcrumb navigation shows "New Enrollment > Group Practice Enrollment > General". The main content area displays "Application ID: 20200701336552" and "Name: ABEL CTR". Below this, there are several form fields: "Handicap Accessible: Yes", "Language(s) Spoken: English", and "End Date: 12/31/2999". A section titled "Address List" contains a table with one row of address information. The "Add Address" button is highlighted with a red box.

Application ID: 20200701336552 Name: ABEL CTR

To add additional addresses, click "Add Address" button.

Handicap Accessible: Yes

Language(s) Spoken: English

End Date: 12/31/2999

Add Address

| Address Type | Address | End Date |
|--------------|--|------------|
| Location | 791 E Jefferson St, Phoenix, ARIZONA 85034 | 12/31/2999 |

Viewing Page: 1

- Type of Address: Select "Pay To Address" in the drop-down menu. Carefully enter, review and click "Validate 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."

Application ID: 20200701336552 Name: ABEL CTR

Add Provider Location Address

Type of Address: **Pay To** End Date:

Location Address: Copy This Location Address

If a department or drawer number is required enter the information in line TWO. (For example: DEPT 222 or DEPARTMENT 222, DRAWN 1111 or DRAWER 1111) If an attention line is required, please enter the information in Line THREE. (For example: ATTN: Billing Dept.)

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

Address validation successful

Address Line 1: *
(Enter Street Address or PO Box Only)

Address Line 2:

Address Line 3:

City/Town: *

State/Province: *

County: *

Country: *

Zip Code: - **Validate Address**

OK Cancel

Page ID: dgEnrlLocationAddress(Provider)

- The provider address will now display in the Address List.

Identity Cloud Service Location Details

az-uat-evo.cns-inc.com/evoBrix/CNSIControlServlet

APEP Provider

valenzuela,veronica Note Pad External Links My Favorites Print Help

New Enrollment > Group Practice Enrollment > General

Application ID: 20200701336552 Name: ABEL CTR

Close Save To add additional addresses, click "Add Address" button.

Handicap Accessible: Language(s) Spoken: (For Multiple Selection, use Ctrl Key)

End Date:

Address List

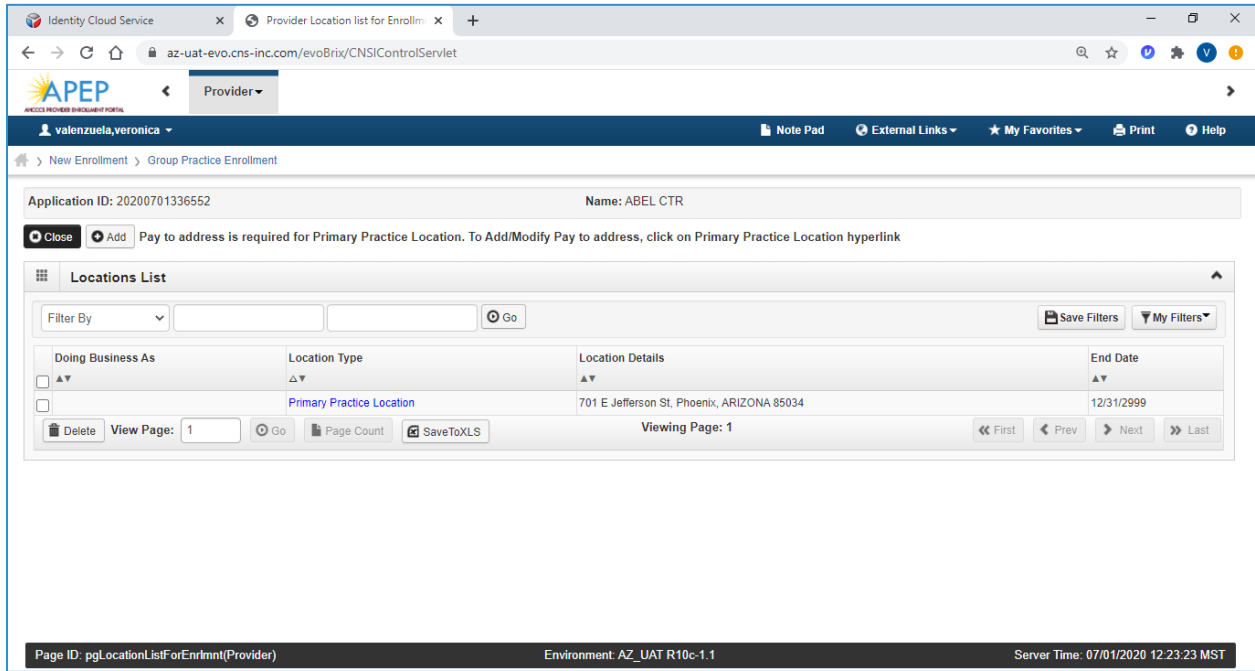
Add Address

| Address Type | Address | End Date |
|--|--|------------|
| <input type="checkbox"/> Location | 701 E Jefferson St, Phoenix, ARIZONA 85034 | 12/31/2999 |
| <input checked="" type="checkbox"/> Pay To | 701 E Jefferson St, Phoenix, ARIZONA 85034 | 12/31/2999 |

 View Page: Go Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Page ID: pgEnrollmentLocationGeneral(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 12:22:44 MST

Note: To add additional practice locations and pay to addresses, select “Add Address” and repeat steps 1 through 6. To continue without adding another service location, select “Save” and then select “Close” to proceed forward.



Application ID: 20200701336552 Name: ABEL CTR

Close Add Pay to address is required for Primary Practice Location. To Add/Modify Pay to address, click on Primary Practice Location hyperlink

Locations List

Filter By [] [] [Go] Save Filters My Filters

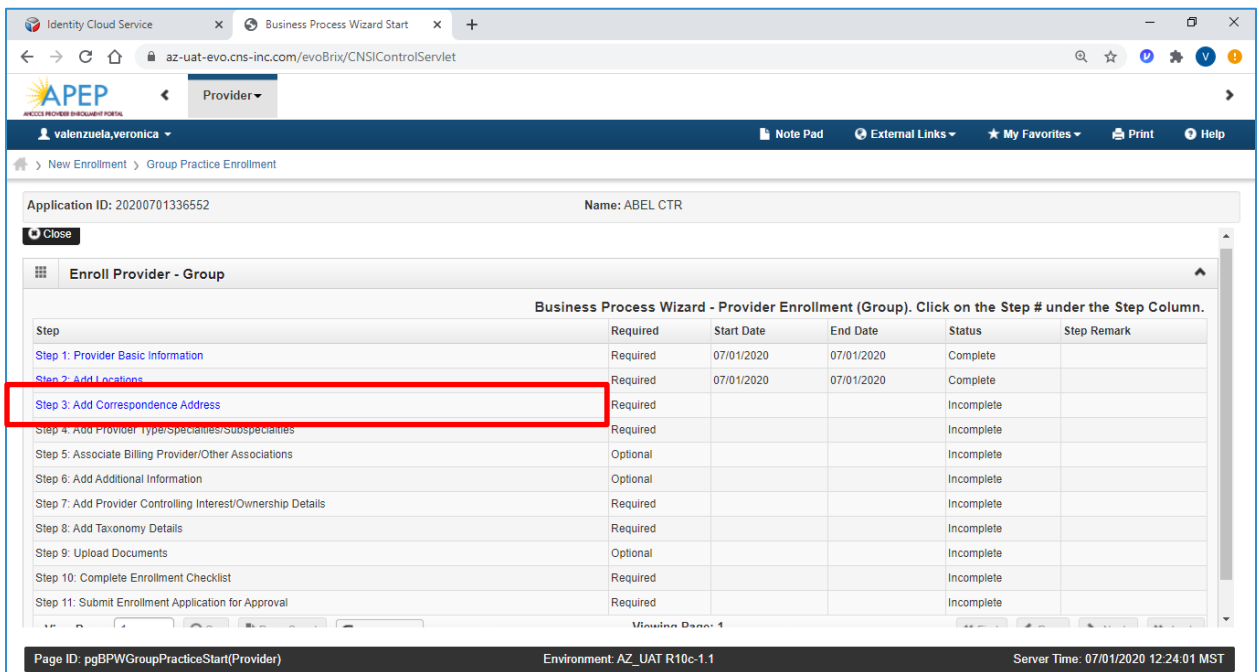
| Doing Business As | Location Type | Location Details | End Date |
|-------------------|---------------------------|--|------------|
| | Primary Practice Location | 701 E Jefferson St, Phoenix, ARIZONA 85034 | 12/31/2999 |

Delete View Page: 1 Page Count SaveToXLS Viewing Page: 1 First Prev Next Last

Page ID: pgLocationListForEnrlnmt(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 12:23:23 MST

Step 3: Add Correspondence Address

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



Application ID: 20200701336552 Name: ABEL CTR

Close

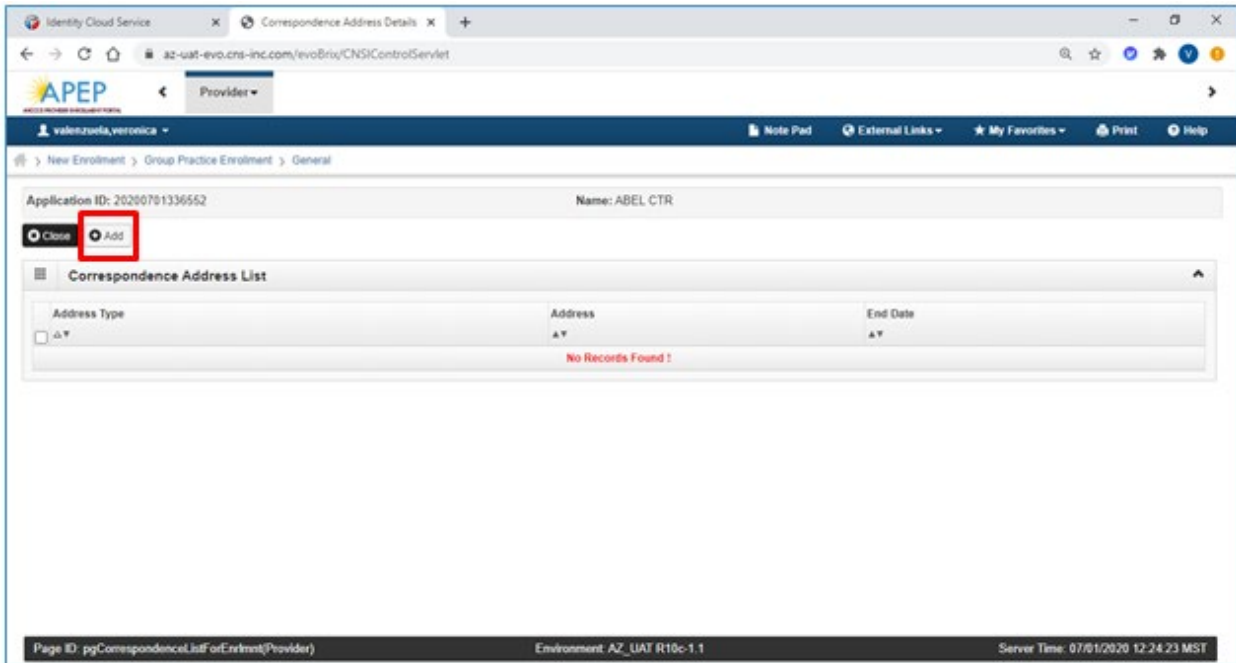
Enroll Provider - Group

Business Process Wizard - Provider Enrollment (Group). Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 2: Add Locations | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 3: Add Correspondence Address | Required | | | Incomplete | |
| Step 4: Add Provider Types/Specialties/Subspecialties | Required | | | Incomplete | |
| Step 5: Associate Billing Provider/Other Associations | Optional | | | Incomplete | |
| Step 6: Add Additional Information | Optional | | | Incomplete | |
| Step 7: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 8: Add Taxonomy Details | Required | | | Incomplete | |
| Step 9: Upload Documents | Optional | | | Incomplete | |
| Step 10: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 11: Submit Enrollment Application for Approval | Required | | | Incomplete | |

Page ID: pgBPWGroupPracticeStart(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 12:24:01 MST

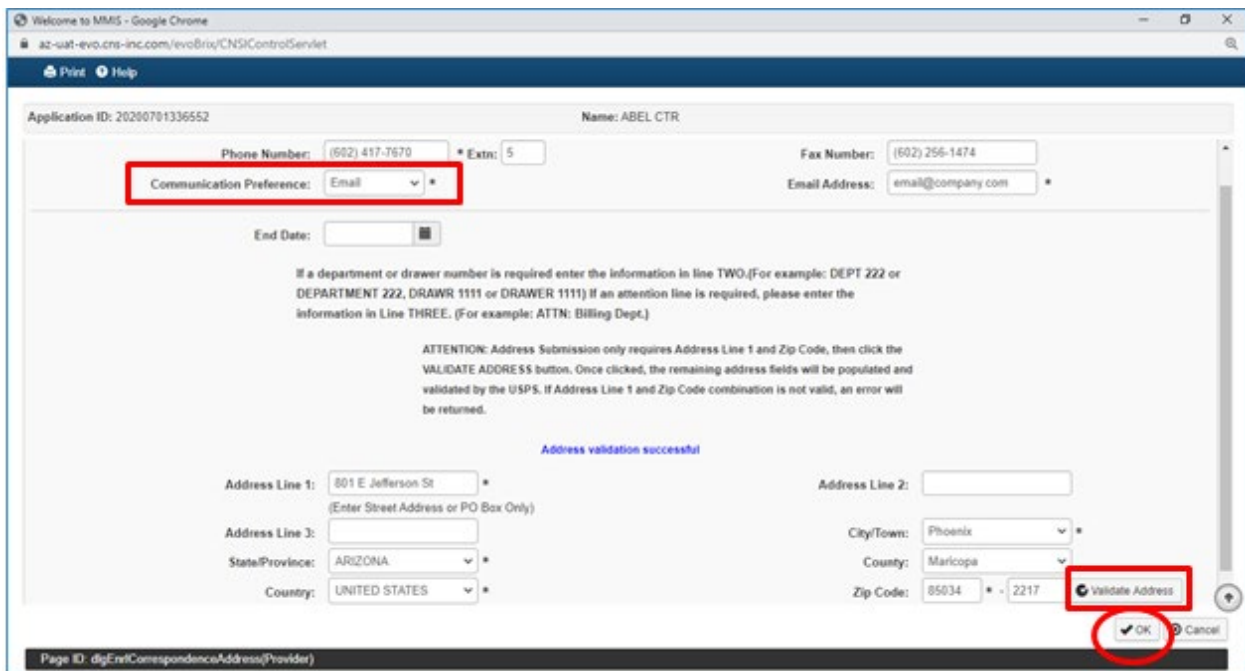
2. Select “Add.”



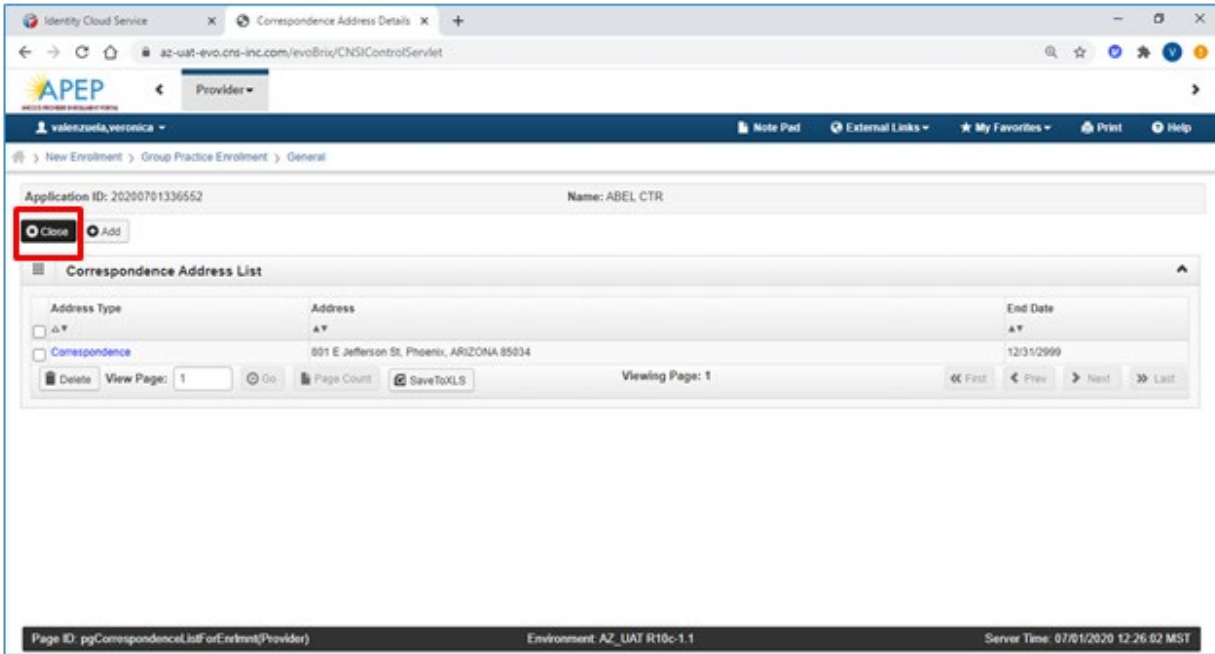
3. In the “Communication Preference” field, select “Standard Mail” or “Email.”

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 click “Validate Address” option. When complete, select “OK.”

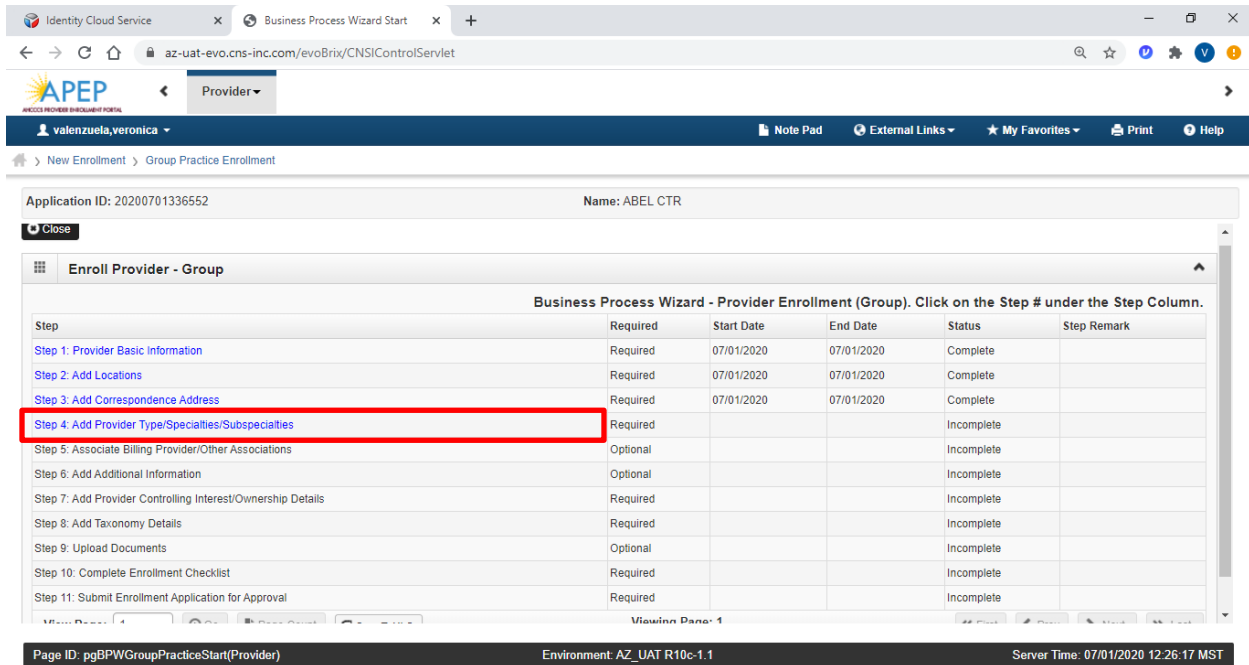


5. Select “Close” to proceed forward.

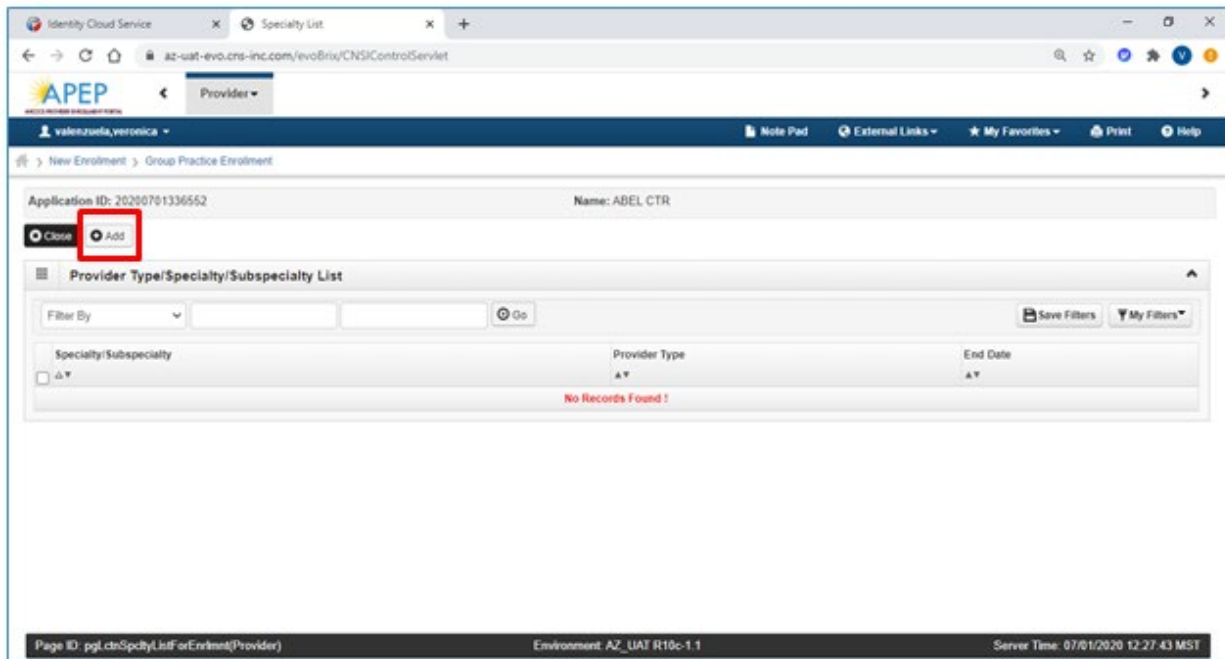


Step 4: Add Provider Type/Specialties/Subspecialties

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



2. Select "Add."

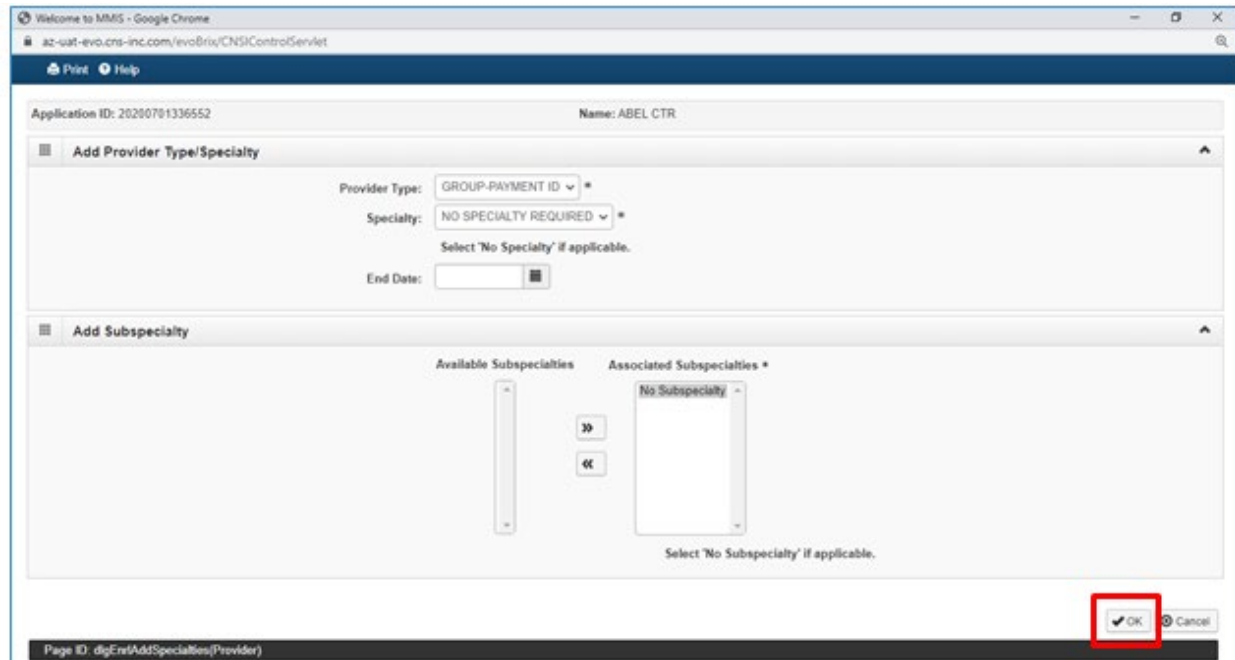
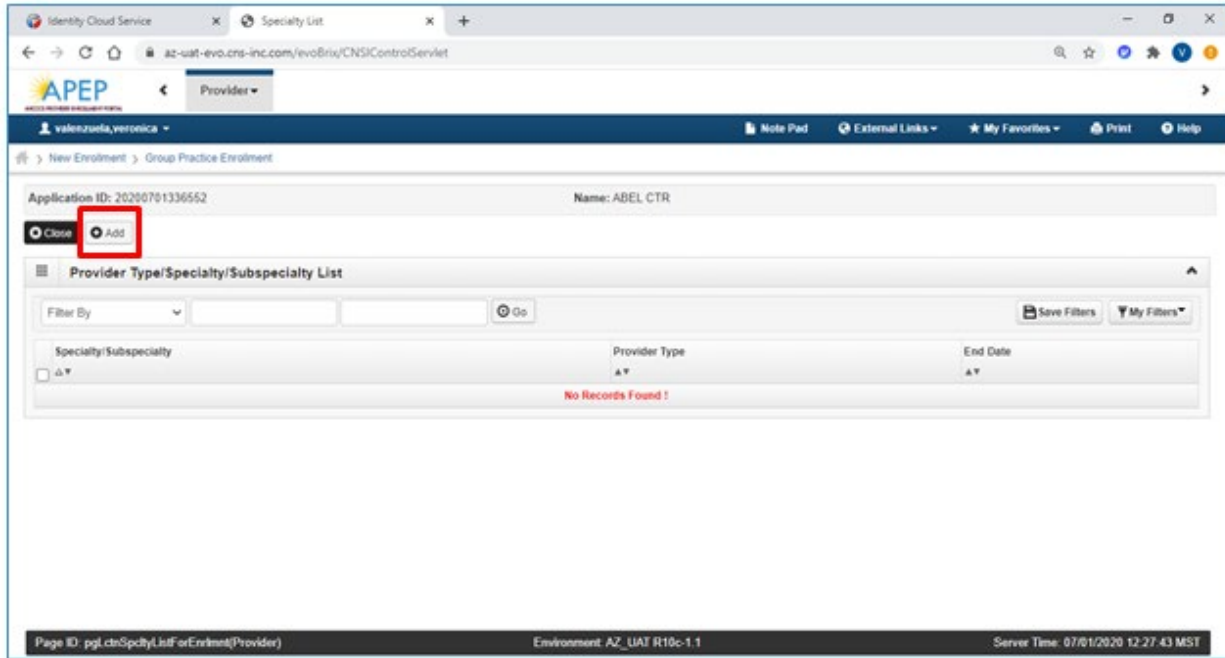


3. Complete the "Add Provider Type/Specialty" and "Add Subspecialty" fields as appropriate.
4. Select, appropriate "Provider Type" in the drop-down option.
5. Select, the "Specialty" in the drop-down option, or "No Specialty" if applicable.

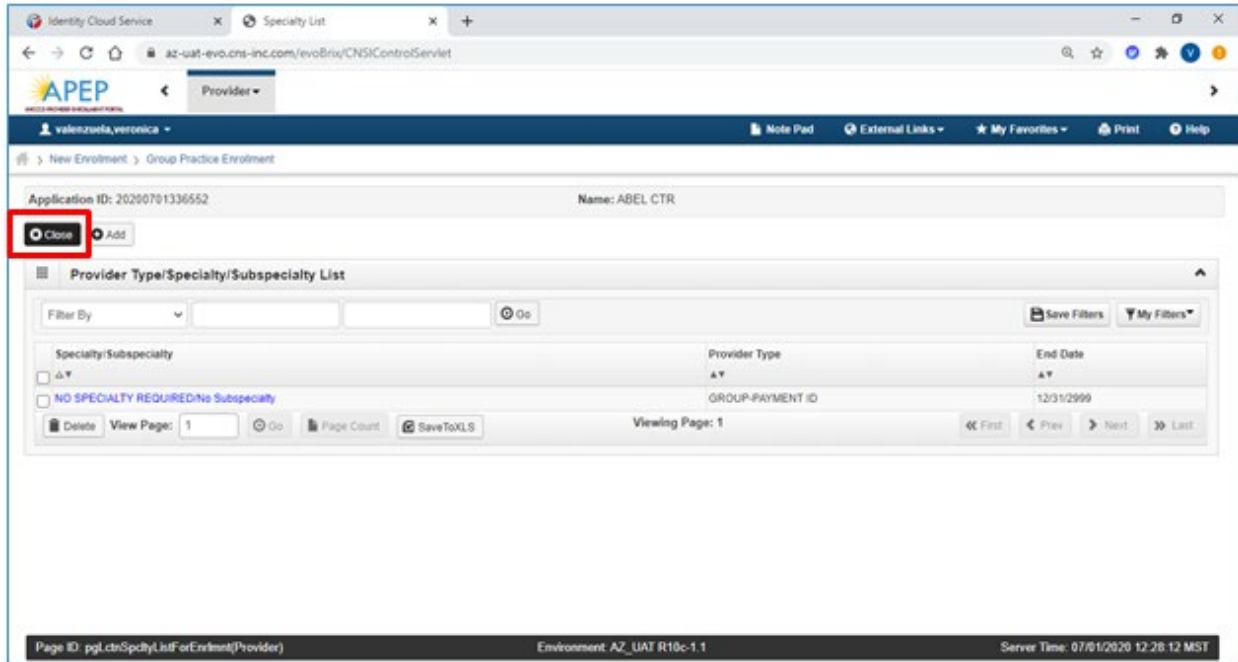
6. Add “Subspecialty”: Select, “Associated Subspecialty”: “No Subspecialty”

Note: For new enrollments, the “Add Provider Type/Specialty & Add Subspecialty” fields will display empty.

7. When complete, select “OK” to proceed forward.



8. Select "Close."



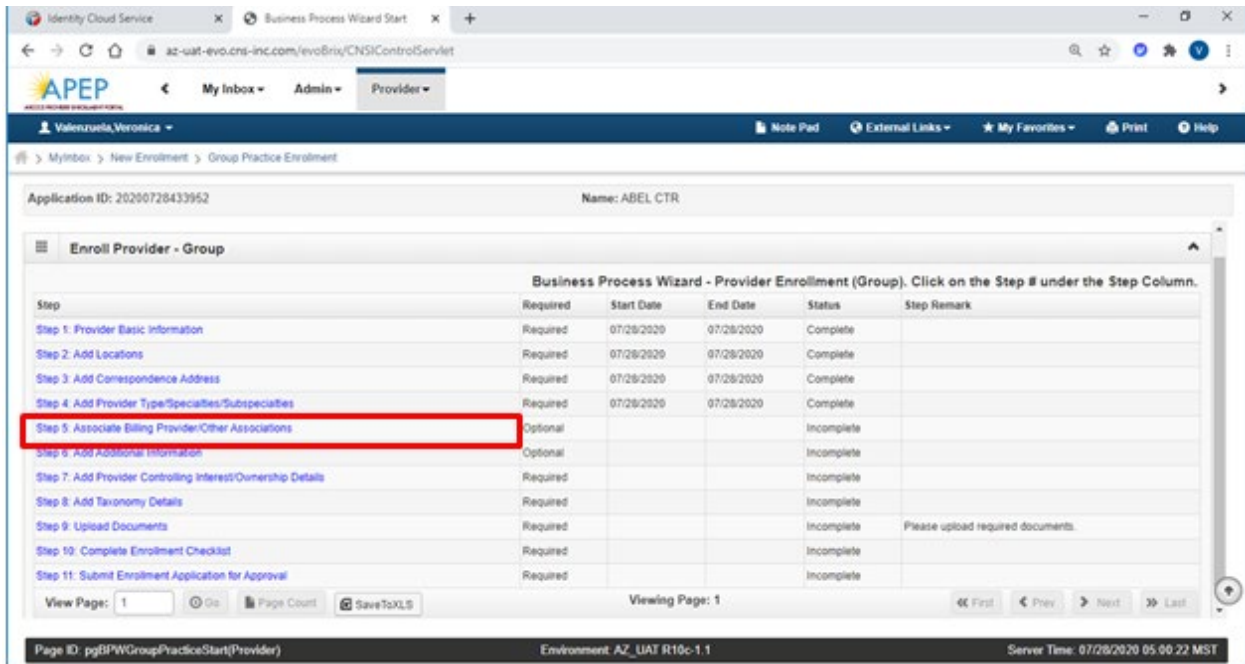
Note: Once Step 4 is completed, the rest of the enrollment steps become available and may be completed in any order.

Step 5: Associate Billing Provider/Other Associations

The next step is Step 5, which is marked as “Optional.” This step is for an Associate Billing Provider. In other words, an employee of the facility, agency, or organization that has already started an application with AHCCCS. If this does not apply to you skip, to Step 6.

To complete Step 5:

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

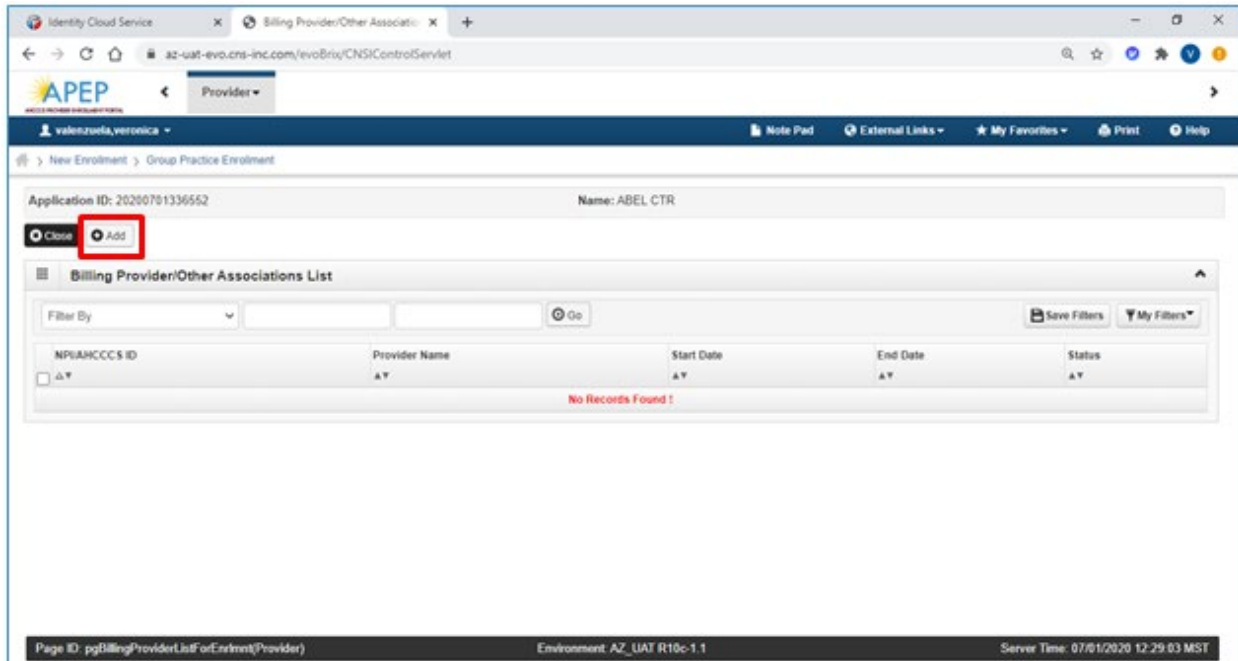


The screenshot shows the 'Enroll Provider - Group' screen in the APEP system. The application ID is 20200728433952 and the name is ABEL CTR. The table below lists the steps of the enrollment process:

| Step | Required | Start Date | End Date | Status | Step Remark |
|--|----------|------------|------------|------------|-----------------------------------|
| Step 1: Provider Basic Information | Required | 07/28/2020 | 07/28/2020 | Complete | |
| Step 2: Add Locations | Required | 07/28/2020 | 07/28/2020 | Complete | |
| Step 3: Add Correspondence Address | Required | 07/28/2020 | 07/28/2020 | Complete | |
| Step 4: Add Provider Type/Specialties/Subspecialties | Required | 07/28/2020 | 07/28/2020 | Complete | |
| Step 5: Associate Billing Provider/Other Associations | Optional | | | Incomplete | |
| Step 6: Add Additional Information | Optional | | | Incomplete | |
| Step 7: Add Provider Controlling Interest/Ownership Details | Required | | | Incomplete | |
| Step 8: Add Taxonomy Details | Required | | | Incomplete | |
| Step 9: Upload Documents | Required | | | Incomplete | Please upload required documents. |
| Step 10: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 11: Submit Enrollment Application for Approval | Required | | | Incomplete | |

Page ID: pgBPWGroupPracticeStart(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/28/2020 05:00:22 MST

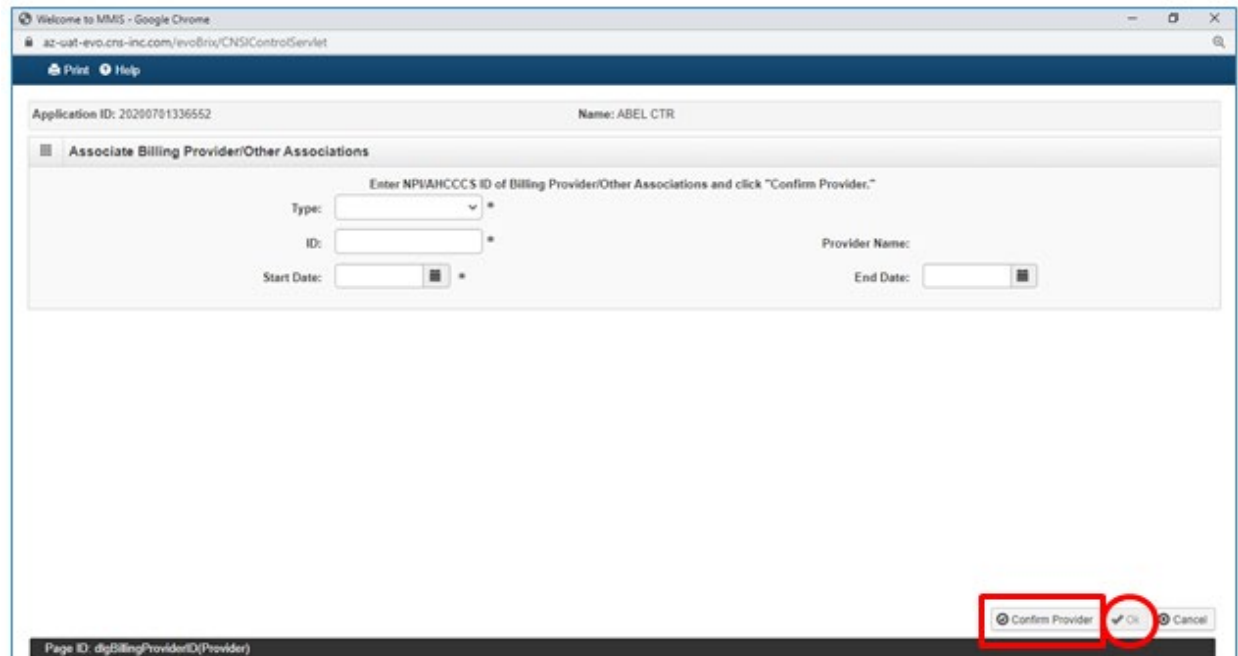
2. Select "Add."



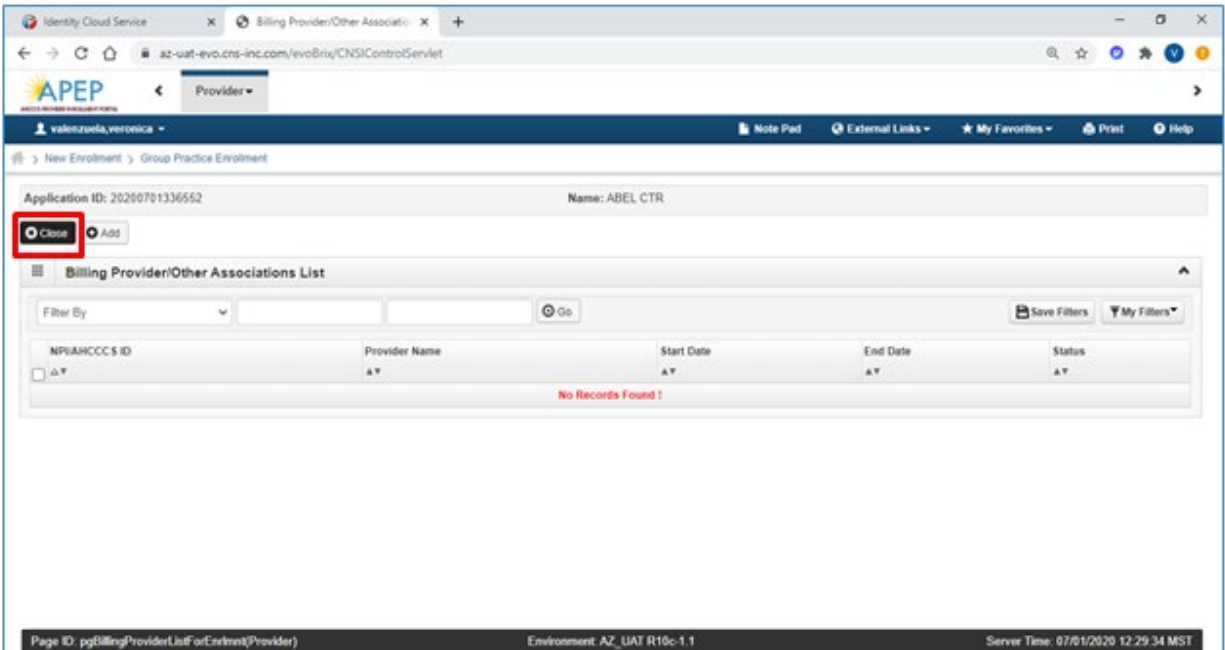
3. Enter the six-digit AHCCCS ID or 10-digit NPI of the billing provider then select "Confirm Provider."

4. 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.

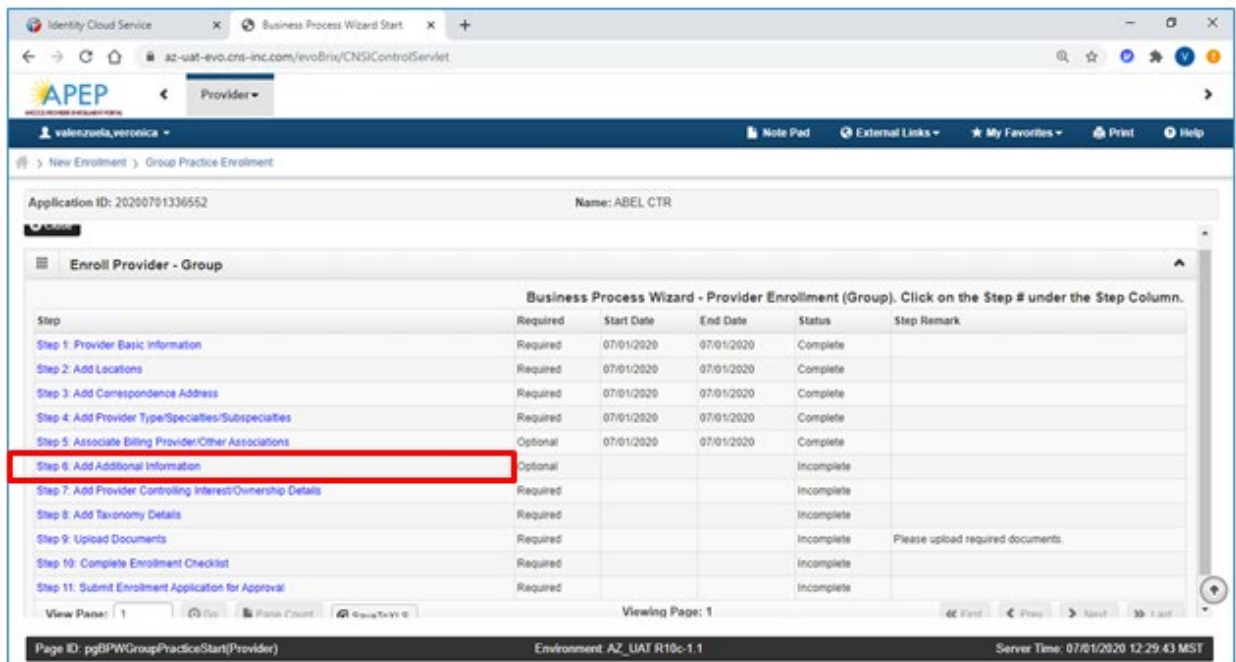


5. Select “Close” to proceed forward.

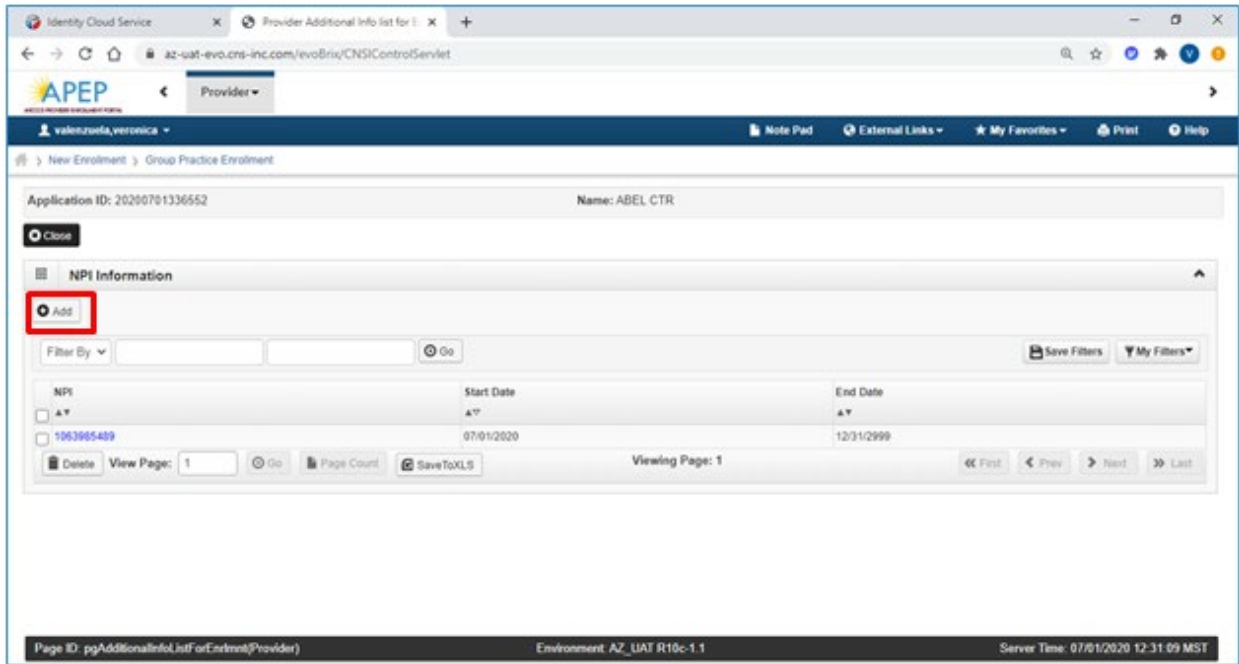


Step 6: Add Additional Information

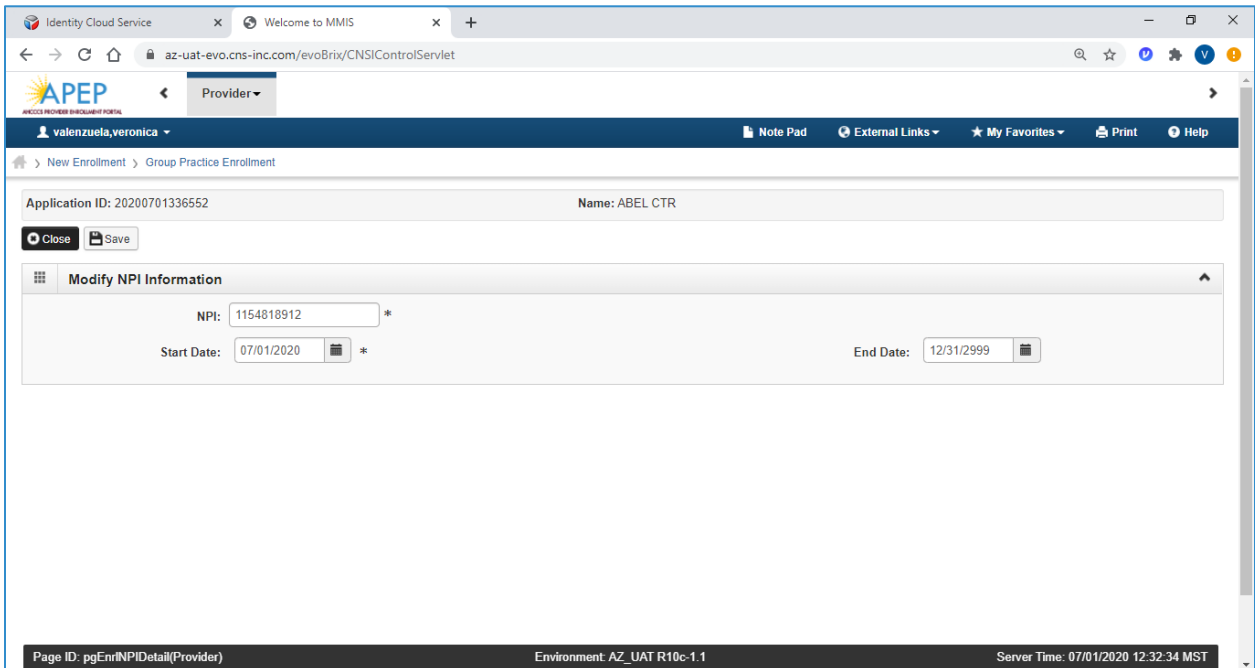
1. Select “Step 6: Add License/Certification/Other.”



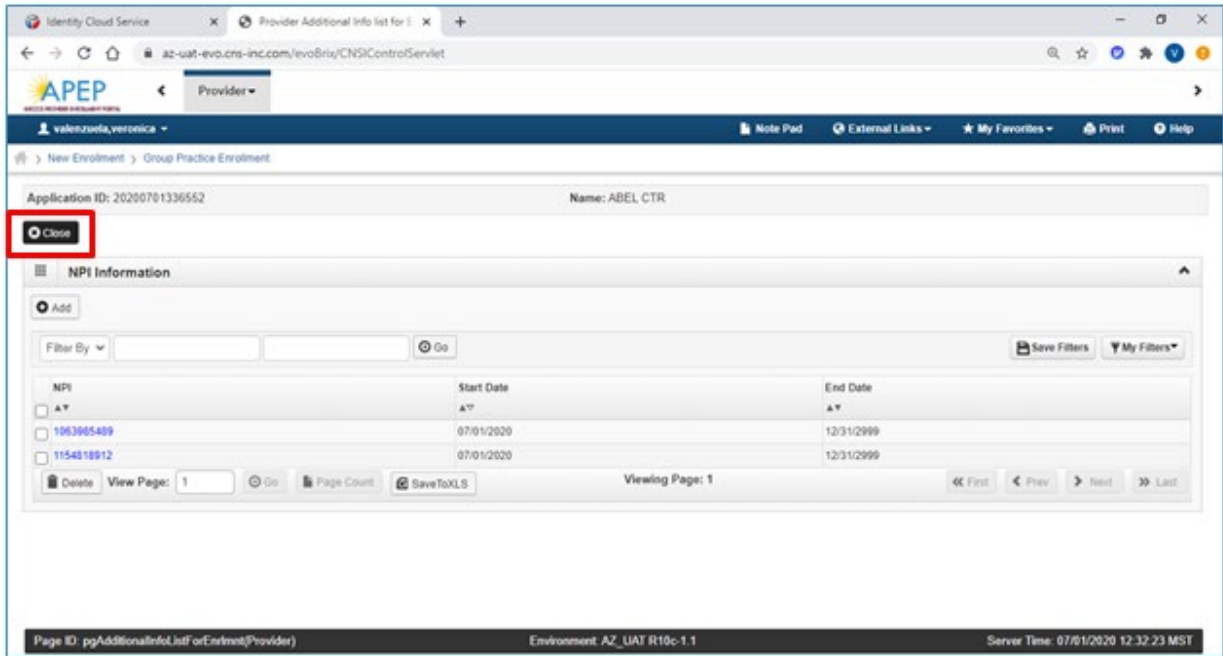
2. Select "Add."



3. Enter the NPI and the valid Start date.

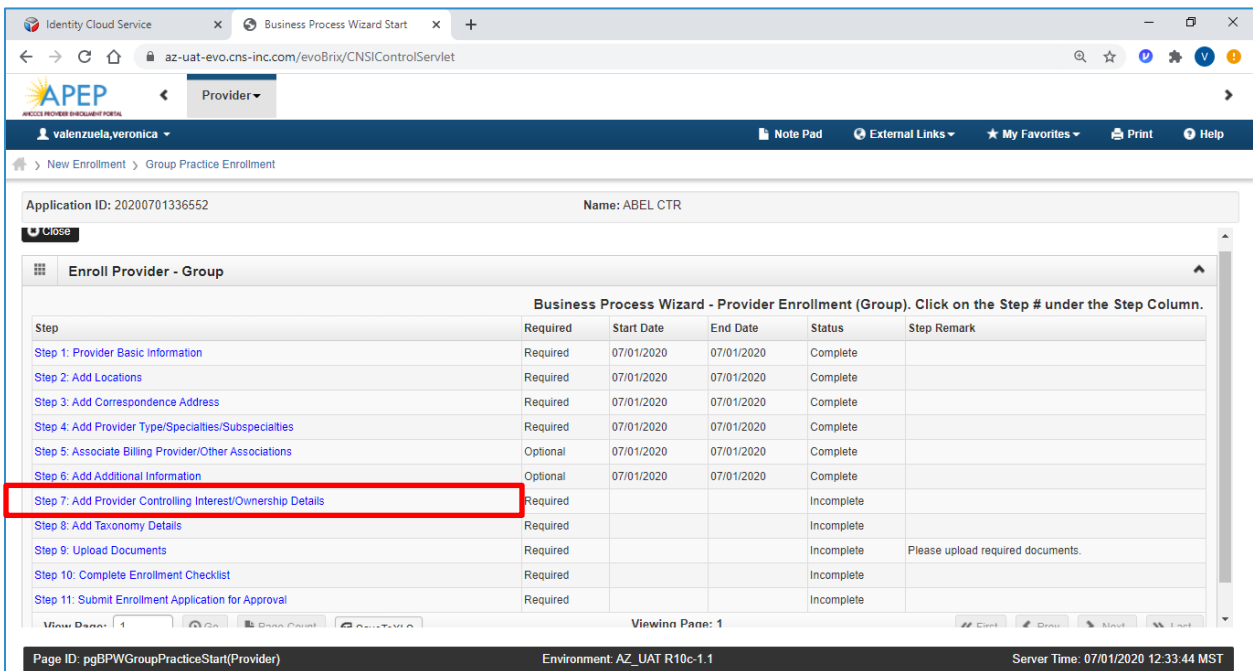


4. Select “Close” to proceed forward.



Step 7: Add Provider Controlling Interest/Ownership Details

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



2. Carefully read all information notated on this page to understand who should be reported.

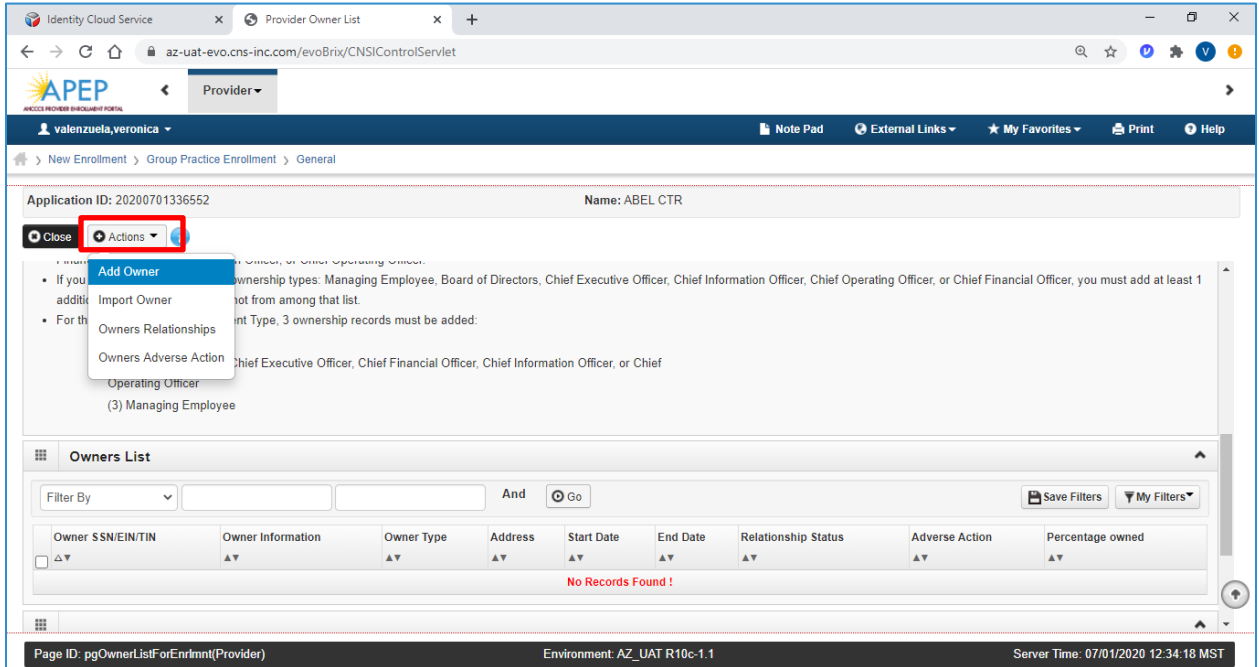
Note: It is important that all information notated on this page is carefully read.

| |
|---|
| <p>PROVIDER OWNERSHIP AND CONTROL DISCLOSURES</p> <p>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.).</p> <p>REQUIRED DISCLOSURE INFORMATION</p> <p>Provider (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation and within 35 days after any change in ownership:</p> <ul style="list-style-type: none"> • 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 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 managed 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. |
| <p>REQUIRED OWNERS</p> <ul style="list-style-type: none"> • 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 10 owner types are selected: 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, 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, or Chief Financial 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: <ul style="list-style-type: none"> (1) Agent (2) Board of Directors, Chief Executive Officer, Chief Financial Officer, Chief Information Officer, or Chief Operating Officer (3) 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, specify Owner Relationships, and provide details about Owners Adverse Action (if applicable).

4. Select “Add Owner” in the drop-down menu.



The screenshot shows a web browser window displaying the 'Provider Owner List' application. The page header includes the AHCCCS logo and navigation tabs for 'New Enrollment', 'Group Practice Enrollment', and 'General'. The main content area shows details for 'Application ID: 20200701336552' and 'Name: ABEL CTR'. A red box highlights the 'Actions' dropdown menu, which is open and shows the 'Add Owner' option selected. Below the dropdown, there is a section titled 'Owners List' with a table that currently displays 'No Records Found!'. The table has columns for Owner SSN/EIN/TIN, Owner Information, Owner Type, Address, Start Date, End Date, Relationship Status, Adverse Action, and Percentage owned. The footer of the page contains the page ID 'pgOwnerListForEnrfmt(Provider)', environment 'AZ_UAT R10c-1.1', and server time '07/01/2020 12:34:18 MST'.

5. Select "Type": in this example Individual Sole Proprietor is selected as owner type. Complete all required fields.
6. Select "OK."

Note: The proprietor has 100% ownership and is the same individual as the Managing Employee.

Provider Controlling Interest/Ownership

| | |
|--|---|
| <p>Type: Partnership * ?</p> <p>SSN: 010020333 *</p> <p>Legal Entity Name: <input type="text"/> <small>(As shown on the Income Tax Return)</small></p> <p>Owner NPI: <input type="text"/></p> <p>First Name: Easter *</p> <p>Suffix: <input type="text"/></p> <p>Phone Number: (602) 417-7000 * Extn: <input type="text"/></p> <p>Start Date: 07/01/2020 *</p> | <p>Percentage Owned: 50 *</p> <p>EIN/TIN: <input type="text"/></p> <p>Entity Business Name: <input type="text"/> <small>(Doing Business As)</small></p> <p>Last Name: Bunny *</p> <p>DOB: 01/01/2000 *</p> <p>Email: <input type="text"/></p> <p>End Date: <input type="text"/></p> |
|--|---|

Please ensure you are providing the home address of this provider. Failure to do so may result in this application/modification being denied.

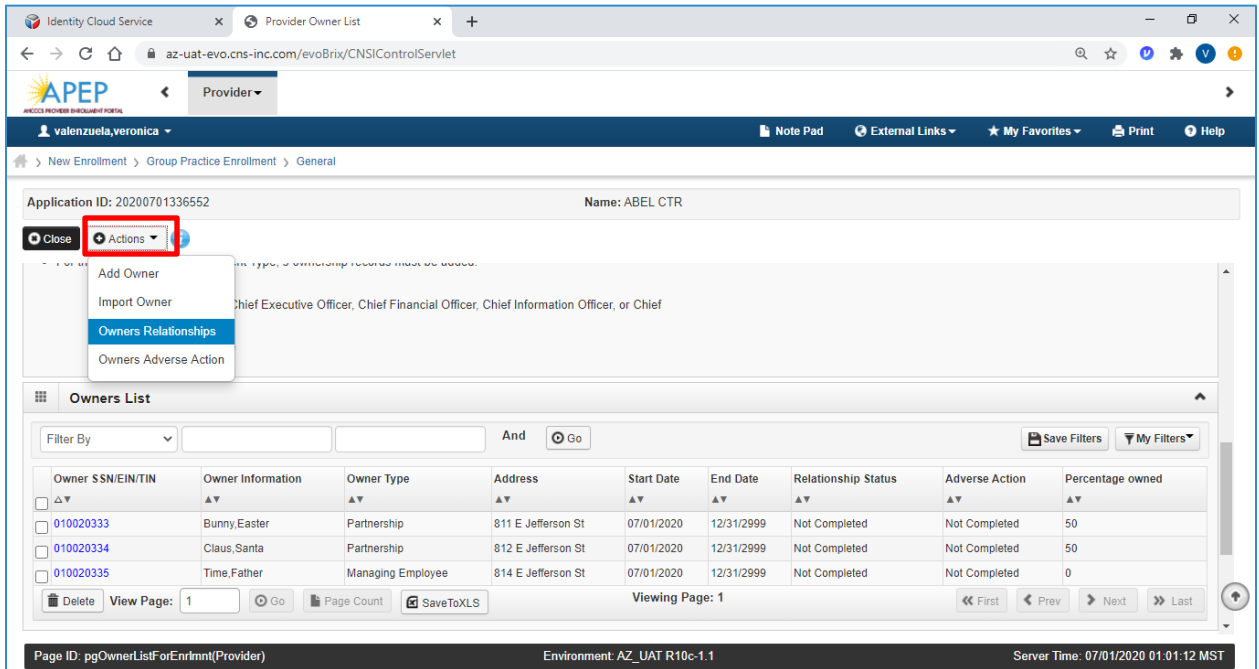
Address Type: Home Address

ATTENTION: Address Submission only requires Address Line 1 and Zip Code, then click the VALIDATE ADDRESS button. Once clicked, the remaining address fields will be populated and validated by the USPS. If Address Line 1 and Zip Code combination is not valid, an error will be returned.

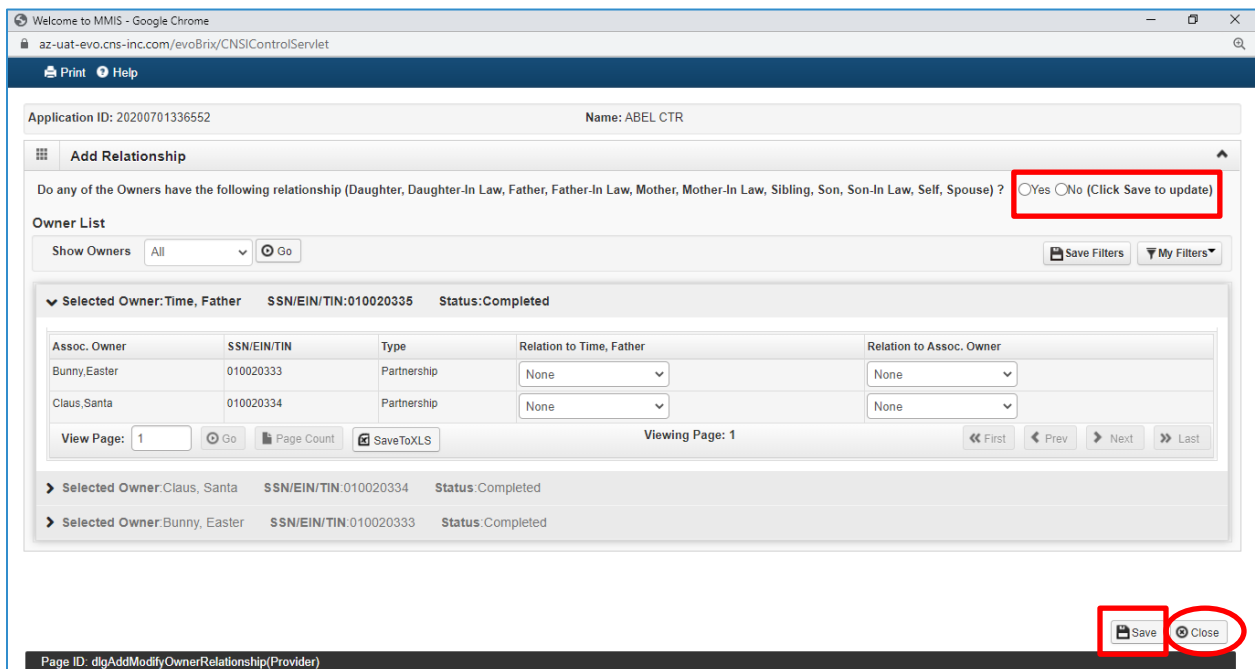
Address validation successful

| | |
|---|---|
| <p>Address Line 1: 811 E Jefferson St * <small>(Enter Street Address or PO Box Only)</small></p> <p>Address Line 3: <input type="text"/></p> <p>State/Province: ARIZONA *</p> <p>Country: UNITED STATES *</p> | <p>Address Line 2: <input type="text"/></p> <p>City/Town: Phoenix *</p> <p>County: Maricopa *</p> <p>Zip Code: 85034 * - 2217</p> |
|---|---|

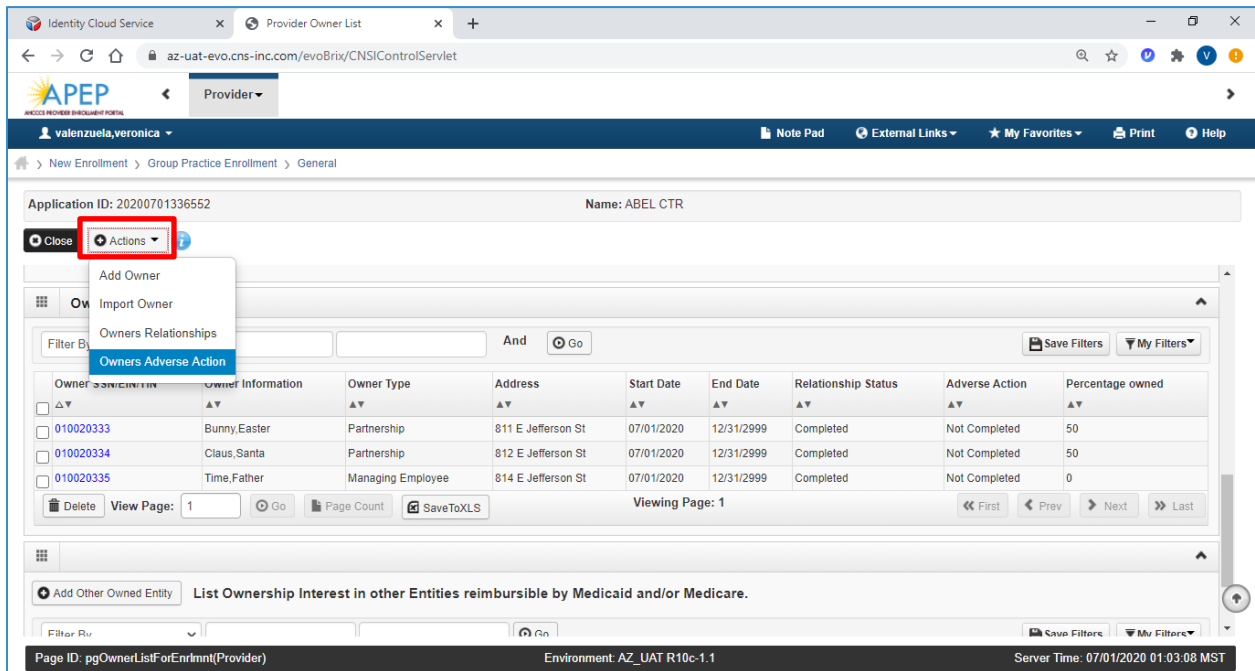
7. Select “Owners Relationships” This option requires an action to proceed forward. Select “Actions” then select “Owners Relationship” to disclose and establish Owner’s Relationships.



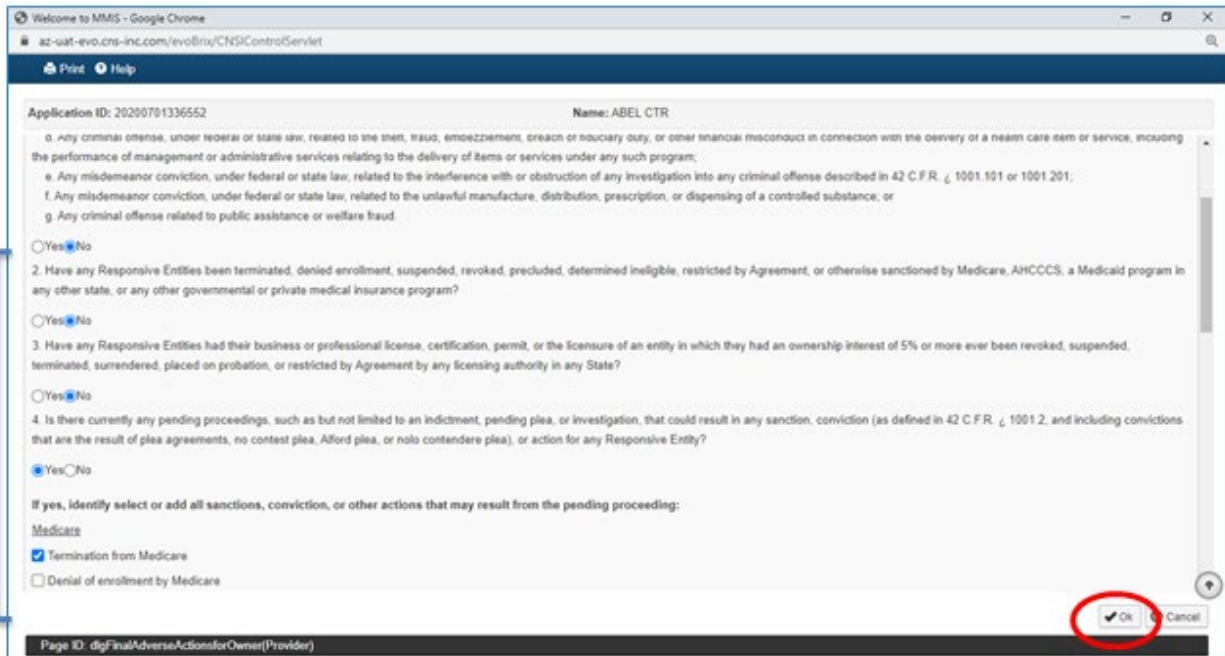
8. Complete the drop-down fields to describe the relationship between provider owners.
Note: If owners have no familial relationship, clicking the “No” option to the question at the top will eliminate the drop-down menu. No relationship will need to be specified.
9. When all information has been entered, select “Save” then select “Close.”



10. For each provider owner, you must disclose any adverse actions taken. Select “Actions” then select “Owners Adverse Action.”

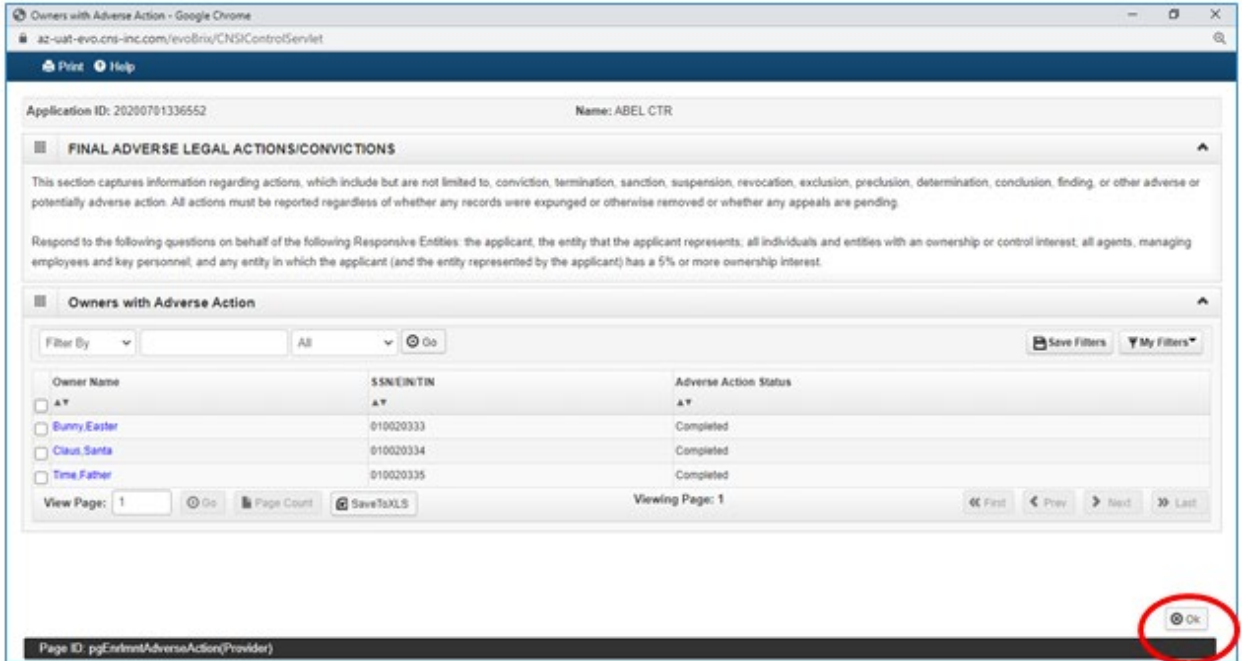


11. For each owner, indicate if any if any adverse actions have been taken by answering “Yes” or “No.”

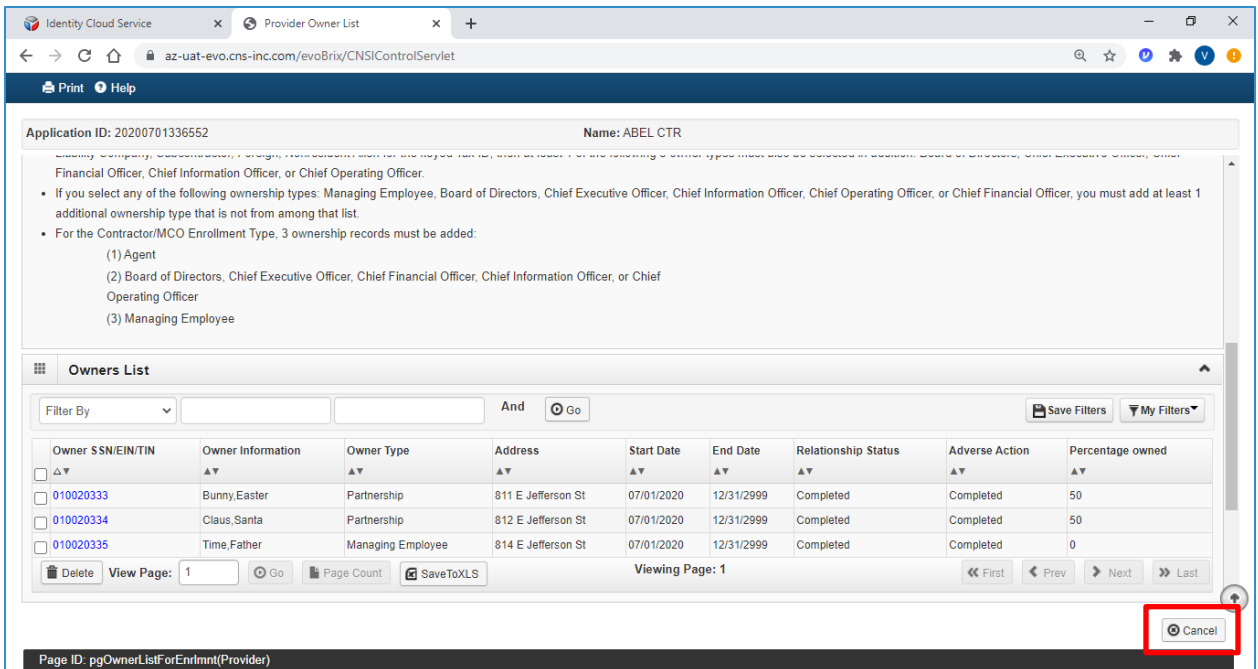


12. Select “Owner’s Relationships” This option requires an action to proceed forward. Select “Actions” then select “Owners Relationship” to disclose and establish Owner’s Relationships.

13. Repeat this step for each Owner and Managing Employee then select “OK.”



14. Select “Close” to proceed forward.

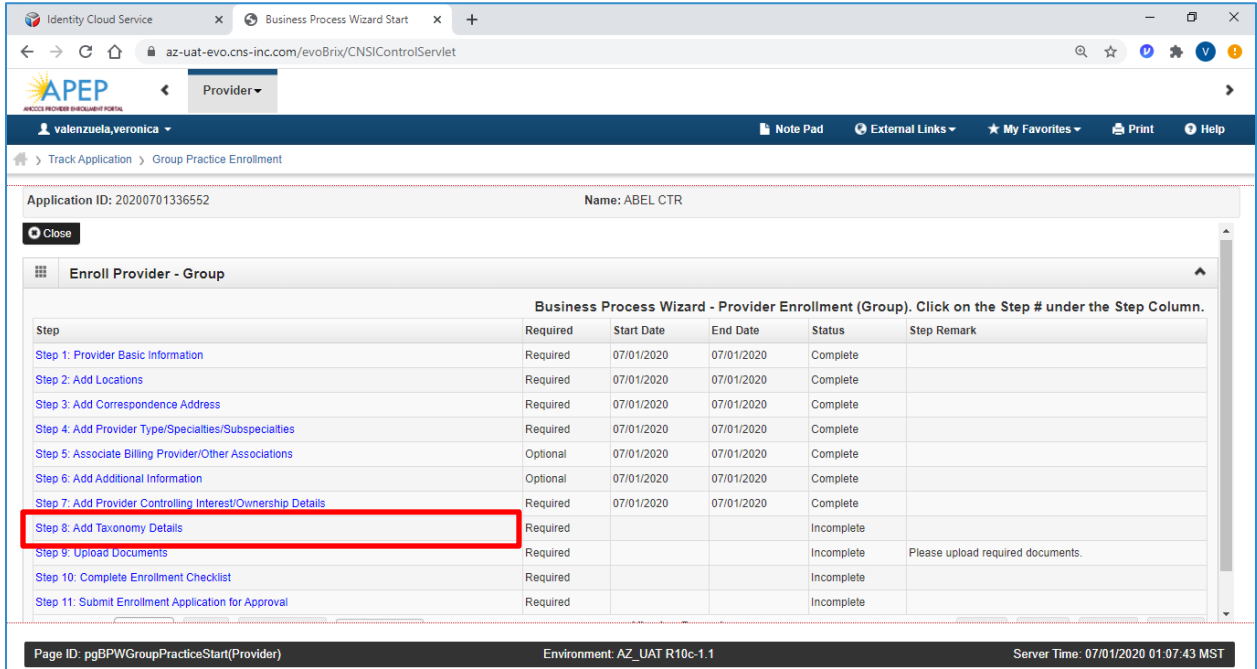


Step 8: Add Taxonomy Details

This step is related to the provider’s National Provider Identifier (NPI) number.

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

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

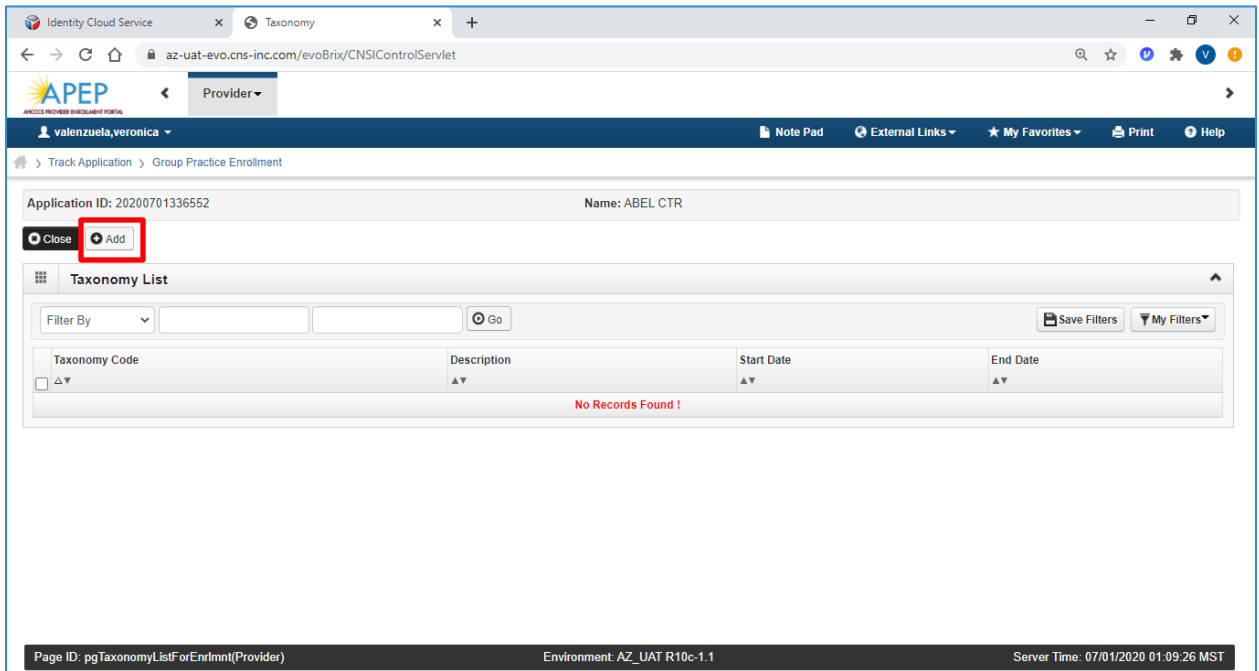


The screenshot shows the 'Enroll Provider - Group' wizard. The table below lists the steps and their completion status:

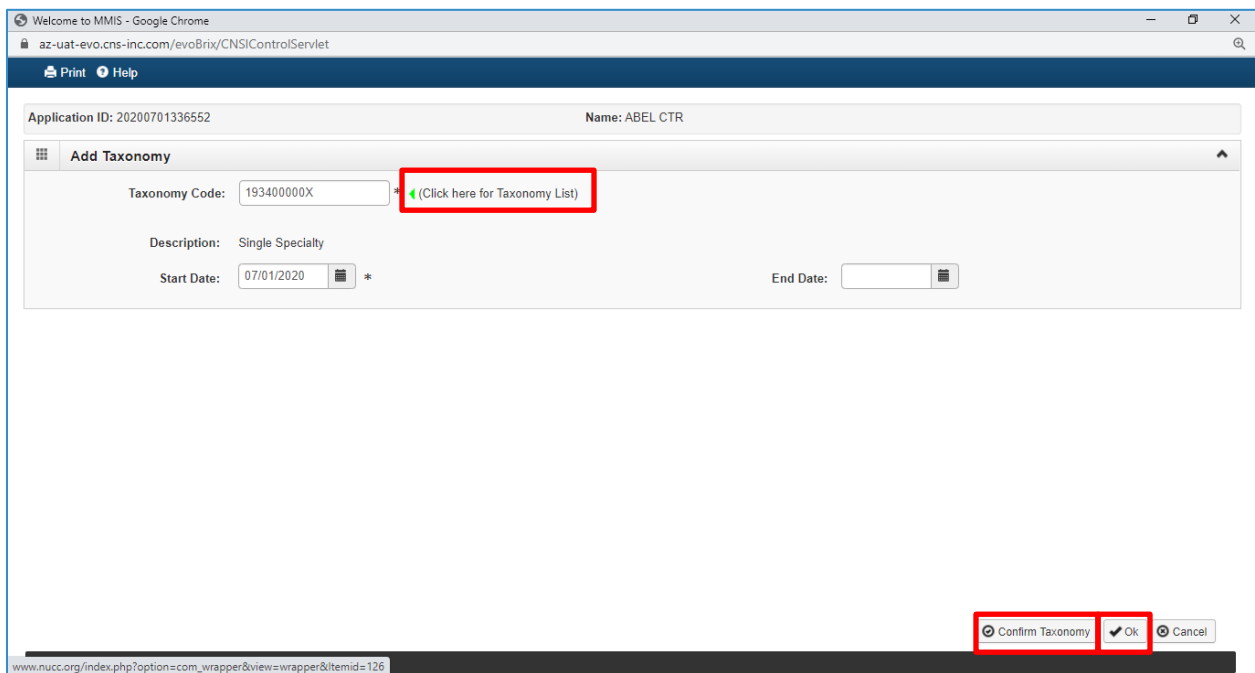
| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-----------------------------------|
| Step 1: Provider Basic Information | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 2: Add Locations | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 3: Add Correspondence Address | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 4: Add Provider Type/Specialties/Subspecialties | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 5: Associate Billing Provider/Other Associations | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 6: Add Additional Information | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 7: Add Provider Controlling Interest/Ownership Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 8: Add Taxonomy Details | Required | | | Incomplete | |
| Step 9: Upload Documents | Required | | | Incomplete | Please upload required documents. |
| Step 10: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 11: Submit Enrollment Application for Approval | Required | | | Incomplete | |

Page ID: pgBPWGroupPracticeStart(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 01:07:43 MST

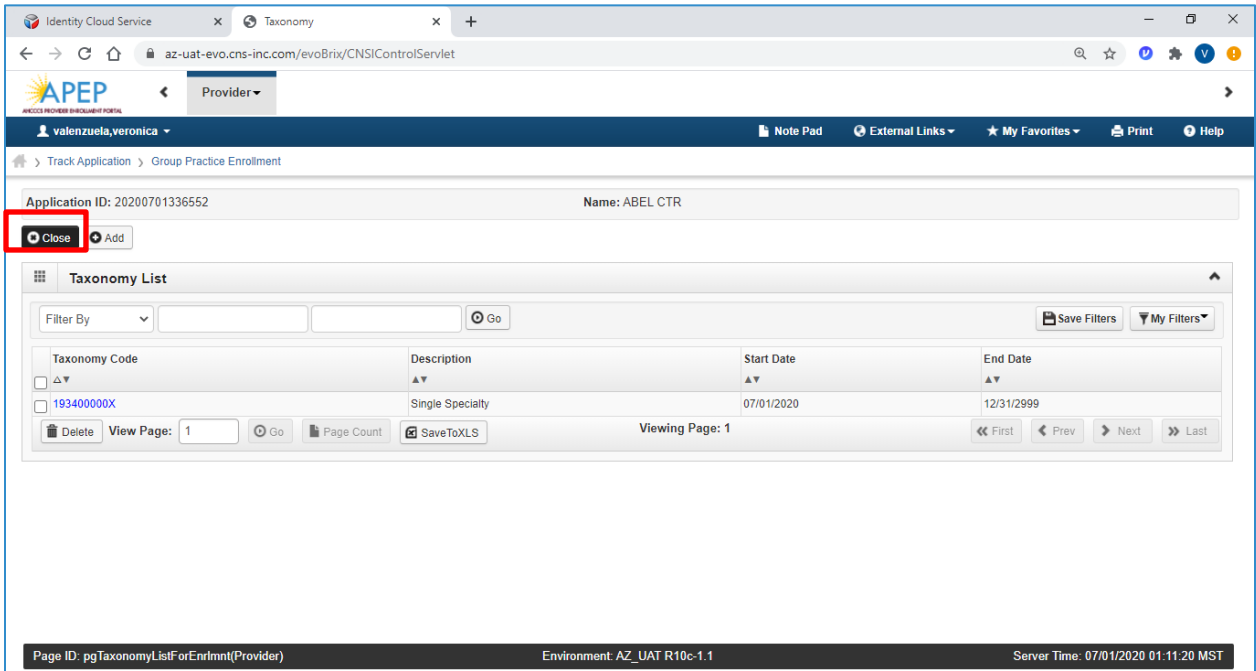
2. Select “Add”



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. Select “Confirm Taxonomy” and click “OK.”



5. Select “Close” to proceed forward.



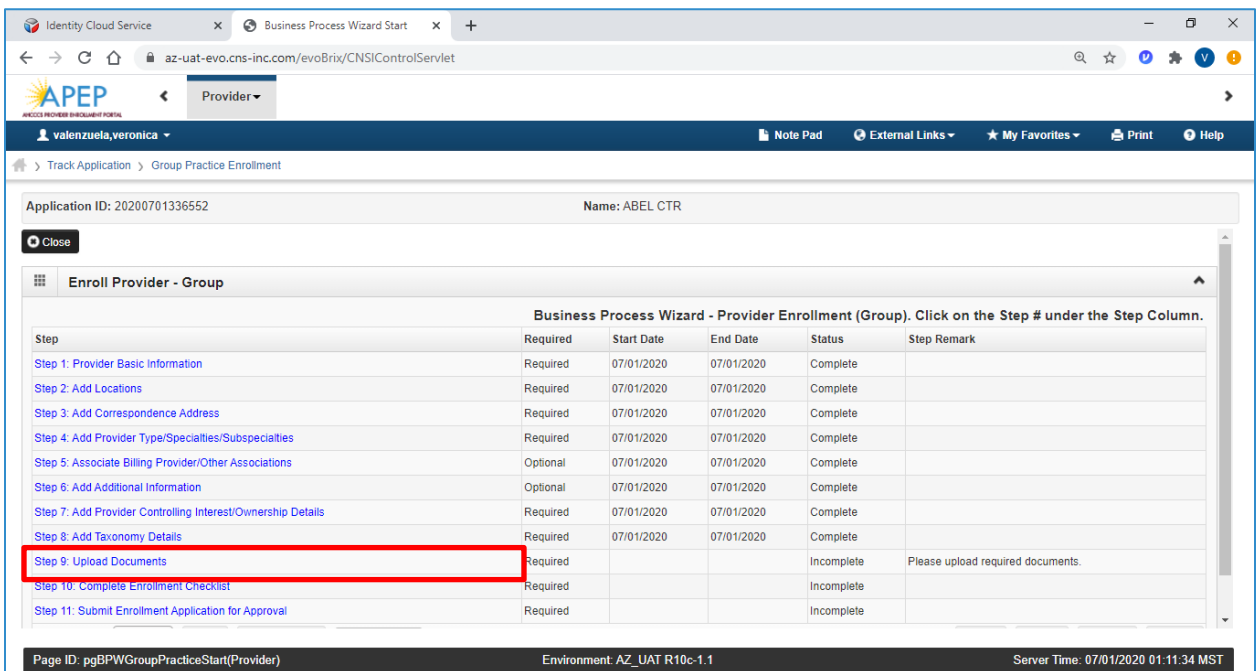
The screenshot shows the 'Taxonomy List' for application ID 20200701336552, named 'ABEL CTR'. The 'Close' button is highlighted with a red box. Below the taxonomy list, there is a table with the following data:

| Taxonomy Code | Description | Start Date | End Date |
|---------------|------------------|------------|------------|
| 19340000X | Single Specialty | 07/01/2020 | 12/31/2999 |

Step 9: Upload Documents

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

1. Select “Step 9: Upload Documents”



The screenshot shows the 'Enroll Provider - Group' step in the Business Process Wizard. The 'Step 9: Upload Documents' row is highlighted with a red box. Below the wizard, there is a table with the following data:

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-----------------------------------|
| Step 1: Provider Basic Information | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 2: Add Locations | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 3: Add Correspondence Address | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 4: Add Provider Type/Specialties/Subspecialties | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 5: Associate Billing Provider/Other Associations | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 6: Add Additional Information | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 7: Add Provider Controlling Interest/Ownership Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 8: Add Taxonomy Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 9: Upload Documents | Required | | | Incomplete | Please upload required documents. |
| Step 10: Complete Enrollment Checklist | Required | | | Incomplete | |
| Step 11: Submit Enrollment Application for Approval | Required | | | Incomplete | |

2. Select "Add"

The screenshot shows a web browser window with the URL `az-uat-evo.cns-inc.com/evoBrix/CNSIControlServlet`. The page title is "Provider" and the user is logged in as "valenzuela,veronica". The breadcrumb trail is "Track Application > Group Practice Enrollment".

Application ID: 20200701336552 Name: ABEL CTR

Close

Document List

Add (highlighted with a red box)

Filter By [] [] Go Save Filters My Filters

| Document ID | Document Type | Document Name | File Name | Start Date | End Date | Uploaded By | Uploaded Date | Document Status |
|--------------------|---------------|---------------|-----------|------------|----------|-------------|---------------|-----------------|
| No Records Found ! | | | | | | | | |

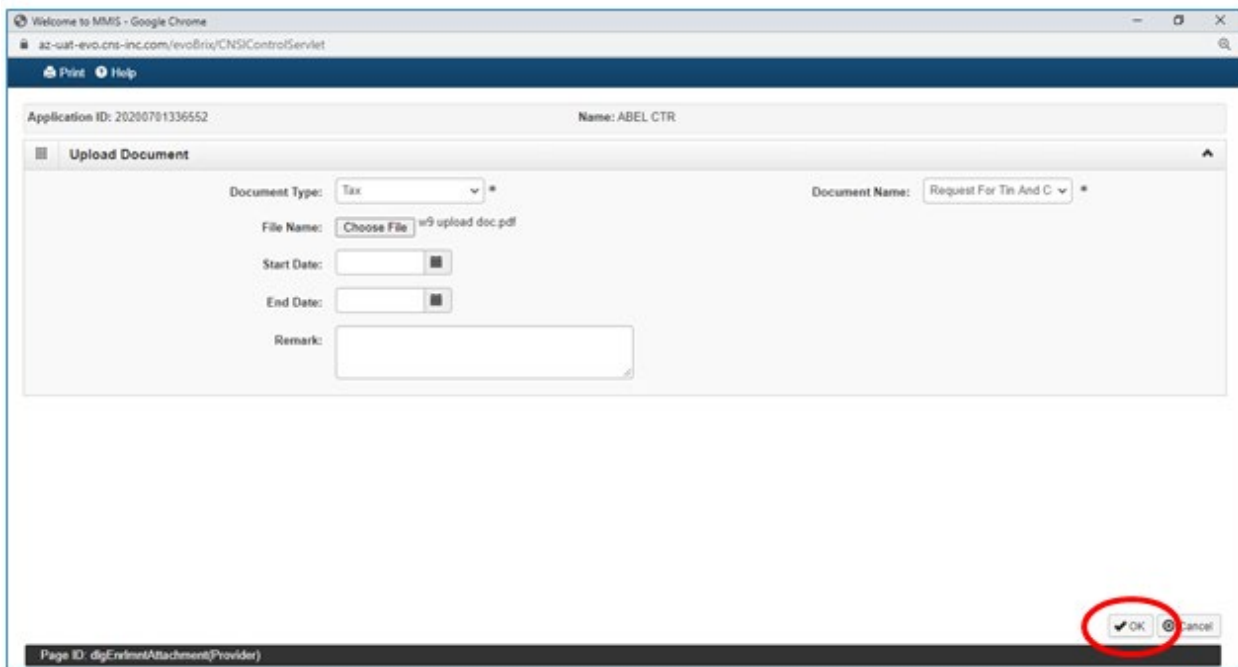
Page ID: pgEnfInmtDocumentList(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 01:11:48 MST

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” applicable for each 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.

5. Select “OK.”

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



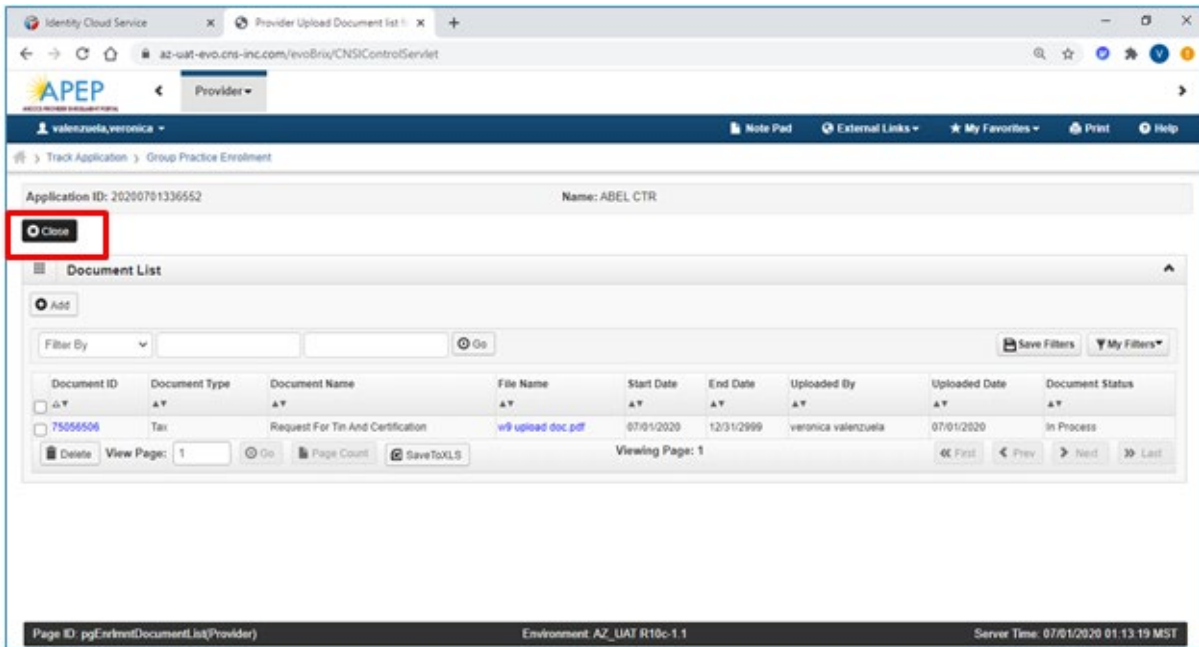
The screenshot shows a web browser window with the URL `az-wat-evo.crs-inc.com/evoBrix/CNSIControlServlet`. The page title is "Welcome to MMS - Google Chrome". The application ID is 20200701336552 and the name is ABEL CTR. The "Upload Document" form contains the following fields:

- Document Type: Tax
- Document Name: Request For Tin And C
- File Name: Choose File (with a file icon)
- Start Date: (empty date field)
- End Date: (empty date field)
- Remark: (empty text area)

The "OK" button is circled in red at the bottom right of the form.

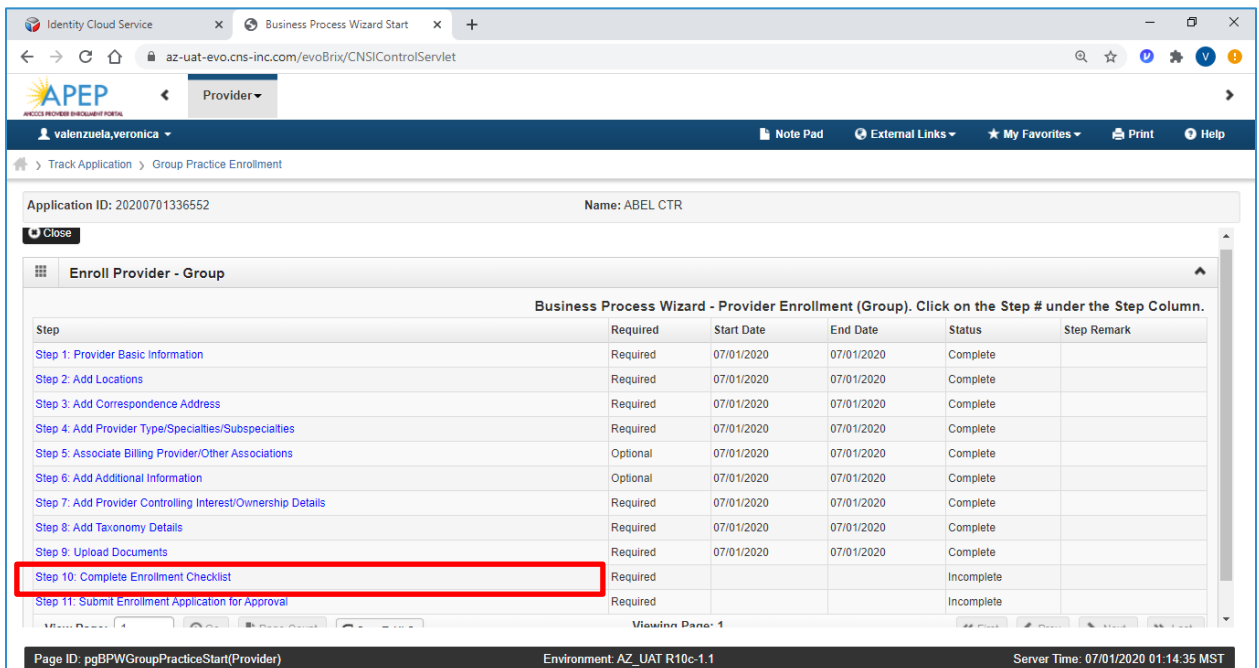
6. Repeat steps 1 through 5 for each document to upload.

7. Once “Upload Documents has been completed, each Uploaded Document will display with the document name and start/end dates.
8. Select “Close” to proceed forward.



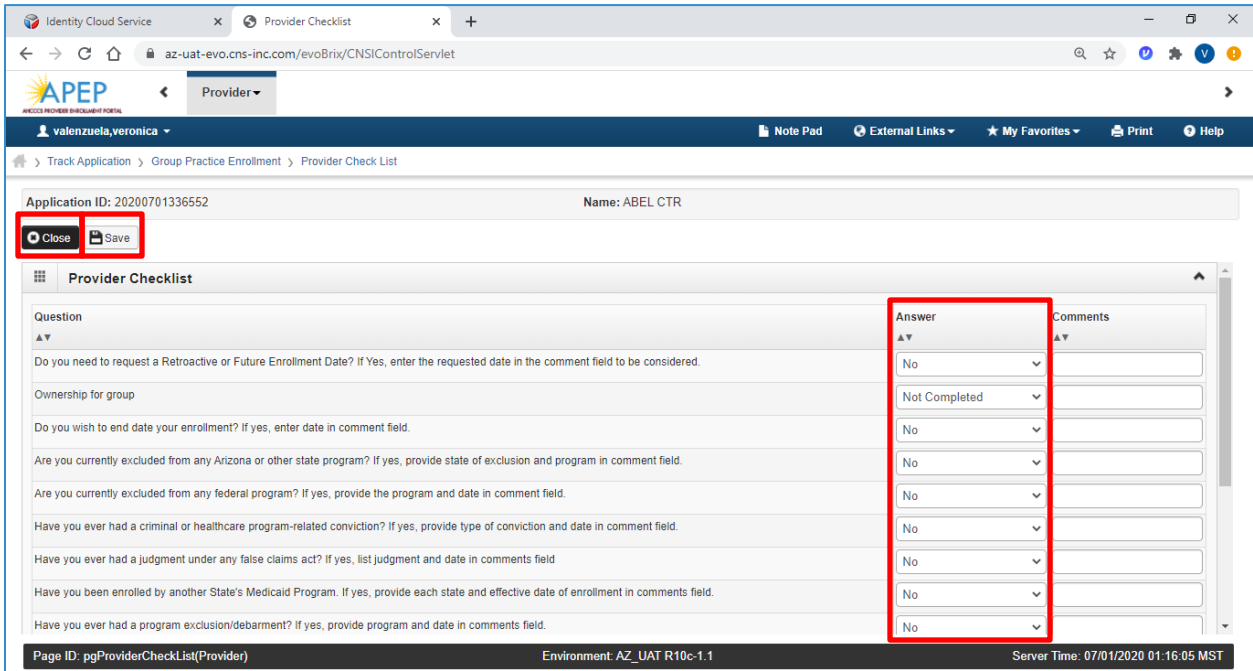
Step 10: Complete Enrollment Checklist

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



2. Answer each question and provide any additional information in the Comments field.
3. 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.



Application ID: 20200701336552 Name: ABEL CTR

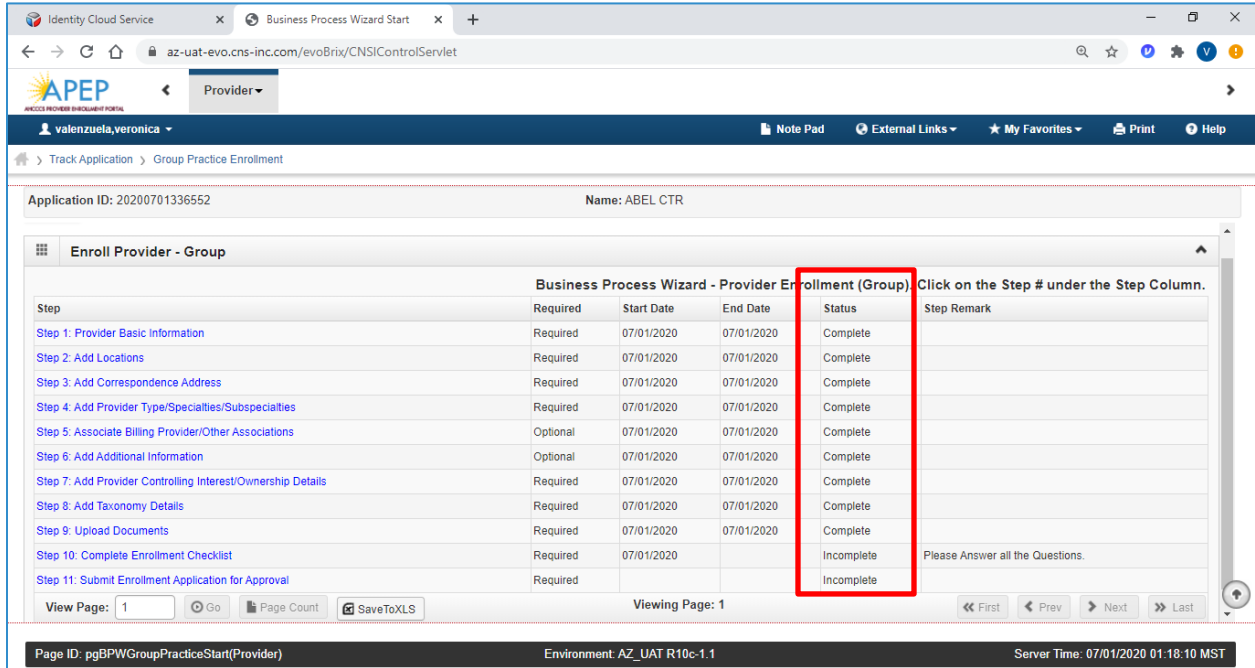
Close Save

Provider Checklist

| Question | Answer | Comments |
|--|---------------|----------|
| Do you need to request a Retroactive or Future Enrollment Date? If Yes, enter the requested date in the comment field to be considered. | No | |
| Ownership for group | Not Completed | |
| Do you wish to end date your enrollment? If yes, enter date in comment field. | No | |
| Are you currently excluded from any Arizona or other state program? If yes, provide state of exclusion and program in comment field. | No | |
| Are you currently excluded from any federal program? If yes, provide the program and date in comment field. | No | |
| Have you ever had a criminal or healthcare program-related conviction? If yes, provide type of conviction and date in comment field. | No | |
| Have you ever had a judgment under any false claims act? If yes, list judgment and date in comments field | No | |
| Have you been enrolled by another State's Medicaid Program. If yes, provide each state and effective date of enrollment in comments field. | No | |
| Have you ever had a program exclusion/debarment? If yes, provide program and date in comments field. | No | |

Page ID: pgProviderCheckList(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 01:16:05 MST

- Carefully review the “Status” column. If any steps show “Incomplete” select the “Incomplete” link to return and complete required information.



Application ID: 20200701336552 Name: ABEL CTR

Enroll Provider - Group

Business Process Wizard - Provider Enrollment (Group) Click on the Step # under the Step Column.

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|----------------------------------|
| Step 1: Provider Basic Information | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 2: Add Locations | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 3: Add Correspondence Address | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 4: Add Provider Type/Specialties/Subspecialties | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 5: Associate Billing Provider/Other Associations | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 6: Add Additional Information | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 7: Add Provider Controlling Interest/Ownership Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 8: Add Taxonomy Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 9: Upload Documents | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 10: Complete Enrollment Checklist | Required | 07/01/2020 | | Incomplete | Please Answer all the Questions. |
| Step 11: Submit Enrollment Application for Approval | Required | | | Incomplete | |

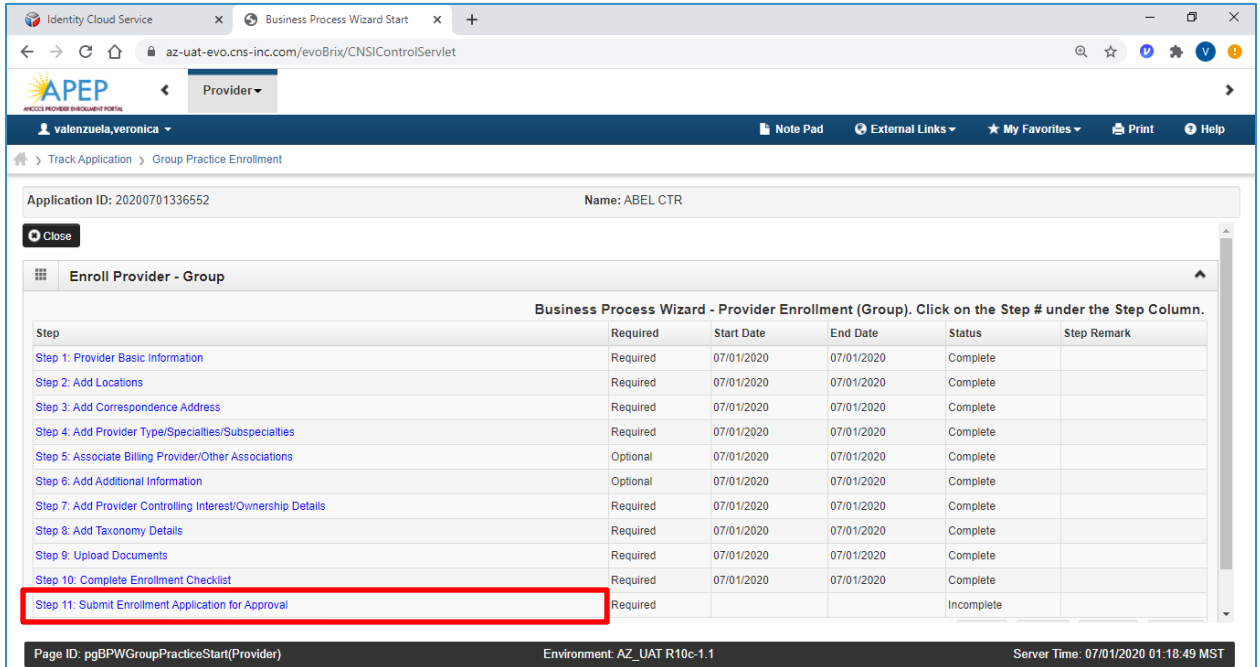
View Page: 1 Viewing Page: 1

Page ID: pgBPWGroupPracticeStart(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 01:18:10 MST

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.

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



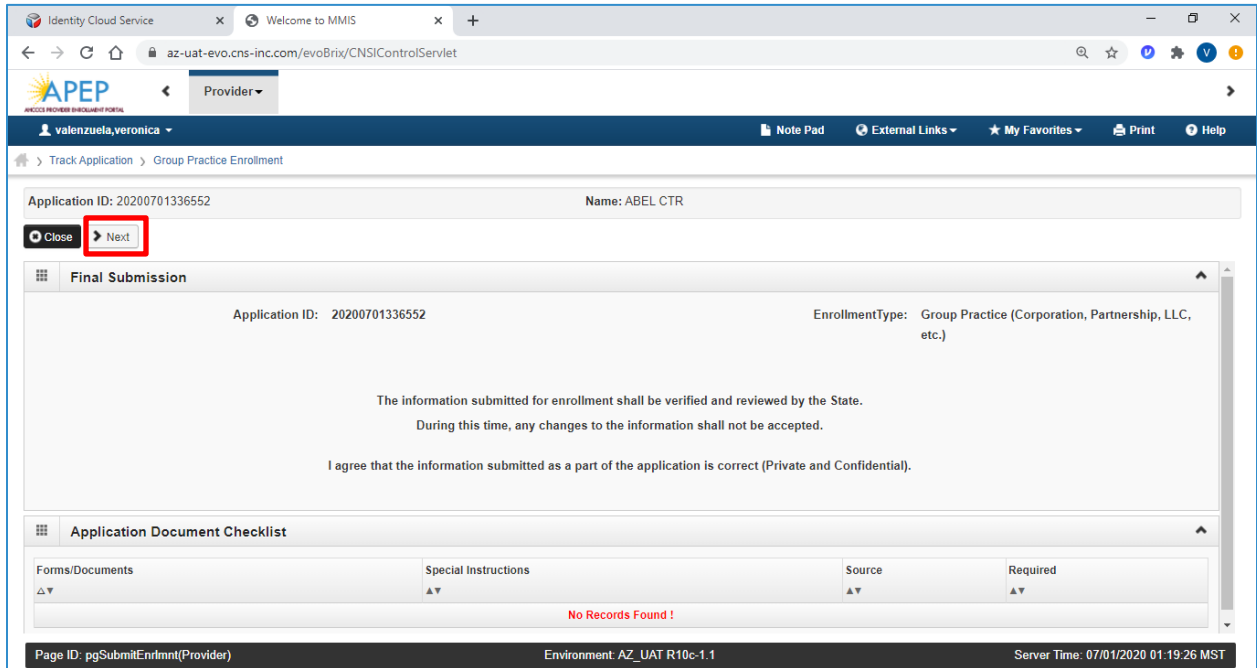
The screenshot shows the APEP Business Process Wizard interface. At the top, the user is logged in as 'valenzuela,veronica'. The application ID is 20200701336552 and the name is ABEL CTR. Below this is a table titled 'Enroll Provider - Group' with the following data:

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|------------|-------------|
| Step 1: Provider Basic Information | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 2: Add Locations | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 3: Add Correspondence Address | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 4: Add Provider Type/Specialties/Subspecialties | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 5: Associate Billing Provider/Other Associations | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 6: Add Additional Information | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 7: Add Provider Controlling Interest/Ownership Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 8: Add Taxonomy Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 9: Upload Documents | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 10: Complete Enrollment Checklist | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 11: Submit Enrollment Application for Approval | Required | | | Incomplete | |

The bottom of the page shows the page ID: pgBPWGroupPracticeStart(Provider), environment: AZ_UAT R10c-1.1, and server time: 07/01/2020 01:18:49 MST.

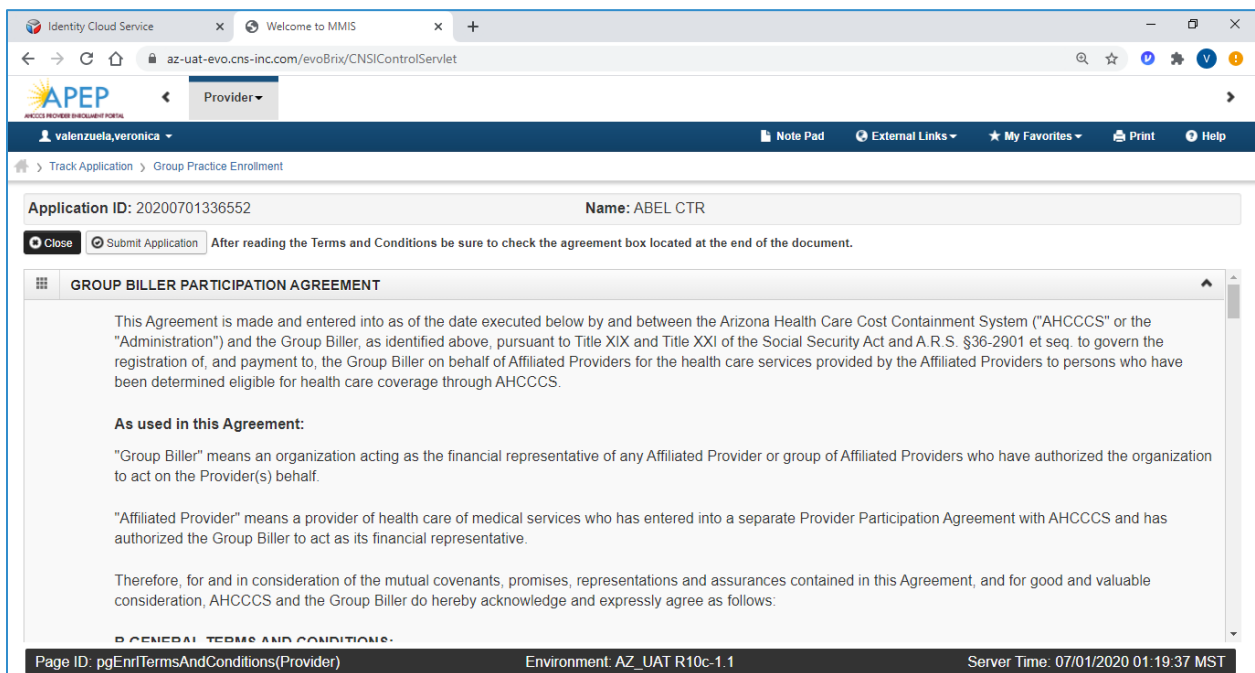
2. Select “Next.”

Note: By selecting “Next” This indicates the information you are submitting is accurate.

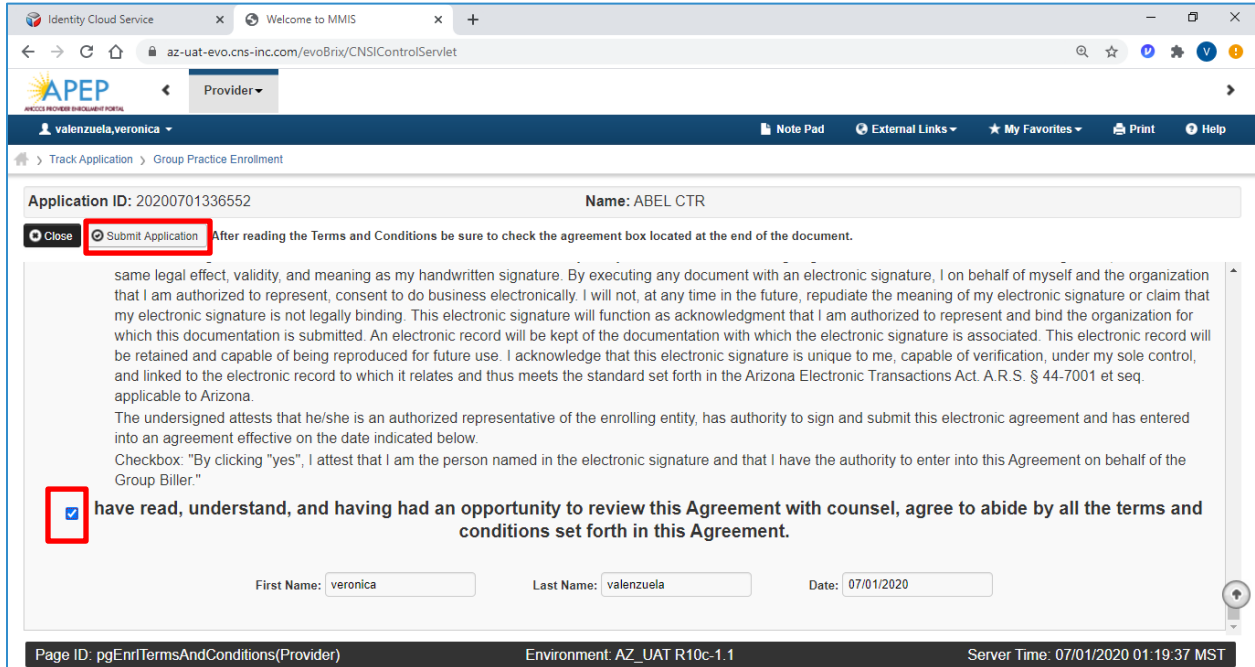


3. Carefully review the Provider Participation Agreement.

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.



4. Select the “Check box” indicating agreement with the Provider Participation Agreement. The signor’s full name and date will automatically display.
5. Select “Submit Application”



Identity Cloud Service Welcome to MMIS

az-uat-evo.cns-inc.com/evoBrix/CNSIControlServlet

APEP Provider Enrollment Portal

valenzuela,veronica

Track Application > Group Practice Enrollment

Application ID: 20200701336552 Name: ABEL CTR

Close Submit Application After reading the Terms and Conditions be sure to check the agreement box located at the end of the document.

same legal effect, validity, and meaning as my handwritten signature. By executing any document with an electronic signature, I on behalf of myself and the organization that I am authorized to represent, consent to do business electronically. 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. This electronic signature will function as acknowledgment 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. I acknowledge that this electronic signature is unique to me, capable of verification, under my sole control, and linked to the electronic record to which it relates and thus meets the standard set forth in the Arizona Electronic Transactions Act. A.R.S. § 44-7001 et seq. applicable to Arizona.

The undersigned attests that he/she is an authorized representative of the enrolling entity, has authority to sign and submit this electronic agreement and has entered into an agreement effective on the date indicated below.

Checkbox: "By clicking "yes", I attest that I am the person named in the electronic signature and that I have the authority to enter into this Agreement on behalf of the Group Biller."

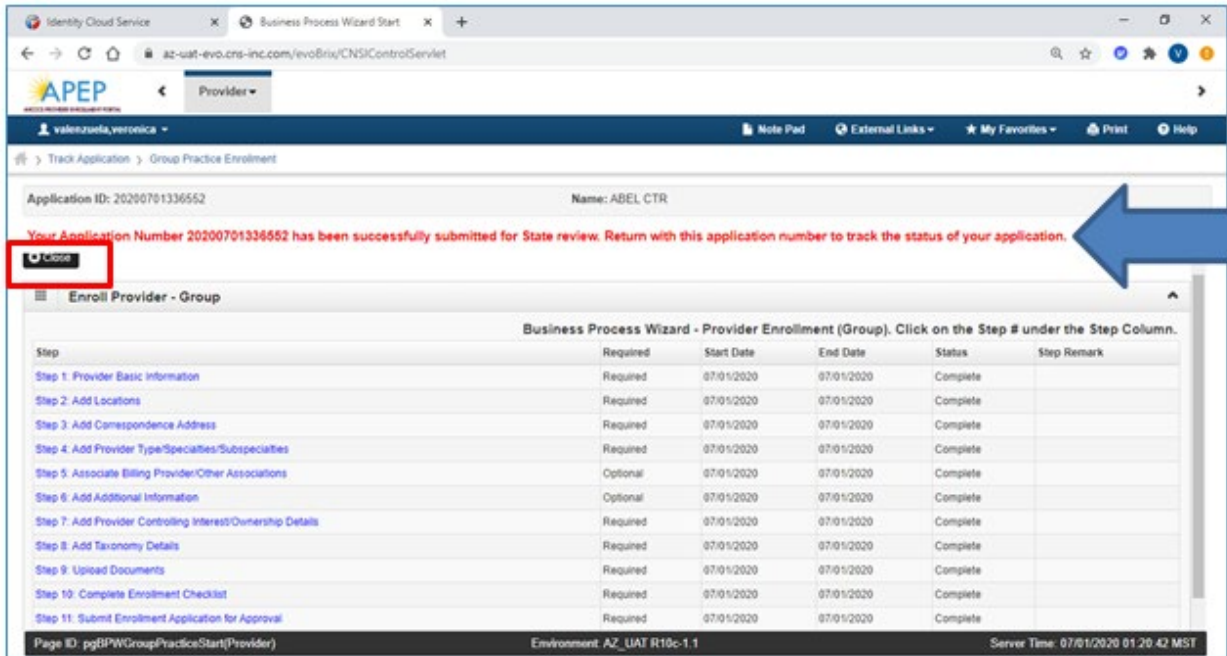
have read, understand, and having had an opportunity to review this Agreement with counsel, agree to abide by all the terms and conditions set forth in this Agreement.

First Name: veronica Last Name: valenzuela Date: 07/01/2020

Page ID: pgEnrTermsAndConditions(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 01:19:37 MST

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.

6. Select, "Close."



The screenshot shows the APEP web application interface. At the top, the user is logged in as 'valenzuela,veronica'. The main content area displays the following information:

- Application ID: 20200701336552
- Name: ABEL CTR

A red message box states: "Your Application Number 20200701336552 has been successfully submitted for State review. Return with this application number to track the status of your application." A blue arrow points to this message. Below the message, a "Close" button is highlighted with a red rectangular box.

Below the message is a table titled "Enroll Provider - Group" with the following data:

| Step | Required | Start Date | End Date | Status | Step Remark |
|---|----------|------------|------------|----------|-------------|
| Step 1: Provider Basic Information | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 2: Add Locations | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 3: Add Correspondence Address | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 4: Add Provider Type/Specialties/Subspecialties | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 5: Associate Billing Provider/Other Associations | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 6: Add Additional Information | Optional | 07/01/2020 | 07/01/2020 | Complete | |
| Step 7: Add Provider Controlling Interest/Ownership Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 8: Add Taxonomy Details | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 9: Upload Documents | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 10: Complete Enrollment Checklist | Required | 07/01/2020 | 07/01/2020 | Complete | |
| Step 11: Submit Enrollment Application for Approval | Required | 07/01/2020 | 07/01/2020 | Complete | |

Page ID: pgBPWGroupPracticeStart(Provider) Environment: AZ_UAT R10c-1.1 Server Time: 07/01/2020 01:20:42 MST