ACOM POLICY 415, ATTACHMENT E,
PROVIDERS THAT DIMINISHED THEIR SCOPE OF SERVICE AND/OR CLOSED THEIR PANEL DUE TO RATES

CONTRACTOR: _____ **DATE:** _____

GSA # (COMPLETE ONE TABLE PER GSA)

(1) PROVIDER NAME	(2) PROVIDER ID	(3) PROVIDER TYPE	(4) SCOPE OF SERVICE DIMINISHED	(5) PANEL CLOSED		(6) PROVIDER CAPACITY	(7) REASON	(8) ATTESTATION

INSTRUCTIONS FOR ATTACHMENT E:

1. The name of the provider.
2. The 6-digit AHCCCS legacy identification number. Do not use a provider's NPI.
3. The Provider Type code as utilized in PMMIS.
4. Type of Service or 'NA' if not applicable
5. 'Y' yes or 'NA' if not applicable // 'A' Medicaid or 'B' Non-Medicaid
6. This column should be populated with the number of members assigned to, residing in, or regularly receiving services from the provider. In the case of hospitals, outpatient facilities, labs, etc. indicate the number of members (unduplicated) that on average utilized the providers during the three month time period prior to the termination date. In the case of nursing facilities and ~~a~~Alternative ~~residential~~ HCBS S~~s~~ettings indicate the number of members residing in the facility at the time of termination notice by the provider.
7. Insert one of the following reasons:

- Increased rate requested (provider initiated)
- AHCCCS FFS rate reduction (pass-through)
- Contractor rate reduction (not associated with an AHCCCS reduction)
- Other (Use only if the termination reason does not fall under one of the first three bullets and ***is a rate related reason***. Describe using only a ***rate related reason***.)

8. Include a statement if the loss of the provider will result in a network gap. See ACOM 439 Material Changes: Provider Network and Business Operations for possible additional reporting requirements. If there will be a gap, indicate how the Contractor will meet member needs after the provider leaves the network.