Moratorium Exemption Request Form

Instructions:
This form is for providers to request an exemption from the moratorium currently in effect for the following provider types:

- A3 – Community Service Agencies,
- B8 – Behavioral Health Residential Facility (BHRF),
- IC – Integrated Clinic,
- 28 – Non-emergency Medical Transportation Provider, and
- 77 – Behavioral Outpatient Clinic.

Exemption requests from the moratorium are considered on a case-by-case basis. To ensure the exemption request can be given full consideration, please make sure to answer all questions on this form. Submit completed forms to ProviderMoratorium@azahcccs.gov

Contact Information	
Name of Contact:	
Phone Number of Contact:	Email of Contact:

Provider Information	
Provider Name:	NPI:
In what county is the provider located?	
Is this provider currently registered with AHCCCS under a different provider type? ☐ No ☐ Yes: Provider ID: Provider Type:	
Is the provider a Federally Qualified Health Center? ☐ No ☐ Yes	
Please select which provider type is being applied for: ☐ Behavioral Health Outpatient Clinics (77) ☐ Behavioral Health Residential Facilities (B8) ☐ Community Service Agencies (A3) ☐ Integrated Clinics (IC) ☐ Non-Emergency Medical Transportation providers (28)	

Has the application already been submitted thought the AHCCCS Provider Enrollment Portal (APEP)?

☐ No. If no, please provide the anticipated date the application will be submitted:

☐ Yes:

Application Number:

Date of application:

Is the provider contracted with any AHCCCS Managed Care Organization (MCO), IHS, 638 facility or Tribal Regional Behavioral Health Authority (TRBHA)?

☐ No

☐ Yes:

Entity Name: Provider Type(s):

Questions for providers applying as Behavioral Health Outpatient Clinics (77) Behavioral Health Residential Facilities (B8) or Integrated Clinics (IC)	
Who are your behavioral health professionals?	
Name: AHCCCS ID: Date Became AHCCCS Provider:	Name: AHCCCS ID: Date Became AHCCCS Provider:
Name: AHCCCS ID: Date Became AHCCCS Provider:	Name: AHCCCS ID: Date Became AHCCCS Provider:

Exemption Screening Questions

Is an exemption being requested due to a Medically Underserved Service Area?

☐ No

☐ Yes - Describe the area:

Is an exemption being requested due to service expansion to support a State Medicaid Agency initiative?

☐ No

☐ Yes – Describe the State Medicaid Agency Initiative:

Is an exemption being sought at the request of an AHCCCS contracted managed care organization (MCO) to ensure that access to care standards are not out of compliance?

☐ No

☐ Yes - Name the managed care organization:
Is an exemption being requested by an AHCCCS contracted managed care organization (MCO) due to another identified need? ☐ No ☐ Yes- Enter the name of the managed care organization and describe the identified need:
Please provide a justification for the exemption:

I affirm under penalty of perjury that the statements and documents provided about the persons named above, that relate to AHCCCS provider enrollment, are true and correct to the best of my knowledge.

Printed name:	Signature:	Date:

Thank you for your interest in being an AHCCCS Provider. Submit completed forms to ProviderMoratorium@azahcccs.gov

AHCCCS INTERNAL USE ONLY		
Request Number:		
Date received by AHCCCS:		
Review notes:		
Form reviewed and verified by:		
Printed name:	Signature:	Date: