



4350 E. Cotton Center Boulevard • Building D • Phoenix, AZ 85040 • (602) 263-3000 • (800) 624-3879

INITIAL REQUEST FORM- ANCILLARY/ FACILITY

Mercy Care Plan contracting and credentialing standards require that Mercy Care obtain, among other things, personal information, such as your name, address, and social security number. Personal information is maintained in contracting and credentialing databases at Mercy Care for in-house tracking, reporting purposes, contracting, credentialing and payment of claims. Providing the required personal information is voluntary; however, failure to provide it will delay the contracting and credentialing process and may preclude a contract.

IN ORDER TO BE CONTRACTED, YOU MUST HAVE AN NPI NUMBER, REGISTERED WITH AHCCCS, HAVE NOT OPTED OUT OF MEDICARE, SUBMIT CLAIMS ELECTRONICALLY, HAVE INTERNET ACCES AND PARTICIPATE WITH ALL MERCY CARE PRODUCTS. TO CONTINUE PROCESSING, ALL FIELDS MUST BE COMPLETED.

EDI and Internet:	Electronic Claim Submissions: <input type="checkbox"/> Y <input type="checkbox"/> N Does your Business have internet Access: <input type="checkbox"/> Y <input type="checkbox"/> N If no, please explain: _____	
Business Name:	Corporate/ TIN Name: _____ DBA Name: _____	
Ownership Change:	Was organization, facility or ancillary previously contracted under a different owner: <input type="checkbox"/> Y <input type="checkbox"/> N Date of ownership change: ____/____/____. Copy of sale/ change required.	
NPI:	Organization NPI: _____ Eff. Date: ____/____/____ Individual NPI (if applicable): _____ Eff. Date: ____/____/____	
Tax ID: Other ID's:	Organization TIN #: _____ Individual TIN #: _____ Eff. Date: ____/____/____	DEA#: _____ Eff. Date: ____/____/____ Medicare #: _____ Eff. Date: ____/____/____ AHCCCS # _____ Eff. date: ____/____/____ Medicare Opt Out? <input type="checkbox"/> Yes <input type="checkbox"/> No CAQH# _____
License:	AZ License #: _____ Date First issued: ____/____/____ Exp date: ____/____/____	
A copy of liability insurance, State License, Accreditation or Medicare Survey must accompany your application before contracting/ renewal can be completed (if applicable)		
Facility:	Hospital: <input type="checkbox"/> Acute <input type="checkbox"/> LTAC <input type="checkbox"/> Critical Access <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Rehabilitation Hospital Other: _____ <input type="checkbox"/> Free Standing Surgical Facility <input type="checkbox"/> Urgent Care <input type="checkbox"/> Dialysis <input type="checkbox"/> Other _____ <input type="checkbox"/> Please indicate specialized service: _____	
Ancillary:	Home Care Services: <input type="checkbox"/> DME <input type="checkbox"/> Orthotics & Prosthetics <input type="checkbox"/> Home Health Agency <input type="checkbox"/> IV Therapy Home Care Specialty or Custom services: _____ Assisted Living Facility: <input type="checkbox"/> Assisted Living Center <input type="checkbox"/> Skilled Nursing Facility Home Community Based Services: <input type="checkbox"/> Attendant Care <input type="checkbox"/> Personal Care <input type="checkbox"/> Homemaker <input type="checkbox"/> Respite	



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Ancillary Continued:	HCBS Other: _____ <input type="checkbox"/> Laboratory <input type="checkbox"/> Optical Establishment <input type="checkbox"/> Sleep Laboratory Transportation: <input type="checkbox"/> Non- Emergent <input type="checkbox"/> Emergency <input type="checkbox"/> Air Evac <input type="checkbox"/> Other _____ <input type="checkbox"/> Please indicate specialized services: _____
Administrative Contact: <small>(MCP's contact)</small>	Contact Name: _____ Email: _____ Phone Number: () _____ Fax Number: () _____

Primary Address: <small>(Main location where provider offers services)</small>	Street: _____ Suite: _____ Office hours: _____ City: _____ State: _____ Zip: _____ Phone: () _____ Fax: () _____ County: _____
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Additional Office <small>(if applicable)</small> <small>(Indicate other offices on separate sheet)</small>	Street: _____ Suite: _____ Office hours: _____ City: _____ State: _____ Zip: _____ Phone: () _____ Fax: () _____ County: _____
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Contract will be mailed to this address unless otherwise specified

Mailing/ Billing Address: <small>(All correspondence, contracts & credentialing info will be sent to this address)</small>	Street: _____ Suite: _____ City: _____ State: _____ Zip: _____ Phone: () _____ Fax: () _____
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Please list other services or important information you want Mercy Care Plan to know that is unique or different.

Language(s) spoken other than English: _____, _____ Cultural Heritage: _____ Is this a Minority or Female-owned Business? <input type="checkbox"/> Y <input type="checkbox"/> N
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The completion of this form does not guarantee network participation. Please allow approximately five business days to evaluate the current network need. If you are approved and MCP can verify that a CAQH application has been completed, please allow approximately ninety business days to complete the credentialing process.

I am _____ of _____ and authorized to submit this application on behalf of _____ . I affirm that all of the information on this form is accurate and complete to the best of my knowledge, information, and belief. I Promise to keep confidential any information that Mercy Care Plan shares with me during this process.

Authorized Signature: _____ **Date:** ____/____/____

PLEASE DO NOT WRITE BELOW THIS LINE - MCP ONLY

Above Health Form Request Approved by Network Development & Contracting

MCP Representative Signature _____ **Date** ____/____/____

Please mail or fax completed form to the attention of Network Development & Contracting Department - (860)-975-3201