

Provider Submission Portal (PSP)

User Guide

If you have any questions or problems submitting, please contact Jennifer Janzen, Eligibility Education and Training Coordinator at Jennifer.Janzen@Solari-Inc.org or contact the Eligibility & Care Services Department at 855.832.2866.

Updated 2/11/2026

Solari Provider Submission Portal User Guide

Select option needed from the popup box:

Select how you want to proceed

Choose the option that applies to this submission.

Start a New Submission
Removal of Designation
Update Existing Documents

Start a New Submission:

PROVIDER SUBMISSION PORTAL



NEW SUBMISSION

Need to attach additional documents? [Click Here](#) Switch to Removal Of Designation? [Click Here](#)

Applicant Info

FIRST NAME*	MIDDLE NAME	LAST NAME*	DATE OF BIRTH*
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>
GENDER*	RACE*	PREFERRED PRONOUN*	PREFERRED LANGUAGE*
<input type="text" value="Not Selected (Required)"/>	<input type="text" value="Not Selected (Required)"/>	<input type="text" value="Not Selected (Required)"/>	<input type="text" value="Not Selected (Required)"/>
IS APPLICANT EXPERIENCING HOMELESSNESS?*			
<input type="radio"/> Yes <input type="radio"/> No			
APPLICANT ADDRESS	CITY	STATE	ZIP CODE*
<input type="text"/>	<input type="text"/>	<input type="text" value="AZ"/>	<input type="text"/>
AHCCCS ID NUMBER	INSURANCE TYPE*		
<input type="text" value="A-"/>	<input type="text" value="Not Selected (Required)"/>		

The first section is the “Applicant Info” section. Use the tab key or your mouse to navigate through the form to enter information or make selections.

Enter Applicant’s First Name, Middle Name or Initial, Last Name and Date of Birth (matching AHCCCS in spelling even if name is misspelled)

Select Gender: Select preference from the drop-down menu

Select Race: Select preference from the drop-down menu

Preferred Pronoun: Select preference from the drop-down menu

Preferred Language: Select preference from the drop-down menu

Is Applicant Experiencing Homelessness? Click Yes or No

Enter Applicant Address, City, State (should auto-populate to AZ) and zip code (matching address on file with AHCCCS)

Enter Applicant’s AHCCCS ID Number (even if coverage has been suspended)

Select Current Insurance Type: AHCCCS, Private/Commercial, or None

Evaluation Info:

Evaluation Info

<p>DETERMINATION TYPE*</p> <p><input checked="" type="radio"/> SMI</p>	<p>AIHP*</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>EVALUATION DATE REQUEST RECEIVED*</p> <p>mm/dd/yyyy <input type="text"/></p>	<p>EVALUATION TIME REQUEST RECEIVED*</p> <p>--:--:-- <input type="text"/></p>
<p>CONSENT SIGNED DATE*</p> <p>mm/dd/yyyy <input type="text"/></p>	<p>CONSENT SIGNED TIME*</p> <p>--:--:-- <input type="text"/></p>
<p>EVALUATION LOCATION*</p> <p><input type="radio"/> Inpatient <input type="radio"/> Outpatient <input type="radio"/> Jail</p>	<p>IS APPLICANT COE?*</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>WAIVER OF 3 DAY DETERMINATION*</p> <p><input type="radio"/> 3 Business Days <input type="radio"/> 20 Days <input type="radio"/> EEP</p>	<p>CONSENT GIVEN BY*</p> <p><input type="radio"/> Self <input type="radio"/> Parent <input type="radio"/> Guardian <input type="radio"/> COT Team</p> <p style="text-align: center;"><input type="button" value="clear"/></p>

The second section is the “Evaluation Info” section. Use the tab key or your mouse to navigate through the form to enter information or make selections.

Determination Type: This will auto-populate to SMI

AIHP: Is the applicant a Tribal member and enrolled with the American Indian Health Program? Click Yes or No

Evaluation Date Request Received: using the calendar icon, choose the date you offered **or** the applicant requested the evaluation

Evaluation Time Request Received: using the clock icon, choose the time of day you offered **or** the applicant requested the evaluation

Consent Signed Date: using the calendar icon, choose the date the applicant (or parent/guardian/COT Team) gave consent

Consent Signed Time: using the clock icon, choose the time of day the applicant (or parent/guardian/COT Team) gave consent

Evaluation Location: Where was the evaluation completed? Click Inpatient, Outpatient, or Jail

Is Applicant under COE? Is applicant inpatient and under Court Ordered Evaluation? click Yes or No

Waiver of 3 Day Determination: (match the choice on the Waiver) click 3 Business Days, 20 Days, or EEP

Consent Given By: Who is consenting on behalf of the applicant? Click Self, Parent, Guardian, or COT Team **if** the person is under COT and refusing to cooperate

Provider Info:

Provider Info

<p>PROVIDER*</p> <input type="text" value="Not Selected (Required)"/>	<p>ASSESSOR NAME*</p> <input type="text"/>
<p>ASSESSOR CREDENTIALS*</p> <input type="text"/>	<p>PACKET SUBMISSION CONTACT*</p> <input type="text"/>
<p>PACKET SUBMISSION PHONE*</p> <input type="text"/>	<p>EXT.</p> <input type="text"/>
<p>PACKET SUBMISSION EMAIL*</p> <input type="text"/>	
<p><small>Please provide a valid work email The Packet Submission Email field is required.</small></p>	
<p><input type="checkbox"/> Same As Packet Submission Info</p>	
<p>CLINICAL CONTACT NAME*</p> <input type="text"/>	<p>CLINICAL CONTACT DIRECT PHONE*</p> <input type="text"/>
<p>EXT.</p> <input type="text"/>	<p>CLINICAL CONTACT EMAIL*</p> <input type="text"/>

The third section is the “Provider Info” section. Use the tab key or your mouse to navigate through the form to enter information or make selections.

Provider: choose your agency name from the drop-down menu

Assessor Name: Who is the BHP signing the Determination Form?

Assessor Credentials: Indicate BHP, LMSW, MD, PNP, etc., of assessor

Packet Submission Contact: Who is submitting the packet into the PSP? Indicate a name, direct phone number, and an email address. This could be an individual or a group email address. This is the email we will use to confirm receipt of the submission, to report any errors or request missing information, and we will also send the outcome to this email. Ensure this is a work email – not a personal email!

Clinical Contact Name: If the Packet Submission Contact is the Assessor, click the box indicating “Same as Packet Submission Info”. This will auto-populate the Clinical Contact information. If this is different, please enter contact information for two people (names, phone numbers, emails separated by a semi colon) who know the applicant and could conduct a staffing with our doctor if necessary.

Attachments:

Attachments

SMI CONSENT FOR ASSESSMENT*

Choose File No file chosen

WAIVER OF THREE DAY DETERMINATION FORM

Choose File No file chosen

SMI DETERMINATION FORM*

Choose File No file chosen

CORE ASSESSMENT*

Choose File No file chosen

OTHER DOCUMENTS

Choose Files No file chosen

Can submit multiple files here. To do so, when the file selector opens hold ctrl and start selecting the files that you want.

Total File Size: 0.00 MB

Review


The fourth section is the “Attachments” section. Please attach .pdf copies of all required forms under the corresponding heading: SMI Consent For Assessment, Waiver Of Three Day Determination Form, SMI Determination Form, Core Assessment, Other Documents to include at least six months of clinically relevant records, a Release of Information (ROI), etc. You can submit multiple files under “other documents” by holding the CTRL key and selecting the files you want.

*If Applicant is under COE or COT, you will be prompted to attach Petition or Court Approved Service Plan.

*If applicant has a legal guardian (for 17.5 year-olds – someone other than a parent), you will be prompted to attach Guardianship Documentation from the Court or Notice To Provider

Review:

Once all files have been attached, click the “Review” button at the bottom of the screen to review all information you have entered. If there are errors, click the back button to go back and correct the information.

PROVIDER SUBMISSION PORTAL


Review

Applicant Information

<p>FIRST NAME</p> <p>LAST NAME</p> <p>EXPERIENCING HOMELESSNESS? No</p> <p>CITY</p> <p>ZIP CODE</p> <p>INSURANCE TYPE Not Selected (Required)</p> <p>RACE Not Selected (Required)</p> <p>PREFERRED LANGUAGE Not Selected (Required)</p>	<p>MIDDLE NAME</p> <p>DATE OF BIRTH</p> <p>APPLICANT ADDRESS</p> <p>STATE AZ</p> <p>AHCCCS ID A</p> <p>GENDER Not Selected (Required)</p> <p>PREFERRED PRONOUN Not Selected (Required)</p>
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Evaluation Information

REMOVAL OF DESIGNATION?	DETERMINATION TYPE
No	SMI
AIHP?	EVAL DATE RECEIVED
No	
EVAL TIME RECEIVED	CONSENT SIGNED DATE
CONSENT SIGNED TIME	EVALUATION LOCATION
INMATE ID	COE?
WAIVER OF 3 DAY DETERMINATION	CONSENT GIVEN BY

Provider Information

PROVIDER	ASSESSOR NAME
Not Selected (Required)	
ASSESSOR CREDENTIALS	PACKET CONTACT
PACKET PHONE	EXT
PACKET EMAIL	CLINICAL CONTACT NAME
CLINICAL CONTACT PHONE	EXT
CLINICAL CONTACT EMAIL	

Attachments

CONSENT FOR ASSESSMENT

WAIVER OF 3 DAY DETERMINATION

DETERMINATION FORM

CORE ASSESSMENT

OTHER DOCUMENTS

TOTAL FILE SIZE:
0.00 MB

« Back

Submit +

Once the packet is submitted, Solari will review the packet for timeliness, accuracy, and completeness. The packet submission contact will receive an email with a unique Web Portal ID indicating that we have received the packet. If there are any errors or missing information or documents, we will email the packet submission contact directly. Please make sure you receive and open the email!

If we request that you upload additional or corrected/updated documentation, click “Update Existing Documents” from the popup box:

Select how you want to proceed

Choose the option that applies to this submission.

[Start a New Submission](#)

[Removal of Designation](#)

[Update Existing Documents](#)

This will open a new window, and you will enter the Web Portal ID you received in the confirmation email.

Submit Updated Documents

WEB PORTAL ID

SMI CONSENT FOR ASSESSMENT
 No file chosen

REMOVAL OF DESIGNATION ATTESTATION
 No file chosen

SMI DETERMINATION FORM
 No file chosen

CORE ASSESSMENT
 No file chosen

WAIVER OF THREE DAY DETERMINATION FORM
 No file chosen

OTHER DOCUMENTS
 No file chosen

Total File Size: 0 MB

Attach the requested documents under the correct heading (Consent, Determination Form, Core Assessment, Waiver, Other Documents) and click the Submit button at the bottom of the window.

If you do not have access to the Web Portal ID, you can use the “Retrieve Web Portal ID” feature.

ATTACH ADDITIONAL DOCUMENTS

Need to make a submission? [Click Here](#)

Retrieve Web Portal ID

APPLICANT LAST NAME

APPLICANT DATE OF BIRTH

PACKET SUBMISSION EMAIL

[Retrieve](#)

Just enter the applicant’s last name, date of birth, and the email of the person who submitted the initial packet, and the Web Portal ID will show up in the box.

Removal of Designation:

Select how you want to proceed

Choose the option that applies to this submission.

Select Removal of Designation from the popup box.

Continue through the Applicant Info section as directed above.

For Evaluation Info you will enter all information as indicated above, but indicating the date and time the applicant signed the Attestation Form which takes the place of the Consent Form in a Removal of Designation Packet:

Evaluation Info

DETERMINATION TYPE* <input checked="" type="radio"/> SMI	AIHP* <input type="radio"/> Yes <input type="radio"/> No
EVALUATION DATE REQUEST RECEIVED* mm/dd/yyyy	EVALUATION TIME REQUEST RECEIVED* --:-- --
ATTESTATION SIGNED DATE* mm/dd/yyyy	ATTESTATION SIGNED TIME* --:-- --
EVALUATION LOCATION* <input type="radio"/> Inpatient <input type="radio"/> Outpatient <input type="radio"/> Jail	IS APPLICANT COET* <input type="radio"/> Yes <input type="radio"/> No
CONSENT GIVEN BY* <input type="radio"/> Self <input type="radio"/> Parent <input type="radio"/> Guardian <input type="radio"/> COT Team <input type="button" value="clear"/>	

Continue through the Provider Info section as directed in the “New Submission” section above.

For Attachments: attach .pdf copies of all required forms under the corresponding headings. Once all files have been attached, click the “Review” button at the bottom of the screen to review all information you have entered. If there are errors, click the back button to go back and correct the information.

Attachments

REMOVAL OF DESIGNATION ATTESTATION FORM*

Choose File No file chosen

SMI DETERMINATION FORM*

Choose File No file chosen

CORE ASSESSMENT*

Choose File No file chosen

OTHER DOCUMENTS

Choose Files No file chosen

Can submit multiple files here. To do so, when the file selector opens hold ctrl and start selecting the files that you want.

Total File Size: 0.00 MB

Review