



AZ Connect Access Agreement & User Registration

What is AZ Connect? AZ Connect is Arizona Priority Care’s (AZPC) new on-line software program that will assist you with verifying member eligibility, allows you to submit prior authorization requests on line, check the status of real time prior authorizations previously submitted and view status of claims submitted to AZPC.

Directions: For access to AZPC’s AZ Connect System, please complete this form and return it to AZPC’s Provider Relations Department via fax at 480-403-8209 or email providerrelations@azprioritycare.com.

INCOMPLETE FORMS WILL BE RETURNED PRIOR TO GRANTING ACCESS

*Please **PRINT** clearly and completely.*

Requestor First Name:	Requestor Last Name:	
Title:	Requestor Phone: ()	Requestor Fax: ()
Practice/Provider Name:		Tax ID# (Required):
Email Address (email address is <u>Required</u> in order for access to be granted):		

ACCEPTANCE OF ARIZONA PRIORITY CARE’S AZ CONNECT DATA ACCESS TERMS & CONDITIONS

I understand and accept that being granted access to Arizona Priority Care’s on-line application, named AZ Connect involves my assuming considerable responsibility for maintaining the integrity and security of Arizona Priority Care’s data. I am responsible for the privacy and confidentiality of any Arizona Priority Care’s data to which I have access.

My signature affixed certifies that I have read and agree to the terms and conditions stated in the first paragraph and will comply with all requirements as directed by Arizona Priority Care.

Requestor Signature (Required):	
Manager/Physician of Group Signature (Required):	Date:

NOTICE: This communication is intended for the use of the individual or entity to whom it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient, or the employee or the agent responsible for delivering the communication to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, email or facsimile and disregard this form

Internal Use Only:

User Name: _____	<input type="checkbox"/> Approved: _____
Provider Relations Rep Name: _____	<input type="checkbox"/> Denied: _____
	<input type="checkbox"/> Tracker: _____