Arizona Priority Care

EXISTING PRACTICE/GROUP*
PROVIDER PARTICIPATION REQUEST FORM

PLEASE COMPLETE THE FOLLOWING AND RETURN VIA EMAIL: Network.Contracting@AZPriorityCare.com

ATTENTION: This is not a provider application. This form is to be used to request the addition of a provider to your existing contract with Arizona Priority Care (AZPC). You will receive an auto confirmation of receipt by AZPC. If you do not receive an auto confirmation, please contact us at 480-499-8700 ext. 8249.

The request to add a provider to your group will be reviewed and responded to within ten (10) business days of receipt of this request form. Once approved, our credentialing department will send to you the paperwork required to initiate the credentialing process. ***PLEASE NOTE:** ***If your group is not currently participating in the AZPC network, please use the "New Group/Practice" Participation Request form located on our website:*** www.azprioritycare.com

Thank you for your continued participation in the Arizona Priority Care network.

Section I

Credentialing Contact Information

Credentialing Contact Name	Title	Telephone	Fax
Credentialing Contact Address			
Email Address			Date

Section II

Provider Information

Last Name	First Name	MI	Degree (MD, DO, etc)	Gender
Group Name (as it appears on W-9)			Date Provider Effective with Group	
Tax ID #:	Individual NPI:	Social Security #:	Date of Birth	
Primary Specialty:	Sub Specialty:	AHCCCS #:	CAQH #:	
Provider Type *PCP ☐ Specialist ☐ * If PCP, do you want members assigned to NPs? ☐ Yes ☐ No			Practice Type: ☐ Office-based practice ☐ House Call Only Practice ☐ Hospitalist ☐ Other: _____	
Certified to participate in Medicare? ☐ Yes ☐ No Medicare #:			Board Certified: ☐ Yes ☐ No Board Certified Date:	
DEA #: DEA State Issued: DEA# Expiration Date:			AZ License #: AZ License Expiration Date:	
Hospital Affiliation(s) (attach list if necessary)			Malpractice Insurance Carrier:	
Electronic Billing Used? ☐ Yes ☐ No Electronic Medical Records? ☐ Yes ☐ No E-Prescribing? ☐ Yes ☐ No			Panel Age Limitations? ☐ Yes ☐ No If Yes, Please specify: Gender Limitations? ☐ Yes ☐ No If Yes, Please specify :	
Foreign Language(s)				

*** Please complete fully. Incomplete sections may result in delayed processing.**

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Section III

Practice Manager Contact Information

Address, City, State, & Zip Code	
Should this address be used for all Provider notices and correspondence? ☐ Yes ☐ No	If no, what address should all provider correspondence be sent to?
Telephone	Fax
Office Manager / Contact Name	Email Address

Section IV

Remit/ Payment Address

Address	
City, State, & Zip Code	
Telephone	Fax

Section V

Primary Practice Address (if applicable, attach page for additional locations)

Address, City, State, & Zip Code			
County	Telephone	Fax	Office Hours/Days
Practice Email Address		Website	
Handicap Accessibility ☐ Yes ☐ No			

*** Please complete fully. Incomplete sections may result in delayed processing.**