PCP Panel Closure Request Form

Please complete the following and return to:
EMAIL: provider.network@azprioritycare.com or **FAX: (480) 499-8729**

Section I

Name/Title of Person Completing this Form

Name/Title (person completing this form)	Telephone	Fax	Date
Email Address			

Section II

Provider Information

Last Name	First Name	MI	Degree (MD, DO, etc)	Gender
Group Name (as it appears on W-9)		Group DBA Name		
Tax ID #	Individual NPI #	Specialty	Panel Closure Effective Date	

Section III

Primary Practice Address

Address, City, State, & Zip Code		
County	Telephone	Fax

Section IV

Provider Acknowledgement

All requests to close a PCP panel must meet contractual guidelines, which includes closing panels to new enrollees under all Health Plans. Once this form is received by the Arizona Priority Care (AZPC) Network Contracting Department, it will be reviewed to confirm that the request meets contractual requirements. Once approved, a confirmation letter will be sent to your office advising of the effective date of the panel closure. Unless your request to close your panel has been approved and communicated to your office, you are contractually obligated to continue accepting new AZPC enrollees.

By signing below, you are acknowledging the terms and conditions of a new enrollee panel closure.

I, _____, attest that my request for panel closure meets the aforementioned conditions.
Print Name

_____ _____

Provider Signature **Date**