Arizona Priority Care™
One Goal, One Priority, Your Healthcare.

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. 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

Provider Last Name	Provider First Name	MI	Degree (MD, DO, etc)	
Individual NPI:	Primary Specialty: ***(not degree)***	Secondary Specialty:	Gender	Date of Birth
Group Name (as it appears on W-9)			Tax ID #:	
DBA (If applicable)			CAQH #:	

Provider Type *PCP ☐ Specialist ☐ Hospitalist ☐ * If PCP, do you want members assigned to NPs? ☐ Yes ☐ No ***(Please indicate Yes or No if provider is an PCP Nurse Practitioner)***	Practice Type: ☐ Office-based practice ☐ House Call Only Practice ☐ Hospital Based ☐ Other: _____
(Medicare PTAN is required to be considered for AZPC network, if pending submit form once you have it.) Certified to participate in Medicare? ☐Yes ☐ No Medicare _____	DEA #: DEA State: DEA# Expiration Date: Board Certified? ☐Yes ☐ No Date Board Certified: Board Certification:
State License #: State: State License Expiration Date:	Gender Limitations? ☐Yes ☐No If Yes, Please specify:
Panel Age Limitations? ☐ Yes ☐ No If Yes, Please specify:	Electronic Billing Used? ☐ Yes ☐ No Electronic Medical Records? ☐ Yes ☐ No E-Prescribing? ☐ Yes ☐ No
Malpractice Insurance Carrier:	Languages spoken by Provider

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 contract correspondence? ☐ Yes ☐ No	**If no, what address should all provider correspondence be sent to?** **Address:** **City:** **State:** **Zip Code:**
Telephone	**Fax**
Office Manager / Contact Name	**Email Address**

Section IV

Remit/ Payment Address

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

Section V - Practice Locations

Primary Practice Address

Address, City, State, & Zip Code			
County	**Telephone**	**Fax**	**Office Hours/Days**
Practice Email Address		**Handicap Accessibility** ☐ **Yes** ☐ **No**	
Practice Website - ***(If provided, will be listed on the provider directory)***			

Secondary Practice Address

** list any additional locations on separate sheet where provider **regularly** sees patients.*

Address, City, State, & Zip Code			
County	**Telephone**	**Fax**	**Office Hours/Days**
Handicap Accessibility ☐ **Yes** ☐ **No**		**Should this location be listed in directory?** ☐ **Yes** ☐ **No**	

Hospital Affiliations *(If needed, list Hospitals on an attached sheet)*

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