Arizona Priority Care

NEW 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 participation in the Arizona Priority Care (AZPC) network. 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.

You will receive a response regarding network need from AZPC within ten (10) business days of receipt of this request form. If approved for network participation, a contract will be sent to you for your review. Once the signed contract has been received by AZPC, our credentialing department will send to you the paperwork required to initiate the credentialing process.

***PLEASE NOTE: If your group is currently participating in the AZPC network, please use the "Add to Existing Group" form located on our website: www.azprioritycare.com**

Thank you for your interest in joining the Arizona Priority Care network.

Section I

Credentialing/Practice Contact Information

Credentialing Contact Name :	Telephone:	Fax:	Email:
Credentialing Contact Address (Include City, State and Zip)			
Practice/Office Manager Name:			Phone:
Practice website:			Email:

Section II

Group/Practice Information

Group Name (as it appears on W-9)	Tax ID #
Primary Specialty:	Certified to participate in Medicare? ☐ Yes ☐ No
Sub Specialty:	Medicare #:
Practice Type: PCP ☐ Specialist ☐ Ancillary ☐	

Section III

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

Primary Location Street Address:	
City, State, & Zip Code:	
County:	Office Hours:
Phone:	Fax:

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