

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

		ivarne/ i	itie of Person	Completii	ng this F	orm				
Name/Title (person completing th		Telephone	Fax			Date				
Email Address		•			•			•		
			Co. at	: II						
			Secti Provider Ir	<u>ion II</u> nformatior	1					
Last Name	First Name			٨	/II De	egree (MD, DO, etc)	Gender			
Group Name (as it appears on W		Group DBA Name								
Tax ID #	ax ID # Individual NPI #			Specialty			Pa	Panel Closure Effective Date		
			<u>Secti</u>	on III						
Address City State 9 7in Code			Primary Prac	ctice Addre	ess					
Address, City, State, & Zip Code										
County Telep			elephone			Fax				
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All requests to close a Po	CP panel i	must m	eet contra	ctual gui	delines	s, whic	ch inc	ludes closing pa	nels to	
new enrollees under all	Health Pl	ans. Or	nce this for	m is rece	ived b	y the A	Arizon	a Priority Care (AZPC)	
Network Contracting De	•	-					-			
requirements. Once app						-		_	effective	
date of the panel closure communicated to your o		-	•	-	-			•	r	
enrollees.	ince, you	i ai e cc	nici accually	Obligate	eu to c	Ontine	ic acc	epting new Azr	_	
By signing below, you ar	e acknow	/ledgin	g the terms	and con	dition	s of a	new e	enrollee panel cl	osure.	
I.	. ;	attest t	hat my req	uest for	panel	closur	e mee	ets the aforemen	tioned	
•			conditions.							
Provider Signature						Da	te			