

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/Office Manager Name:				Pho	ione.	
Practice website:				Ema	Email:	
Section II						
Group/Practice Information						
Group Name (as it appears on W-9)					Tax ID #	
Primary Specialty:	$\overline{}$	Certified to participate in Medicare? Yes No				
Sub Specialty:		Medicare #:				
Practice Type: PCP Specialist Ancillary 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:				

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