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

Arizona Priority Care Demographic Update Form

Please complete the applicable information and email to:

Email: provider.network@azprioritycare.com

* ☐ **Change in Provider/Group (Provider/Group Name Change, Request for Specialty/Scope of Practice Change)**

☐ **Primary Address Change** ☐ **Billing Address Change** ☐ **Add Location** ☐ **Remove Location**

Current Information:	Group/Provider Name: ______ NPI #: ______ Tax ID #: ______ **Does update apply to all providers under Tax ID?** ☐ **Yes** ☐ **No** *If no, please attach roster listing only applicable providers*
Change Request (If applicable) ☐ **Provider Name Change** ☐ **Group Name** ☐ **Specialty Change** ☐ **Scope of Practice**	New Provider Name*: ______ Specialty Change: ______ Scope of Practice Change: ______ New Group Name (attach new W9): ______ Change in Degree/Credentials: ______ *** For Provider Name Changes, please submit either a court record showing change, State License showing new name, or copy of State Issued ID reflecting new name. For Specialty change or Credential change, please submit copy of licensing agency/Board showing change. Group Name Change must include copy of W-9 with the legal name.**

Address Changes

New Primary Address:	Street: ______ Suite #: ______ City: ______ State: ______ ZIP Code: ______ Telephone: ______ Fax: ______ Effective Date: ______ Should the previous primary address be removed or kept as a secondary location? ☐ Remove ☐ Secondary Location Comments: ______
New Billing Address: (Attach new W9)	Street: ______ Suite# ______ City: ______ State: ______ ZIP: ______ Effective Date: ______ Phone: ______ Fax: ______
3rd Party Billing Agency Information	3rd Party Biller? Yes ☐ No ☐ Billing Agency Name: ______ Address: ______ Suite# ______ City ______ State: ______ ZIP: ______ Phone: ______ Fax: ______ Contact Name: ______ Email: ______
New Correspondence Address:	Street: ______ Suite #: ______ City: ______ State: ______ ZIP: ______ Phone: ______ Fax: ______ Effective Date: ______
New Additional Location: (If applicable, attach page for additional locations)	Street: ______ Suite #: ______ City: ______ State: ______ ZIP: ______ Phone: ______ Fax: ______ Effective Date: ______
Remove Location: (If applicable, attach page for additional locations)	Street: ______ Suite #: ______ City: ______ State: ______ ZIP: ______ Phone: ______ Fax: ______ Effective Date: ______

Signature: ______ **Print Name/Title:** ______

Email Address: ______ **Date:** ____/____/______

If you have questions, please call 480-499-8700 ext. 8249or email us at Provider.Network@AZPriorityCare.com