# Existing Practice - Provider Participation Request Form
# Frequently Asked Questions

The **Existing Practice - Provider Participation Request Form** is used to add a new provider to an existing group contracted with Arizona Priority Care (AZPC). Below are the answers to a few frequently asked questions that may be helpful when submitting requests.

**Do I submit an Information Release Form when submitting my request to add a provider?**

- ***No, all requests to add a provider(s) must be reviewed and approved by the Contracting department prior to it being submitted to the credentialing department. We ask that you wait until a Credentialing Coordinator contacts you to request the Information Release form(s). Submitting this form at the same time as the Provider Participation Request form will result in you being asked to re-submit it once credentialing reaches out to you.***

**How long will it take to process my request?**

- Requests are processed in the order in which they are received.
- Provider Participation Request Forms should be submitted to Provider.Network@AZPriorityCare.com
- Processing times will vary based on date received, volume of requests and the timing of the next credentialing meeting.
- The Credentialing department's goal is to complete the credentialing within 60 days receipt of the Information Release Form ***(Please see information above on when to submit the Information Release Form).*** For Instance:
    - If a release form is received at the end of February the provider will go to April meeting
    - If a request is received at the end of March the provider will go June meeting.
- Incomplete forms will cause a delay in processing.
- AZPC is a Medicare Advantage network. All providers being added will need to provide their Medicare PTAN on the form at the time of submission in order to be processed. ***Forms submitted without the Medicare PTAN will not be processed.***

**How often are credentialing meetings held**?

- Credentialing meetings are held on the 3rd Thursday of February, April, June, August, October, and December.
- The credentialing department's deadline to process any applications received for the credentialing committee, will be 2 weeks prior to the credentialing meeting.

**I received a letter stating that a provider has been credentialed, does that mean he/she can now treat AZPC members?**

- Once credentialing is complete, you will receive a letter from the AZPC credentialing department with the Provider's credentialing effective date. ***This is not the Provider's AZPC effective date. You will need to wait until you have received notification from the Network Contracting department that the provider(s) are approved to treat AZPC members.***
- AZPC Provider effective dates will typically be the 1st day of the month following the credentialing date. ***For example a provider that completes credentialing in February would be made effective March 1st.***
- Once credentialing is complete, the Network Contracting department will load the provider into its system and notify the Health Plans of the provider's participation. The Network Contracting department will send a separate letter with the provider's official effective date. ***This is the date the provider will be able to see AZPC members.***

If you have questions or concerns about the credentialing status of a request that exceeds the timing provided above please contact our credentialing team at Credentialing@AZPriorityCare.com.

We at AZPC value your partnership and look forward to your continued participation in our network. If you have any questions, please contact us at (480) 499-8700.

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

# EXISTING PRACTICE/GROUP*
## PROVIDER PARTICIPATION REQUEST FORM

**PLEASE COMPLETE THE FOLLOWING AND RETURN VIA EMAIL: Provider.Network@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). .

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: | Group NPI: | | Tax ID #: |
| Primary Specialty (Do not list degree here) | Secondary Specialty: (If applicable) | | Gender: |
| Group Name (as it appears on W-9) | | | Date of Birth: |
| DBA (If applicable) | | | CAQH # |
| Provider Type *PCP ☐ Specialist ☐ Hospitalist ☐<br>* If PCP, do you want members assigned to NPs? ☐ Yes ☐ No<br>***(Please indicate Yes or No if provider is an PCP Nurse Practitioner)*** | Practice Type:<br>☐ Office-based practice<br>☐ House Call Only Practice<br>☐ Hospital Based<br>☐ Other: _____ | | AHCCCS Number#:<br>State License #:<br>SL Expiration Date: _____ |
| ***(Medicare PTAN is required to be considered for AZPC network, if pending submit form once you have it.)***<br>Certified to participate in Medicare? ☐ Yes ☐ No<br>Medicare #:_____ | DEA #:<br>DEA State:_____<br>DEA# Expiration Date: | | Board Certified: ☐ Yes ☐ No<br>Date Board Certified: _____ |
| Panel Age Limitations? ☐ Yes ☐ No<br>If yes, please specify: _____ | Electronic Billing Used? ☐ Yes ☐ No<br>Electronic Medical Records? ☐ Yes ☐ No<br>E-Prescribing? ☐ Yes ☐ No | | |
| Gender Limitations? ☐ Yes ☐ No<br>If yes, please specify: _____ | Malpractice Insurance Carrier:<br>Languages spoken by Provider | | |

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

## Section III

### Practice Manager Contact Information

| | | |
|---|---|---|
| **Office Manager/Contact Name** | | |
| **Phone:** | **Fax:** | **Email:** |
| ***What address should correspondence be sent to for all Provider notices and contract correspondence*** ***(This address will be used for all mailings related to contract changes, health plan changes, etc.)*** | | |
| **Address** | | |
| **City, State, & Zip Code** | | |
| **Email:** | **Phone:** | **Fax:** |

## Section IV

### Remit/ Payment Address

| | | |
|---|---|---|
| **Address** | | |
| **City, State, & Zip Code** | | |
| **Phone:** | **Fax** | **Email** |
| **Do you have a 3rd party billing agency? ☐ Yes ☐ No (If yes, complete information below)** | | |
| **Billing Agency Name:** | **Contact Name:** | **Email:** |
| **Billing Agency Name:** | **Phone:** | **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)*

| |
|---|
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| |
| |

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