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

Provider/Physician Roster

Please complete the applicable information and email or fax to: Email: Provider.Network@AZPriorityCare.com
Fax: Attn: Provider Network (480) 499-8729

SECTION A: GROUP AND CONTACT DETAIL			
Group Legal Name			
Group DBA			
Group Tax Identification Number		**Group NPI:**	

Contact Name and Title		Direct Email:	Direct Phone:	*DocuSign Recipient
Office Manager				**YES ☐ NO ☐**
Credentialing Contact (For all credentialing questions)				**YES ☐ NO ☐**
Contract Negotiator:				**YES ☐ NO ☐**
Authorized Signatory:				**Default Recipient**

*** Please indicate which contacts should be included as DocuSign recipients**

SECTION B: PRACTICE/GROUP ADDRESS INFORMATION			
ADDRESS TYPE	**STREET ADDRESS** (Include City, ST, ZIP)	**PHONE AND FAX**	
Correspondence Address: (for all contractual mailings)		**Phone:**	
		Fax:	
Remit/Payment Address: (for all claims payments)		**Phone:**	
		Fax:	

PHYSICAL OFFICE LOCATIONS

Note: Only 5 locations per provider are allowed to be listed in the directory. Please list the primary location for the group and any additional locations. If you have more than 5, please attach a separate page for documentation.

Address Locations	Street Address	City, State, Zip	Office Location Phone and Fax	
Address – 1 (Primary Address)			**Phone:**	
			Fax:	
Address – 2			**Phone:**	
			Fax:	
Address – 3			**Phone:**	
			Fax:	
Address – 4			**Phone:**	
			Fax:	
Address - 5			**Phone:**	
			Fax:	

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Section C: Provider Detail **IMPORTANT REMINDER: If you are submitting your own roster, include all data elements on this roster. Failure to do so may require additional forms to be completed.**							
Physician Name & Degree (Please Include Provider Degree)	**Location Assignment** Indicate the Address #s that are applicable for the provider (i.e. 1,2,4 or 1-5)	**Specialties**	**NPI:**	**AHCCCS#**	**Medicare #** **Mandatory (Required to Process)**	**Languages** *(Indicate languages spoken by Provider)*	**Membership Assignment** (For NPs in a PCP Practice – Y/N)

Please add any additional providers on an additional page. Please include all information requested on this roster.