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

Provider/Group Update Form

Arizona Priority Care Group/Provider Update Form Please complete the applicable information and email or fax to:
Email: provider.network@azprioritycare.com
Fax: 480-499-8729

Current Group Information:	Group Name: _____ DBA: _____ Group Tax ID #: _____ NPI: _____ Phone: _____ Office Contact Name: _____ Office Email: _____

Group/Provider Name Change

☐ Provider Name Change	Current Provider Name: _____ NPI: _____ New Provider Name: _____
☐ Group Name Change	Current Group Name: _____ Group NPI _____ New Group Name **(attach new W9):**_____

Provider Degree/Specialty Update

☐ Specialty Change ☐ Degree Change	Provider Name: _____ NPI #: _____ Specialty Change: _____ Change in Provider Degree/Credentials: _____ ***(*Specialty change-please list the specialty, not the degree. For NPs and Pas, please list the specialty of the supervising physician if unsure)***

Group Tax ID Change

New W-9 Required	Current Tax ID: _____ New Tax ID: _____ Effective Date: _____ (***All Tax ID changes will require submission of a new W-9 with this form)***

Group Change of Ownership - *This type of change will require review and possible changes to the existing contract. You will be contacted by your AZPC Contract Manger to discuss specifics regarding changes.*

New W-9 Required	Current Practice Name: _____ Current Tax ID: _____ New Group or Owner Name: _____ New Tax ID _____ Change of Ownership Effective Date: _____ New Owner Name: _____

Signature: _____ Print Name/Title: _____
Email Address: _____ Date: _____

If you have any questions, please email us at Provider.Network@AZPriorityCare.com

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