Arizona Priority Care Demographic Update Form

Please complete the applicable information and email to:
Email: provider.network@azprioritycare.com

☐ **Primary Address Change** ☐ **Billing Address Change** ☐ **Change Billing Agency Info** ☐ **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*

Provider Information	Provider Name: _____ NPI #: _____ Provider Name: _____ NPI #: _____ Provider Name: _____ NPI #: _____

Address Changes

Please note, practices updating 4 or more providers or locations can submit a roster in lieu of this form. Please ensure it captures all fields listed on form. If updating a primary address, note if existing primary should be removed, or kept as a secondary location. Provider/Physician Rosters can be found at: Provider Forms

AZPC will load up to 5 locations per provider. Please only include those locations where provider sees members at least 1 day per week.

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: _____
Address Update ☐ **Add** ☐ **Remove**	Street: _____ Suite #: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____Effective Date: _____
Address Update ☐ **Add** ☐ **Remove**	Street: _____ Suite #: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____Effective Date: _____
Address Update ☐ **Add** ☐ **Remove**	Street: _____ Suite #: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____Effective Date: _____

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

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