

Arizona Priority Care Demographic Update Form

Please complete the applicable information and email to:

Email: provider.network@azprioritycare.com

☐ Billing Address Change ☐ Mailing Address Change ☐ Billing Agency Change

☐ Add Location ☐ Remove Location ☐ Primary Address Change

Current Information:	Group/Provider Name: _____
	NPI #: _____ Tax ID #: _____
	Does update apply to all providers under Tax ID? ☐ Yes ☐ No
	<i>If no, please attach roster listing only applicable providers</i>

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](#)

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: _____
New Mailing Address:	Street: _____ Suite# _____ City: _____ State: _____ ZIP: _____ Effective Date: _____ Phone: _____ Fax: _____
3rd Party Billing Agency Information	3 rd 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: _____

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

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