

NEW PRACTICE/GROUP*
JOIN OUR NETWORK REQUEST FORM

PLEASE COMPLETE THE FOLLOWING AND RETURN VIA EMAIL: Network.Contracting@AZPriorityCare.com

Attention: This is not a provider application. This form is to be used to request participation in the Arizona Priority Care (AZPC) network. You will receive an auto confirmation of receipt by AZPC. All requests will be responded to within 60 days.

A Medicare PTAN must be included for consideration to participate in the AZPC network. You will receive a response regarding network need from AZPC within sixty **(60) business days** of receipt of this request form. If approved for network participation, a contract will be sent to you for your review. Once the signed contract has been received by AZPC, our credentialing department will send to you the paperwork required to initiate the credentialing process.

***PLEASE NOTE: If your group is currently participating in the AZPC network, please use the "Add to Existing Group" form located on our website... <https://azprioritycare.com/tools/>**



If you do not have a PTAN ID, you are not eligible to be contracted with AZPC.

Section 1
Group / Practice Information

Group Name (as it appears on W-9 / IRS Letter)		TAX-ID: Group NPI:
Practice Type: PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Ancillary <input type="checkbox"/> Hospital <input type="checkbox"/> Home Health <input type="checkbox"/> MultiSpecialty <input type="checkbox"/> Other <input type="checkbox"/>		
Primary Specialty		(Medicare PTAN is required for consideration to the AZPC Network.)
Secondary Specialty		Certified to participate in Medicare? NO <input type="checkbox"/> YES <input type="checkbox"/>
Does your practice offer Mobile Services? NO <input type="checkbox"/> YES <input type="checkbox"/> Does your practice offer TeleHealth Services? NO <input type="checkbox"/> YES <input type="checkbox"/>		Medicare PTAN:
How many office locations do you have?		
How many MD / DOs are in your practice?		
How many MidLevel Clinicians are in your practice?		

Section 2
Demographic Information

Primary Office Location

NOTE: If your practice has multiple locations this would be requested during the Contracting / Credentialing process.

Address 1	Suite #	City	State	Zip Code	Phone
What Counties do you provide services in?					
Apache <input type="checkbox"/>	Cochise <input type="checkbox"/>	Coconino <input type="checkbox"/>			
Gila <input type="checkbox"/>	Graham <input type="checkbox"/>	Greenlee <input type="checkbox"/>			
La Paz <input type="checkbox"/>	Maricopa <input type="checkbox"/>	Mojave <input type="checkbox"/>			
Navajo <input type="checkbox"/>	Pima <input type="checkbox"/>	Pinal <input type="checkbox"/>			
Santa Cruz <input type="checkbox"/>	Yavapai <input type="checkbox"/>	Yuma <input type="checkbox"/>			
Website:					
Does your group provide services outside of Arizona? YES <input type="checkbox"/> NO <input type="checkbox"/>					

AFFILIATIONS

Are you currently contracted with any of the following Health Plans?

Alignment Blue Cross Blue Shield AZ eternalHealth SCAN

Are you currently affiliated with any vendor that is currently contracted with AZPC?

Yes No Unknown

Are you currently affiliated with any ACOs?

Yes No Unknown

Section 3

Point of Contact

Point of Contact (or Equivalent)	Name, Title	Email	Phone
Office Manager			
Credentialing POC			
Contract Manager			

Please add any pertinent information about your group when the request is being reviewed, that could help establish your agreement with Arizona Priority Care.