NEW PRACTICE/GROUP*

JOIN OUR NETWORK REQUEST FORM

PLEASE COMPLETE THE FILLABLE FORM 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** **located on our website... https://azprioritycare.com/tools/**

If you do not have an active PTAN ID, you would not be eligible for a contract with AZPC.

Section 1

Group / Practice Information

Group Name (as it appears on W-9 / IRS Letter)	
Tax ID:	**Group NPI:**
Practice Type (Only Select One): **PCP** ☐ **Specialist** ☐ **Multi-Specialty** ☐ **Behavioral Health** ☐ **Physical Therapy** ☐ **Ancillary** ☐ **Hospital** ☐ **Home Health** ☐ **Skilled Nursing Facility** ☐	
Medicare PTAN is required for consideration to the AZPC Network **Certified to participate in Medicare? YES** ☐ **NO** ☐ **Medicare PTAN #:**	
Primary Specialty:	
Secondary Specialty:	
Does your practice offer Mobile Services?	
Are you a Mobile Only Practice?	
How many MD / DOs are in your practice?	
How many MidLevels (APPs) clinicians are in your practice?	
If you are offered an agreement, what is your preferred method of receiving agreements? **Email/PDF** ☐ **Electronically/ AdobeSign** ☐	

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	☐	Cochise	☐	Coconino	☐
Gila	☐	Graham	☐	Greenlee	☐
La Paz	☐	**Maricopa**	☐	Mojave	☐
Navajo	☐	**Pima**	☐	**Pinal**	☐
Santa Cruz	☐	**Yavapai**	☐	Yuma	☐

Website:

Does your group provide services outside of Arizona? YES ☐ NO ☐

AFFILIATIONS

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

AETNA ☐ Alignment ☐ BCBS – AZ ☐ eternalHealth ☐ SCAN ☐

Are you currently affiliated with any vendor that is currently contracted with Arizona Priority Care (AZPC)?

Yes ☐ No ☐ Unknown ☐

Hospital Privileges – Do all your clinicians have hospital privileges at AZPC Contract Hospital Facilities?

Banner ☐ Tenet/Abrazo ☐ Honor Health ☐

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.