Arizona Priority Care™ Celebrating 15 Years

One Goal. One Priority. Your Healthcare.

Agent Referral

NEW PCP 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. 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 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** ☐ **ASC**	
Medicare PTAN is required for consideration to the AZPC Network **Certified to participate in Medicare? YES** ☐ **NO** ☐ **Medicare PTAN #:**	
Primary Specialty:	**Secondary Specialty:**
How many office locations do you have?	**Does your practice offer Telehealth Services?** Yes / No
Does your practice offer Mobile Services? Yes / No	**Are you a Mobile Only Practice?** Yes / No
How many MD / DOs are in your practice?	**How may MidLevels (APP) in the practice?**
If you are offered an agreement, what is your preferred method of receiving agreements? **Email/PDF** ☐ **Electronically/ AdobeSign** ☐	

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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 Primary Office Location	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?

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 – Where do your clinicians have hospital privileges?

Banner ☐ Tenet/Abrazo ☐ Honor Health ☐ Other

Section 3

Point of Contact

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

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

Agent Name: