Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

Claims Issue Log

Please verify in EZ-Net/AZ Connect that the original claim was submitted over 60 days ago and sent to the Arizona Priority Care address before submitting this form.

Group/Vendor Name:	**TIN:**	**Date Sent to AZPC:**
Contact Name:	**Contact Phone:**	
Contact Email:	**Contact Fax:**	

Member Name:	***For AZPC Use Only***
Member ID:	**Reviewed By (Claims Rep):**
Claim Number:	**Review Date:**
DOS:	**Claim Reprocessed:** ☐ YES ☐ NO *(if no, provide info in note box below)*
Provider Name:	**New Claim Number** *(if applicable)*:
Total Billed Amount:	**Notes:**
Submitted Over 60 Days Ago? ☐ YES ☐ NO	
Notes:	

Member Name:	***For AZPC Use Only***
Member ID:	**Reviewed By (Claims Rep):**
Claim Number:	**Review Date:**
DOS:	**Claim Reprocessed:** ☐ YES ☐ NO *(if no, provide info in note box below)*
Provider Name:	**New Claim Number** *(if applicable)*:
Total Billed Amount:	**Notes:**
Submitted Over 60 Days Ago? ☐ YES ☐ NO	
Notes:	

Use additional pages as needed.

REVISED 1/20/2026 SGD