



HEALTH CHOICE ARIZONA  HEALTH CHOICE GENERATIONS  BOTH

Request for Participation  Update Information and Change Sheet

PCP  Specialist  Facility  Ancillary  Dentist  Other

**Return to Network Services at the appropriate fax number:**

- Maricopa/ Pinal/ Gila Counties: Fax **480-303-4433**
- Apache/ Navajo/ Mohave/ Coconino Counties: Fax **480-760-4709**
- Yuma/LaPaz Counties Fax **866-851-2623**
- Pima/Santa Cruz Counties: Fax **520-322-5784**
- All Dentists (**Statewide**): FAX **480-760-4706**

Please complete entire form. (COMPLETE ONE SHEET PER PROVIDER PER LOCATION INCLUDING EMPLOYED PHYSICIANS EXTENDERS)

PROVIDER NAME: \_\_\_\_\_

PRACTICE NAME: \_\_\_\_\_

PRACTICE ADDRESS: \_\_\_\_\_

CITY, ST, ZIP: \_\_\_\_\_

APPT SCHEDULING PHONE: \_\_\_\_\_ BACK OFFICE PHONE: \_\_\_\_\_

FAX(REFERRAL DESK): \_\_\_\_\_ EMERGENCY PHONE: \_\_\_\_\_

OFFICE HRS: \_\_\_\_\_

BUSINESS E-MAIL: \_\_\_\_\_

AHCCCS NUMBER: \_\_\_\_\_ MEDICARE/UPIN: \_\_\_\_\_ NPI: \_\_\_\_\_

AZ LIC: \_\_\_\_\_ DEA NUMBER: \_\_\_\_\_ SSN: \_\_\_\_\_

MALPRACTICE INSURANCE NAME: \_\_\_\_\_ POLICY: \_\_\_\_\_ DOB: \_\_\_\_\_

PROVIDER'S GENDER  M  F PHYSICIAN LANGUAGES: \_\_\_\_\_

SPECIALTY: (1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

GENDER(S) ACCEPTED:  M  F AGE RANGE  0-99  0-16  0-18  18-99  21-99  OTHER: \_\_\_\_\_

STAFF LANGUAGES: \_\_\_\_\_ # MEMBERS CAN BE ACCOMODATED BY PRACTICE \_\_\_\_\_

IASIS HEALTHCARE PRIVILEGES:  Phoenix St Lukes  Tempe St Lukes  Mesa General  Mountain Vista  Biltmore Surgical

HOSPITAL PRIVILEGES: \_\_\_\_\_

COVERING PHYSICIANS: \_\_\_\_\_

NUMBER OF EMPLOYED PHYSICANS, PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS AND CERTIFIED NURSE MIDWIVES  
Each will require a separate form \_\_\_\_\_

OTHER CONTRACTED AHCCCS PLANS AND APPROXIMATE NUMBER OF MEMBERSHIP ASSIGNED

APIPA \_\_\_\_\_  PHP \_\_\_\_\_  MCP \_\_\_\_\_  Care 1st \_\_\_\_\_  Other \_\_\_\_\_

**This is your billing information. Checks are made out to this name and sent to this address. This information must be registered with AHCCCS before entry into our database. W-9 Required**

PAYEE NAME \_\_\_\_\_

PAYEE ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

TAX ID \_\_\_\_\_ GROUP NPI # \_\_\_\_\_ TAX ID EFFECTIVE DATE \_\_\_\_\_

PROVIDER SIGNATURE: \_\_\_\_\_

DATE \_\_\_\_\_