

TRACKING ID #:



**PROVIDER INTEREST FORM**

**Thank you for your interest in contracting with Phoenix Health Plan and Abrazo Advantage Health Plan. Network Management will review for network need. A Provider Service Representative or the CVO will contact you for additional information.**

**DIRECTIONS:**

- **PLEASE COMPLETE THIS FORM AND FAX TO 602-674-6670**
- **PLEASE INCLUDE: W-9**
- **ATTACH ADDITIONAL ADDRESSES (IF APPLICABLE)**

Practitioner's Name & Degree:		Effective Date with Practice:	
Group or Corporate Name:			Tax ID #:
DOB:	DEA #:	License #:	
Lines of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	Type I NPI#:	Type II NPI#:	
Is provider a Medicare participating provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	AHCCCS I.D.#:	Group AHCCCS I.D.#:	
Primary Specialty:	Board Certification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Exam:	
Secondary Specialty:	Board Certification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Exam:	
Want Contract as PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age Range:	Are You a Baby Arizona Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(OB/GYN Providers)</b>	
Do you participate in the VFC Program (Vaccines for Children)? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>(PCPs seeing members 18 or &lt; must participate)</b>			
Hospitals where Practitioner has Privileges:			
Languages other than English spoken by PRACTITIONER:			
Languages other than English spoken by OFFICE STAFF:			
<b>Billing Address:</b>		City:	Zip Code:
Billing Phone Number:		Billing Fax #:	
<b>Primary Practice Address:</b>		City:	Zip Code:
Phone #:		Fax #:	
Office Hours:			
<b>**Additional Practice locations: Please attach list**</b>			
<b>Correspondence / Mailing Address:</b>		City:	Zip Code:
EMAIL Address:			
Credentialing Contact:		Phone #:	Fax #:
Office Contact <i>(All Other)</i> :		Phone #:	Fax #:
<b>FOR PHP INTERNAL USE ONLY:</b>		Sent to CUTS: _____ Audited: _____	
<input type="checkbox"/> Basic <input type="checkbox"/> Full <input type="checkbox"/> Delegated <input type="checkbox"/> Provisional: _____		<input type="checkbox"/> Site Audit Completed: _____	
Sent to Credentialing: _____ Credentialing Approval: _____		<input type="checkbox"/> TBNT Date Letter sent: _____	