TRACKING ID #:

PROVIDER INTEREST FORM

FAX TO: 602-674-6670

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 INCLUDE W-9**
- **ATTACH ADDITIONAL ADDRESSES (IF APPLICABLE)**
- **INCLUDE ORAL CONSCIOUS SEDATION OR PEDS TOOL TRAINING CERTIFICATES (IF APPLICABLE)**

Practitioner's Name & Degree:			Effective Date with Practice:
Group or Corporate Name:			Tax ID #:
DOB:	License #:	AHCCCS I.D.#:	DEA #:

Practitioner's NPI#:	Group NPI#:	Group AHCCCS I.D.#:
Lines of Business: ☐ Medicaid ☐ Medicare	Is provider a Medicare participating provider? ☐ Yes ☐ No	
Primary Specialty:	Board Certification: ☐ Yes ☐ No	Date of Exam:
Secondary Specialty:	Board Certification: ☐ Yes ☐ No	Date of Exam:
Contracting as PCP? ☐ Yes ☐ No	Age Range:	

PCP Providers: Are you a VFC (Vaccines for Children) Provider? ☐ Yes ☐ No ***(PCPs seeing members 18 or < must participate)***

PCP Providers: Are you PEDS/NICU Trained? ☐ Yes ☐ No *(If yes, attach Certificate)*

OB/GYN Providers: Are you a Baby Arizona Provider? ☐ Yes ☐ No

Dental Providers: Do you provide Oral Conscious Sedation? ☐ Yes ☐ No *(If yes, attach Certificate)*

Ambulatory Surgery Centers and Hospitals where Practitioner has active Privileges:

Languages other than English spoken by PRACTITIONER:

Languages other than English spoken by OFFICE STAFF:

Primary Practice Address:		City:	Zip Code:
Phone #:	Fax #:	Office Hours:	
Office Manager:		EMAIL Address:	

****Please attach any additional addresses: Billing, Correspondence, Satellite****

Contact Person:	Phone #:	Fax #:
EMAIL Address:		

FOR PHP INTERNAL USE ONLY:

Reason for Credentialing: ☐ New Credentialing ☐ Change ☐ Adding to existing group

☐ Full ☐ Delegated ☐ Provisional: _____	Sent to Credentialing: _____	Credentialing Approval: _____
☐ TBNT Date Letter sent: _____	PCT Initiated: _____	PCT Audited: _____