Practitioner/Practice Change Form

Practitioner/Group Name_____

NPI#_____ **CAQH#**_____

Please add Practitioner and/or Group Name, NPI # and CAQH # on the above lines. Only complete the appropriate change type requested. NOT ALL SECTIONS NEED TO BE COMPLETED. Fax/email this form and any required documentation to each of the health plans you are contracted with.

Request Type: (Must Complete)	☐ Service Address ☐ Termination ☐ Name Change ☐ Billing Contact ☐ Billing Name/Address ☐ Credentialing Contact ☐ Specialty ☐ Practitioner Type ☐ Panel Change ☐ Other (AHCCCS Reg #, NPI# etc)

Practitioner/Group Information: (Must Complete)	Practitioner's Name:		Group Name:
	Practitioner's NPI#	**CAQH #**	Practitioner's AHCCCS#
	Group Federal Tax ID#		Group NPI#

Service Address Change:

Is this a:
☐ **Primary location**

☐ **Secondary location**

☐ **Covering location**

Address 1	☐ **Add** ☐ **Delete**	**EFFECTIVE DATE:**
Street:		Suite #:
City:	State:	Zip Code:
Appointment Telephone:	Fax:	Email:

Office Hours:	**Day**	**Open**	**Closed**	**Day**	**Open**	**Closed**	**Special Considerations: (i.e., closed for lunch, etc)**
	Mon			Fri			
	Tues			Sat			
	Wed			Sun			
	Thurs						

List Practitioner in Directories at this address: ☐ Yes ☐ No

Location NPI: Handicap accessible ☐ Yes ☐ NO

Address 2	☐ **Add** ☐ **Delete**	**EFFECTIVE DATE:**
Street:		Suite #:
City:	State:	Zip Code:
Appointment Telephone:	Fax:	Email:

Office Hours:	**Day**	**Open**	**Closed**	**Day**	**Open**	**Closed**	**Special Considerations: (i.e., closed for lunch, etc)**
	Mon			Fri			
	Tues			Sat			
	Wed			Sun			
	Thurs						

List Practitioner in Directories at this address: ☐ Yes ☐ No

Location NPI:

INTERNAL USE ONLY:

Site visit required
☐ YES

☐ NO

AZ AHP

Practitioner/Practice Change Form

Practitioner/Group Name_____

NPI#_____ **CAQH#**_____

Practitioner Termination Request: (Practitioner is leaving the practice/group for any reason)	PCP Member Reassignment? ☐ Yes ☐ No	Effective Date of Term:
	Reassigned Practitioner Name:	Reassigned Practitioner NPI:
	Reason for Term: ☐ Leaving practice/group ☐ Retired ☐ Death ☐ Other (Explain):	

Practitioner Location Change: (Practitioner is remaining with the practice but changing locations)	PCP Member Reassignment? (Will members remain at previous location?) ☐ Yes ☐ No	Effective Date of Change to New Location:
	Reassigned Practitioner Name :	Reassigned Practitioner NPI:

Practitioner Name Change:	Previous Last, First, and Middle Name:	New Last, First, and Middle Name:
	Effective Date:	
Required Documentation	*For any name changes, a copy of Practitioner's current license reflecting the change is required to be submitted with this form and/or AHCCCS Registration, NPI #*	

Billing/Remit Address:	Legal Name:	Previous Legal name	
	Street:	Suite #:	
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		
Required Documentation	*A W 9 must be submitted*		

Billing Contact Change:	Name:	Title:	
	Street:	Suite #:	
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		

AZ AHP

Practitioner/Practice Change Form

Practitioner/Group Name_____

NPI#_____ **CAQH#**_____

Credentialing Contact Change	Name:		Title:
	Street:		Suite #:
	City:	State:	Zip Code:
	Telephone:	Fax:	Email:
	Effective Date:		

Practitioner Specialty or Provider Type Change:	Previous Practitioner Specialty/Provider Type:	
	New Practitioner Specialty/Provider Type:	Effective Date:
Required Documentation	***Any change in this section may require a credentialing event. If changing your NPI# and/or AHCCCS Registration you MUST complete the Practitioner or Organizational/Facility Application as appropriate***. *Please confirm with your Practitioner Rep at the health plans for what is required.* *For any change in Specialty, documentation that supports the change in specialty needs to be submitted with this form, i.e., education, certification, etc. update with AHCCCS prior to submitting,*	

Panel Change: (Complete for any change to panel—open and closed, number of members assigned, change in ages of members with effective date of change)	Panel ☐ OPEN ☐ CLOSE ☐ MAX PANEL LIMIT ☐ AGES	
	If change in max panel limit or age range of member, please provide an explanation:	
	Effective Date:	

AZ AHP

Practitioner/Practice Change Form

Practitioner/Group Name_____

NPI#_____ **CAQH#**_____

Other Changes (any other change being requested)	☐ AHCCCS Registration # ☐ NPI# ☐ DEA # ☐ TIN # ☐ Other (Describe i.e., change in languages spoken, hospital privileges etc.):	
	Previous #	Current #
	Effective Date:	

Request Submitted by	Name:	Title:
	Date:	
	Phone:	Email:

Revised 1 2022

AZ AHP

Practitioner/Practice Change Form

Practitioner/Group Name_____

NPI#_____ **CAQH#**_____

Credentialing Alliance

AZAHP PRACTITIONER CHANGE FORM

The Fax number and phone number for each participating plan is listed in the table below.

If your intent is to apply for participation in a Health Plan network, please send only to the Plan(s) you are interested in joining. NOT ALL plans provide services in every county. Please contact the Plan directly to verify that they provide services in your county and that they are accepting new providers.

If you are adding a practitioner under an existing Health Plan contract, please only send to the Plan(s) you are contracted with.

HEALTH PLAN	PHONE	FAX/EMAIL	WEBSITE
Arizona Complete Health – Complete CarePlan	(888)788-4408	(866)687-0514 AzCHProviderData@azcompletehealth.com	www.azcompletehealth.com
Banner University Health Plans	(520) 874-5290 or (800) 582-8686	Email is preferred method to send completed BUHPDATATEAM@Bannerhealth.com (520) 874-7142	www.BannerUFC.com/ACC www.BannerUFC.com/ALTCS www.BannerUCF.com www.BannerUHP.com
Care1st Health Plan Arizona	(602) 778-1800 (options in order 5, 7)	(602) 778-1875 SM_AZ_PNO@care1stAZ.com	www.care1staz.com
DentaQuest	(800) 233-1468	(262)241-7401 initialproviderenrollment@dentaquest.com	http://www.dentaquest.com/state-plans/regions/arizona/az-dentist-page
Health Choice	(800) 322-8670 (options in order 4, 7)	Request to participate/Contract: hchcontracting@azblue.com Request to credential/Already Contracted: hchcredentialing@azblue.com	www.healthchoiceaz.com www.healthchoicepathway.com
Molina Complete Care Az	(800) 424-5891	(888)656-0369 MCCAZProvider@MagellanHealth.com	www.mccofaz.com
Mercy Care	(602) 263-3000	Network Management (Provider Relations and Contracting) MercyCareNetworkManagement@MercyCareAZ.org. Fax: (860)975-3201	www.mercycareaz.org
UnitedHealthcare Community Plan	For questions please Email: networkhelp@uhc.com	Submission to the RFP Portal is the preferred method for accepting the pdf UHC RFP Portal (855) 523-9998 Cred_applications@uhc.com	www.uhcprovider.com

Each plan retains the right to make their own contracting decisions (whether or not to add practitioners to their network) and also will make their own credential committee decisions (review of primary source verification information obtained by Verisys Credentialing, resulting in approval/denial by the plan's committee).. You will receive separate communication from each plan regarding the effective date of your credentialing and the effective date of your contract.