



# FACILITY/ANCILLARY PROVIDER DATA FORM

**PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST**

New providers shall receive confirmation of their effective date with the health plan. Members may not be seen until the provider has received confirmation that a request or change is approved and completed in the system (this includes approval by the credentialing committee if applicable).

<b>DIRECTIONS:</b>	
<b>Attach the following:</b>	
<input type="checkbox"/> IRS 941 Coupon or accurate W-9	<input type="checkbox"/> Copy of State license
<input type="checkbox"/> Liability insurance face/certificate	<input type="checkbox"/> Copy of all accreditation certificates (including Medicare)
<input type="checkbox"/> Drug Enforcement Administration (DEA) certificate (as applicable)	<input type="checkbox"/> CLIA Certification
<input type="checkbox"/> List of practitioners providing services at each location (include AHCCCS I.D., Individual NPI and Start Dates)	
<input type="checkbox"/> <b>NON-ACCREDITED FACILITIES:</b> Copy of most recent State and/or Medicare Survey/Audit	

Tax ID #:	AZ License #:	AHCCCS I.D. #:	Medicare #:
1099 Registered Name (Required):			
Facility Name/dba if applicable:			
Extent of Handicap Facilities:			Organizational NPI #:

Billing Service Name: (If applicable)	Phone #:	Fax #:
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<b>PAY TO ADDRESS</b> (All payments sent to this address)	Address:	Zip Code:
	Phone #:	Fax #:

<b>PRIMARY ADDRESS</b> (Physical location where services are performed)	Address:		Zip Code:
	Phone #:	Fax #:	Office Hours: AZ License #:
	Modalities:		Organizational NPI:

<b>ADDITIONAL LOCATIONS</b> (Indicate other additional locations on an attached sheet)	Address:		Zip Code:
	Phone #:	Fax #:	Office Hours: AZ License #:
	Modalities:		Organizational NPI:

<b>MAILING ADDRESS</b> (All correspondence will be sent to this address)	Correspondence / Mailing Address:	Zip Code:
	E-mail Address:	

Credentialing Contact:	Phone #:	Fax #:
Contact (All Other):	Phone #:	Fax #:

Describe Your Medical Record Keeping System(s):
Describe Your Cost Record Keeping System(s):

**FAX TO: Care1st Provider Network Operations 602.778.1875**

**QUESTIONS: 602.778.1800 (Options in order 5, 7)**