

PRACTITIONER DATA FORM



PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST. New providers receive written confirmation of their effective date with the health plan. Members may not be seen until the provider receives written confirmation that a request or change is approved and completed (this includes approval by the Credentialing Committee if applicable). **Please Type or Print Clearly**

To:	Return To:
Fax #: _____ Phone #: _____	Fax #: _____
RE:	Phone #: _____

DIRECTIONS:

- Please type or print this form clearly and return the completed form with attachments
- Certification in your requested specialty or documentation of your examination date is required in order to successfully complete the contracting process

Attach the following:

- | | |
|---|---|
| <input type="checkbox"/> IRS 941 coupon or accurate W9
<input type="checkbox"/> Documentation of malpractice coverage \$1 million/\$3 million
<input type="checkbox"/> Documentation of board certification or scheduled exam date
<input type="checkbox"/> Copy of Arizona License

<input type="checkbox"/> CAQH Registered <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, CAQH # _____ If already registered and have completed your application, please be sure that Care1st Health Plan is authorized to access your data | <input type="checkbox"/> DEA
<input type="checkbox"/> Curriculum Vitae
<input type="checkbox"/> General Anesthesia Permit, Conscious Sedation Permit and/or Oral Conscious Sedation Permit
<i>(applicable for Dental providers only)</i> |
|---|---|

Practitioner's Name & Degree: (Last) (First) (M.I.) (Degree)			Practitioner's Effective Date w/Practice:		
1099 Registered Name (Required):				Tax ID #:	
Group Practice Name (DBA): (If applicable)					
Lines of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare		Individual NPI#:		Organizational NPI#:	
DOB:	DEA #:	AZ License #:		SSN:	
Is provider a Medicare participating provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			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:	
<input type="checkbox"/> Female <input type="checkbox"/> Male		Want Contract as PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		Age Range:	
PCP's ONLY: Do you treat one or more of the following diagnoses? <input type="checkbox"/> Anxiety <input type="checkbox"/> ADHD <input type="checkbox"/> Depression					
Do you participate in VFC (Vaccines for Children)? <input type="checkbox"/> Yes <input type="checkbox"/> No (PCPs seeing AHCCCS members 18 & < must participate)					VFC PIN Code:
Are You a Baby Arizona Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No			Is Practice/Clinic an FQHC or RHC? <input type="checkbox"/> FQHC <input type="checkbox"/> RHC		
Hospitals & Ambulatory Surgery Center(s) where practitioner has privileges:					
Names of Practitioners in Call Group (Must be contracted with plan):					

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST. New providers will receive written confirmation of their effective date with the health plan. Members may not be seen until the provider receives written confirmation that a request or change is approved and completed (this includes approval by the Credentialing Committee if applicable). **Please Type or Print Clearly**

BILLING SERVICE (If applicable)	Name:			
	Address:		Phone:	
	City:	State:	Zip Code:	Fax:

PAY TO ADDRESS (All payments sent to this address)	Address:		City:	State:
	Billing Phone Number:	Billing Fax #:		Zip Code:

PRIMARY ADDRESS (Physical location where services are performed)	Address:		City:	Zip Code:
	Phone #:	Fax #:		County:
	Office Hours:		Office Contact (<i>All Other</i>):	

ADDITIONAL OFFICE: (Indicate other additional offices on an attached sheet)	Address:		City:	Zip Code:
	Phone #:	Fax #:		County:
	Office Hours:			

MAILING ADDRESS: (All correspondence will be sent to this address)	Address:		City:	Zip Code:
	E-mail Address:			County:

CREDENTIALING CONTACT:	Name:			
	Address:		Phone:	
	City:	State:	Zip Code:	Fax:

Languages other than English spoken by PRACTITIONER:
Languages other than English spoken by OFFICE STAFF:
Any other Name(s) Possible in Records?

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)