THE UNIVERSITY OF ARIZONA HEALTH PLANS
LETTER OF INTEREST PROVIDER FORM - PROFESSIONAL

IN ORDER TO BE CONTRACTED, YOU MUST HAVE A VALID NPI NUMBER AND BE REGISTERED WITH AHCCCS. IF YOU ARE NOT REGISTERED WITH AHCCCS OR NEED TO UPDATE YOUR INFORMATION WITH AHCCCS, PLEASE CALL 602-417-7670 BEFORE FILLING OUT THIS FORM.

DIRECTIONS:

- ¤ **PAGE 1 SHOULD BE FILLED OUT FOR THE GROUP PRACTICE**
- ¤ **PAGE 2 SHOULD BE FILLED OUT FOR EACH DOCTOR IN YOUR PRACTICE**
- ¤ **FAX COMPLETED FORM, ALONG WITH AN IRS 941 COUPON OR ACCURATE W9 TO 602-344-8358 OR EMAIL TO THE CONTRACTING DEPARTMENT AT CONTRACTING@UAHEALTH.COM**

Please be sure to complete this form in its entirety so that we may process your request. Please be aware the completion of this form does not guarantee network participation. If you are approved to be added to The University of Arizona Health Plans network, a credentialing application must be completed and a contract signed by both parties before members may be seen. The credentialing process can take up to 120 days, from the receipt of a completed credentialing application.
Please Type or Print Clearly

I'm requesting to Contract with:	Maricopa Health Plan (MHP) University Family Care (UFC) University Care Advantage (UCA) University Healthcare Group (UHCG)
EDI and Internet:	Electronic Claim Submissions: Yes No If no, please explain: ______________ Does your Business have internet Access: Yes No If no, please explain: ______________
Is Practice / Clinic an FQHC or RHC?	FQHC RHC
1099 Registered Name (W9):	
Group Practice Name (DBA if applicable):	
Tax ID Number:	
Administrative Contact:	Contact Name: ______________ Email: ______________ Phone Number: ______________ Fax Number: ______________
Corporate Address:	Street: ______________ Office Hours: ______________ City: ______________ State:________ Zip: ______________ Phone: ______________ Fax ______________
Primary Address:	Street: ______________ Office Hours: ______________ City: ______________ State:________ Zip: ______________ Phone: ______________ Fax ______________
Additional Address:	Street: ______________ Office Hours: ______________ City: ______________ State:________ Zip: ______________ Phone: ______________ Fax ______________
****Additional practice locations: Please attach list****	
Correspondence / Mailing Address:	Street: ______________ Office Hours: ______________ City: ______________ State:________ Zip: ______________ Phone: ______________ Fax ______________

Checks are made out to the 1099 registered name and sent to the billing address listed below. This address should match the address on your W-9. This information must be registered with AHCCCS before entry into our database.

Billing (Pay-to) Address:	Street: ______________ City: ______________ State:________ Zip: ______________ Phone: ______________ Fax ______________

(CONTINUE TO NEXT PAGE)

Provider Information: **(if you have multiple providers in your practice, please fill out this page for each provider)**

Include the following documents for each provider:

- ♦ **Copy of DEA**
- ♦ **Documentation of malpractice coverage $1 million/$3 million**
- ♦ **Curriculum Vitae**
- ♦ **Documentation of board certification or scheduled exam date**
- ♦ **AZ State Conscious Sedation Certificate (applicable for Dental providers only)**
- ♦ **Copy of State License**

Are you currently employed with this group?	Yes No
Provider Name & Degree:	
Provider Information:	Gender: Male Female DOB: / / (mm/dd/yy) SSN: ____________________
Provider Primary Specialty:	Board Certified Yes No Date of Exam ______________
Provider Secondary Specialty:	Board Certified Yes No Date of Exam ______________
If not Board Certified, are you actively pursuing Board Certification:	Yes No
Where did Provider complete Residency?	**Where:** **When:**
Is Provider Medicare Certified?	Yes No **Are you currently, or have you ever been on the Medicare Opt out list?** Yes No
Language(s) spoken by PROVIDER:	
Language(s) spoken by STAFF:	
Age Range of patients:	0-99 0-16 0-18 18-99 21-99 OTHER ________
Do you participate in Vaccines for Children (VFC)? (PCPs seeing AHCCCS members 19 & < must participate)	Yes No VFC PIN Code: ____________
Are You a Baby Arizona Provider?	Yes No
ID Numbers:	UPIN ID # ______________ DEA # ______________ Medicare ______________ AZ License # ______________ Date Issued: ______________ AHCCCS ID # ______________ NPI # ______________
License:	Date first licensed to practice medicine (other than AZ) Year: _________ State: ________ ID # ________________ Are you a member with CAQH (credentialing data source)? Yes No
Has the Provider ever been terminated from a Health Plan for cause?	Yes No If yes, what was the reason? ________________ When did this occur? ________________
Hospital / Free Standing Surgery Facilities: (circle status)	____________ **Active Courtesy Provisional** ____________ **Active Courtesy Provisional** ____________ **Active Courtesy Provisional** ____________ **Active Courtesy Provisional**
Hospital admission preference:	
Call Coverage Practice(s) / Physician Name(s): (Must be registered with AHCCCS)	

I hereby affirm that the information submitted on this form is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application.

Authorized Signature:____ Date:__________________