

## Letter of Intent to Participate

**Fax to: 602-674-6670**

**New Practice/Organization (Include W-9 and Roster)**

Choose Line(s) of Business:     Phoenix Health Plan     Abrazo Advantage Health Plan

**Addition of Practitioner to Existing Group**

**Effective Date:** \_\_\_\_\_

Group Name: \_\_\_\_\_

Tax ID: \_\_\_\_\_    Group AHCCCS #: \_\_\_\_\_    Group NPI #: \_\_\_\_\_

Name of Practitioner: \_\_\_\_\_

Practitioner AHCCCS #: \_\_\_\_\_    Practitioner NPI #: \_\_\_\_\_

Specialty/Service Type: \_\_\_\_\_

|                        |             |
|------------------------|-------------|
| Primary Address:       |             |
| City, State, Zip Code: |             |
| Phone Number:          | Fax Number: |

|                                 |             |
|---------------------------------|-------------|
| Mailing Address (if different): |             |
| City, State, Zip Code:          |             |
| Phone Number:                   | Fax Number: |

Please list all of your active privileges at any Ambulatory Surgery Centers and Hospitals:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
 Print Name/Title

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Contact Phone Number                      Contact Fax Number