

Letter of Intent to Participate
Fax to: 602-674-6670

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

Name of Provider: _____

Provider AHCCCS #: _____ Provider NPI #: _____

Group Name: _____

Tax ID: _____ Group AHCCCS #: _____ Group NPI #: _____

Specialty Type: _____

SELECT REASON: New Group/Organization (Include W-9 and Roster)

Adding Provider to Existing Group

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:

Respectfully,

Signature

Date

Print Name / Title

Contact Phone Number