



**UNIVERSITY PHYSICIANS HEALTH PLANS
LETTER OF INTEREST PROVIDER FORM - PRACTITIONER**

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

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 UPH 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) <input type="checkbox"/> University Family Care (UFC) <input type="checkbox"/> University Physicians Healthcare Group (UP HCG) <input type="checkbox"/>	Maricopa Care Advantage (MCA) <input type="checkbox"/> University Physicians Care Advantage (UPCA) <input type="checkbox"/>
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EDI and Internet:	Electronic Claim Submissions: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____	Does your Business have internet Access: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain: _____
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Is Practice / Clinic an FQHC or RHC?	<input type="checkbox"/> FQHC <input type="checkbox"/> RHC
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1099 Registered Name (W9): Group Practice Name (DBA if applicable):	_____
Tax ID Number:	_____

Administrative Contact:	Contact Name: _____ Email: _____ Phone Number: _____ Fax Number: _____
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Corporate Address:	Street: _____ Office Hours: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
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Primary Address:	Street: _____ Office Hours: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
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Additional Address:	Street: _____ Office Hours: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
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****Additional practice locations: Please attach list****

Correspondence / Mailing Address:	Street: _____ Office Hours: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____
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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: _____
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(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: (check status)	Active	Courtesy	Provisional
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____