ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROVIDER REGISTRATION FORM

SHADED FIELDS FOR AHCCCS PROVIDER REGISTRATION STAFF ONLY *Please Type or Print in Ink*

SECTION I

1a) PROVIDER AHCCCS ID NUMBER (Complete Only if you are currently registered and have a Provider No)		1b) PROVIDER NPI (NATIONAL PROVIDER IDENTIFIER) NUMBER (if applicable)	
2) PROVIDER NAME(Last Name/First Name/Middle Initial or business/facility name)			
3) SOCIAL SECURITY NUMBER	4) DATE OF BIRTH	5) GENDER	6) DEGREE
7) PROVIDER TYPE		8) FFS TYPE	9) IHS INDICATOR
10) APPLICATION DATE Month ____ Day ____ Year ____		11) FIRST DATE OF SERVICE FOR WHICH A CLAIM WILL BE SUBMITTED Month ____ Day ____ Year ____	

SECTION II ADDRESS INFORMATION

CORRESPONDENCE ADDRESS

ADDR C SITE 01

12) STREET LINE 1: _____

13) STREET LINE 2: _____

14) CITY/STATE/ZIP: _____

15) COUNTY CODE: _____ 16) COUNTRY CODE: _____

17) BUSINESS PHONE: (_____) _____ - _____ 18) EMERGENCY PHONE (_____) _____ - _____

19) ATTENTION TO: _____

PAY-TO ADDRESS

ADDR P SITE 01

12) STREET LINE 1: _____

13) STREET LINE 2: _____

14) CITY/STATE/ZIP: _____

15) COUNTY CODE: _____ 16) COUNTRY CODE: _____

17) BUSINESS PHONE: (_____) _____ - _____ 18) EMERGENCY PHONE (_____) _____ - _____

19) ATTENTION TO: _____

ADDITIONAL PAY-TO INFORMATION 21) END DATE: _____ 22) EMPLOYER TAX ID: _____

SERVICE ADDRESS

ADDR S SITE 01

12) STREET LINE 1: _____

13) STREET LINE 2: _____

14) CITY/STATE/ZIP: _____

15) COUNTY CODE: _____ 16) COUNTRY CODE: _____

17) BUSINESS PHONE: (_____) _____ - _____ 18) EMERGENCY PHONE (_____) _____ - _____

19) ATTENTION TO: _____

20) BEGIN DATE: _____ 21) END DATE: _____

ADDITIONAL SERVICE INFORMATION: 23) PAY-TO LOCATION CODE: _____

PAY-TO ADDRESS

ADDR SITE

P 02

12) STREET LINE 1: _____

13) STREET LINE 2: _____

14) CITY/STATE/ZIP: _____

15) COUNTY CODE: _____ 16) COUNTRY CODE: _____

17) BUSINESS PHONE: (_____) _____ - _____ 18) EMERGENCY PHONE (_____) _____ - _____

19) ATTENTION TO: _____

ADDITIONAL PAY-TO INFORMATION 21) END DATE: _____ 22) EMPLOYER TAX ID: _____

SERVICE ADDRESS

ADDR SITE

S 02

12) STREET LINE 1: _____

13) STREET LINE 2: _____

14) CITY/STATE/ZIP: _____

15) COUNTY CODE: _____ 16) COUNTRY CODE: _____

17) BUSINESS PHONE: (_____) _____ - _____ 18) EMERGENCY PHONE (_____) _____ - _____

19) ATTENTION TO: _____

20) BEGIN DATE: _____ 21) END DATE: _____

ADDITIONAL SERVICE INFORMATION: 23) PAY-TO LOCATION CODE: _____

PAY-TO ADDRESS

ADDR SITE

P 03

12) STREET LINE 1: _____

13) STREET LINE 2: _____

14) CITY/STATE/ZIP: _____

15) COUNTY CODE: _____ 16) COUNTRY CODE: _____

17) BUSINESS PHONE: (_____) _____ - _____ 18) EMERGENCY PHONE (_____) _____ - _____

19) ATTENTION TO: _____

ADDITIONAL PAY-TO INFORMATION 21) END DATE: _____ 22) EMPLOYER TAX ID: _____

SERVICE ADDRESS

ADDR SITE

S 03

12) STREET LINE 1: _____

13) STREET LINE 2: _____

14) CITY/STATE/ZIP: _____

15) COUNTY CODE: _____ 16) COUNTRY CODE: _____

17) BUSINESS PHONE: (_____) _____ - _____ 18) EMERGENCY PHONE (_____) _____ - _____

19) ATTENTION TO: _____

20) BEGIN DATE: _____ 21) END DATE: _____

ADDITIONAL SERVICE INFORMATION: 23) PAY-TO LOCATION CODE: _____

SECTION III

LICENSING*

24) LICENSE NUMBER	25) ISSUE DATE (MM/DD/YYYY)	26) EXPIRATION DATE	27) NEXT RENEWAL DATE

* A COPY OF THE LICENSE MUST BE ATTACHED

PROVIDER SPECIALTY INFORMATION- MANDATORY FOR PHYSICIAN, DENTISTS, PODIATRISTS, OSTEOPATHS, AND REGISTERED NURSE PRACTITIONERS

28) SPECIALTY	29) BEGIN DATE (MM/DD/YYYY)	30) END DATE

BED COUNT INFORMATION - HOSPITALS, NURSING HOMES, AND HOSPICES ONLY

31) BED TYPE	32) STATE CERTIFIED COUNT	33) MEDICARE CERTIFIED COUNT	34) MEDICAID CERTIFIED COUNT	35) BEGIN DATE (MM/DD/YYYY)	36) END DATE

SECTION IV

AUTHORIZED SIGNATURE

37) SIGNATURE	38) PRINT NAME	39) BEGIN DATE (MM/DD/YYYY)

GROUP BILLING AUTHORIZATION

40) GROUP NAME/AHCCCS ID NUMBER AND/OR NPI NUMBER	41) ASSOCIATION BEGIN DATE (MM/DD/YYYY)	42) ASSOCIATION END DATE

MEDICARE INFORMATION **(Mandatory for all providers. If not a Medicare provider indicate by placing N/A in block #42)**

43) MEDICARE ID NO	44) MEDICARE COVERAGE	45) INTERMEDIARY NUMERIC CODE	46) CARRIER NUMERIC CODE	47) BEGIN DATE (MM/DD/YYYY)	48) END DATE

Has the practice/organization that you represent or any of the signatories listed in (37) ever applied for or received an AHCCCS provider identification number under any other name than noted on this form?

☐ NO

☐ YES (Please explain)

_____

_____

_____

Have you or the practice/organization that you represent or any of the signatories listed in (37) ever been terminated, suspended, advised of any deficiencies or otherwise subject to any corrective or disciplinary action by a governmental body? This includes a professional licensing or certification board and any city, state, county or federal entities. If yes, include documentation from issuing entity.

☐ NO

☐ YES (Please explain)

_____

_____

_____

I hereby authorize the groups listed in (40) to bill on my behalf and receive payment for services provided to AHCCCS members.
I affirm under penalty of law that the information I have provided on this form is true, accurate and complete to the best of my knowledge.

49) _____
PROVIDER SIGNATURE (ONLY)

50) _____
DATE

51) _____
PROVIDER NAME (PLEASE TYPE OR PRINT)

Reset Form