



STATE OF ARIZONA
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
PROMOTING HONESTY AND INTEGRITY
OFFICE OF INSPECTOR GENERAL

Douglas A. Ducey
Governor,
Jami Snyder
Director

Revalidation Address Verification Form

(Completed W-9 must be included, for each unique Tax Identification Number listed)

NAME (Last, First, M.I. or Company Name): _____
SOCIAL SECURITY NUMBER: _____ GENDER: FEMALE MALE DATE OF BIRTH: _____
AHCCCS PROVIDER ID#: _____ NPI # _____

LIST ALL CURRENT ADDRESSES

NOTE: Form will be returned if not completed.

CORRESPONDENCE ADDRESS

STREET LINE #1: _____
STREET LINE #2: _____
CITY: _____ STATE: _____ ZIP: _____
BUSINESS PHONE: () - - EMERGENCY PHONE: () - -
ATTENTION TO: _____

PAY-TO ADDRESS (SITE 01)

STREET LINE #1: _____
STREET LINE #2: _____
CITY: _____ STATE: _____ ZIP: _____
BUSINESS PHONE: () - - EMERGENCY PHONE: () - -
ATTENTION TO: _____
EMPLOYER TAX ID# _____ BEGIN DATE: _____ END DATE: _____

SERVICE ADDRESS (SITE 01) *Must be a Street Address*

STREET LINE #1: _____
STREET LINE #2: _____
CITY: _____ STATE: _____ ZIP: _____
BUSINESS PHONE: () - - EMERGENCY PHONE: () - -
FAX PHONE: () - - ATTENTION TO: _____
BEGIN DATE: _____ END DATE: _____ PAY-TO LOC. CODE:* _____

(*=Please indicate the locator code for the pay-to address that applies to this service address.)

I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.
SIGNATURE:** _____ TITLE: _____ DATE: _____

****Must be signature of Provider or Authorized Signor on file with AHCCCS**

PAY-TO ADDRESS (SITE 02)

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () - EMERGENCY PHONE: () -

ATTENTION TO: _____

EMPLOYER TAX ID# _____ BEGIN DATE: _____ END DATE: _____

SERVICE ADDRESS (SITE 02) *Must be a Street Address*

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () - EMERGENCY PHONE: () -

FAX PHONE: () - ATTENTION TO: _____

BEGIN DATE: _____ END DATE: _____ PAY-TO LOC. CODE:* _____

(*=Please indicate the locator code for the pay-to address that applies to this service address.)

PAY-TO ADDRESS (SITE 03)

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () - EMERGENCY PHONE: () -

ATTENTION TO: _____

EMPLOYER TAX ID# _____ BEGIN DATE: _____ END DATE: _____

SERVICE ADDRESS (SITE 03) *Must be a Street Address*

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () - EMERGENCY PHONE: () -

FAX PHONE: () - ATTENTION TO: _____

BEGIN DATE: _____ END DATE: _____ PAY-TO LOC. CODE:* _____

(*=Please indicate the locator code for the pay-to address that applies to this service address.)

I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.

SIGNATURE:** _____ TITLE: _____ DATE: _____

**Must be signature of Provider or Authorized Signor on file with AHCCCS

05/2018