AzAHP Provider Roster (ADD) Template

Last Name	First Name	Middle Initial	Title/Degree	Specialty	Board Certified	Social Security	DOB	SEX (M/F)	AZ License #	AZ License Exp Date	AHCCCS ID#	Individual NPI #	Medicare #	DEA#	DEA Exp Date	Malpractice Policy #	Start Date W/Grp	Practice Address, City, St, Zip	County	Phone	Fax

AzAHP Provider Roster (CHANGE) Template

Last Name	First Name	Middle Initial	AZ License #	AZ License Exp Date	Specialty	AHCCCS ID#	Individual NPI #	Medicare #	Social Security	DEA#	DEA Exp Date	Malpractice Policy #	Grp Eff Date	Grp Tin	Practice Address, City, St, Zip	County	Phone	Fax	*Change/Update

*Please provide detail (specific information) about the change being requested (e.g. address change, new address, etc.)

AzAHP Provider Roster (TERM) Template

Last Name	First Name	Middle Initial	AZ License #	AZ License Exp Date	AHCCCS ID#	Individual NPI #	Medicare #	DEA#	DEA Exp Date	Malpractice Policy #	Termination Eff Date	Grp Tin	Practice Address, City, St, Zip