STATE OF ARIZONA
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

PROMOTING HONESTY AND INTEGRITY

OFFICE OF INSPECTOR GENERAL

Janice K. Brewer
Governor,

Thomas J. Betlach
Director

Provider Address Update Form

(Completed W-9 Must Be Included)

NAME (Last, First, M.I.): ______________________

SOCIAL SECURITY NUMBER: ______________ GENDER: ☐ FEMALE ☐ MALE DATE OF BIRTH: ______________

AHCCCS PROVIDER ID#: ______________ NPI # ______________

CHECK ONE: ☐ **ADD ADDITIONAL INFORMATION**

☐ **REPLACE EXISTING INFORMATION**

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*

10/2012