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