



ASPA'S Provider Address Update Form

(This is not an Application or a re-credentialing packet)

Provider Name: _____ Provider NPI Number _____

Provider email: _____

NOTE: FORM WILL BE RETURNED IF NOT COMPLETED. PLEASE TYPE OR PRINT LEGIBLE

CORRESPONDENCE/MAILING ADDRESS

CHECK ONE: _____ ADD BELOW INFO/REMOVE PREVIOUS INFO _____ ADD INFORMATION _____ DELETE INFORMATION

Date of change: _____ Tax ID: _____ Group NPI Number _____

Practice Name: _____

Street Address, Suite Number: _____

City, State, Zip code: _____

Phone: _____ Fax: _____

Office Contact: _____ Office Contact Email: _____

PAY-TO/BILLING ADDRESS

PLEASE NOTE YOUR ADDRESS ON YOUR W-9 MUST MATCH YOUR BILLING ADDRESS.

**** Completed W-9 must be attached**

CHECK ONE: _____ ADD BELOW INFO/REMOVE PREVIOUS INFO _____ ADD 2nd Tax ID _____ DELETE 2nd Tax ID

Date of change: _____ Tax ID: _____ Group NPI Number _____

Practice Name: _____

Street Address, Suite Number: _____

City, State, Zip code: _____

Phone: _____ Fax: _____

Office Contact: _____ Office Contact Email: _____

PRIMARY ADDRESS (SITE 1)

CHECK ONE: _____ ADD INFORMATION _____ DELETE INFORMATION

Date of change: _____ Tax ID: _____ Group NPI Number _____

Practice Name: _____

Street Address, Suite Number: _____

City, State, Zip code: _____

Phone: _____ Fax: _____

Office Contact: _____ Office Contact Email: _____

Office Website: _____ Office Hours: _____

SERVICE ADDRESS (SITE 2)

CHECK ONE: ADD INFORMATION DELETE INFORMATION

Date of change: _____ Tax ID: _____ Group NPI Number _____

Practice Name: _____

Street Address, Suite Number: _____

City, State, Zip code: _____

Phone: _____ Fax: _____

Office Contact: _____ Office Contact Email: _____

Office Website: _____ Office Hours: _____

SERVICE ADDRESS (SITE 3)

CHECK ONE: ADD INFORMATION DELETE INFORMATION

Date of change: _____ Tax ID: _____ Group NPI Number _____

Practice Name: _____

Street Address, Suite Number: _____

City, State, Zip code: _____

Phone: _____ Fax: _____

Office Contact: _____ Office Contact Email: _____

Office Website: _____ Office Hours: _____

CREDENTIALING CONTACT INFORMATION

Credentialing Contact: _____

Street Address, Suite Number: _____

City, State, Zip code: _____

Phone: _____ Fax: _____

Credentialing email: _____

PLEASE NOTE: If you have changed practices all plans you were contracted with prior to the change will follow you. If you are adding a 2nd Tax ID you will need to fill out a new ASPA PAYOR PARTICIPATION ATTACHMENT. If you do not wish to remain on the same plans you will need to indicate on the attached ASPA PAYOR PARTICIPATION ATTACHMENT.

PRINT PROVIDER NAME

PROVIDERS AHCCCS Number

PROVIDERS Medicare Number

PROVIDER SIGNATURE

** Must be provider's signature in order to be completed for processing.

*** **Completed W-9 must be attached**

3030 N. Central Ave. Suite 1405, Phoenix, AZ 85012
www.azspa.com

Telephone: 602.265.2524
Fax: 602.636.2487



October 15, 2018

www.azspa.com

Required Information For ASPA Contracted Plans

CLIA Certificates

Medicare, Tricare, and AHCCCS Plans are now requiring that we show proof when an office has a CLIA /CLIA Waiver Certificate. This pertains to any practice whether they are PCP or Specialist.

Please fax a copy of your CLIA Certificate along with a list of providers in your practice to 602-636-2487. If you do not have and not required to have a CLIA please see indicate below.

_____ We do not require a CLIA as we do not do any lab type draws or tests in our practice location(s).

Name of Practice: _____

Tax ID _____ Number of Office Locations _____

Contact Person _____ Phone Number _____

Email Address _____

Helping the Independent Provider Stay Independent