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 RETUNED 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**

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 Waver 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