

ASPA'S Provider Address Update Form

(This is **NOT** an application or a re-credentialing packet)

Provider Name: _____ Provider NPI Number _____

PLEASE NOTE: Beginning 2/1/2026 if you have more than one Tax ID, ASPA will charge a one-time fee of **\$75.00** for each additional tax id. ASPA **WILL NOT** add any additional TAX ID information until payment has been received.

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 signature of Authorized signor in order to be completed for processing.**

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

3030 N. Central Ave. Suite 1106, Phoenix, AZ 85012

Telephone: 602.265.2524

www.azspa.com

Fax: 623.999.1055

Update 1-14-26

Practitioner/Provider Name: _____

Tax ID : _____ **NPI #:** _____

Please answer the following questions. These questions are now being REQUIRED by ALL plans.

Do you provide Services to Individuals with Physical Special needs/Chronic Conditions?

YES NO

Do you provide services to individuals with Behavioral special needs/chronic conditions?

YES NO

Difficulty with communication or cooperating (ie: Autism or Intellectual Disabilities)?

YES NO

Do you treat Anxiety? YES NO

Do you treat Depression? YES NO

Do you treat substance abuse? YES NO

PCP's: Do you provide OB/GYN Services?

YES NO

Do you offer telemedicine services

YES NO

Are you a medication assisted treatment Prescriber (MAT)?

YES NO

Do you provide services to individuals with Emotional special needs/chronic conditions?

YES NO

Do you provide services to individuals with Developments special needs/chronic Conditions?

YES NO

Do you provide services to individuals with Mobility limitations (ie: Wheelchair bound)?

YES NO

Do you treat ADHD? YES NO

Do you treat HIV: YES NO

**PCP's and OB/GYN's ONLY:
Do you provide EPSDT services?**

YES NO

**Do you participate in VFC?
(Vaccines for Children under 18)**

YES NO

(if Yes) please provide your VFC Pin code

**Do you have XDEA?
IF yes, please provide Certificate**

YES NO

Do you E-Prescribe? YES NO

Line of Business: (choose all that Apply)

Medicaid Medicare Commercial

CAQH number _____

AHCCCS number _____

Medicare number _____

Age Range: ALL Ages Older than 18 Younger than 18

Copy of CLIA if applicable.

Copy of Current W9.

Please fill out the attached add/drop forms in full. If not fully completed it will be returned and no steps will be taken until the form is completed and returned.

- Mark **Add/Yes** for any plans you wish to be active with.
- Mark **Drop/No** to any plans you do not wish to be active with.

To be sure you are active with the same plans as the providers in your group please reach out to Tonya at tonya@azspa.com and ask for a list of plans. She will get you a list of the plans your providers are with under the ASPA contract. ASPA has noticed that if the providers in a group do not have the same plans this could cause you to have some billing issues and providers not being paid under the ASPA contract. These providers can be seen as Non. PAR. To prevent this from happening to the providers in your group all providers should be under the same plans and active with ASPA.

Each form **MUST** be signed by the provider. Unless your practice is covered by an ASPA Group Contract, then the first two pages can be signed by an administrator. The individual forms for plans must have each provider's signature. If not signed by the provider, it will be returned, and no steps will be taken to load plans until completed and returned. If you do not know if your practice is covered under a ASPA Group contract, please reach out to Tonya at tonya@azspa.com and she will let you know.

A W-9 **MUST** be returned with the forms as the plans will not add without it. The billing address on the W-9 Must match the billing address on file. If it does not match the plan will not add.

ASPA PAYOR PARTICIPATION ATTACHMENT

Please Review the list of Payor Below. Should you wish to make any changes, i.e. add or drop a plan please indicate below.

PLEASE NOTE: If you have changed practices all plans you were contracted with in your previous practice will follow you.

PLEASE NOTE – ASPA's plans retain the right to refuse a provider access to participate under the ASPA contract.

ASPA will make every effort to assist you in this process; we recommend that if you are transitioning from a direct contract or another network into an ASPA contract, you should contact the plan prior to contacting ASPA to make sure they will allow the transfer.

ACPN- AMERICA'S CHOICE PROVIDER NETWORK	☐	ADD	☐	DROP
AMERIPLAN HEALTH & MEDICAL PLANS OF AMERICA	☐	ADD	☐	DROP
ANTIDOTE	☐	ADD	☐	DROP
AZ COMPLETE HEALTH AHCCCS - MEDICAID		CLOSED PANELS	☐	DROP
AZ COMPLETE HEALTH AMBETTER		CLOSED PANELS	☐	DROP
AZ COMPLETE HEALTH WELLCARE		CLOSED PANELS	☐	DROP
CLOSED PANELS EXCEPT FOR EXISTING GROUPS IF IN EXISTING GROUP CONTACT Karen@azspa.com				
CLARITEV - INTEGRATED HEALTH PLAN AUTO MEDICAL PLAN	☐	ADD	☐	DROP
CLARITEV - INTEGRATED HEALTH PLAN DISCOUNT SAVINGS CARD	☐	ADD	☐	DROP
CLARITEV - INTEGRATED HEALTH PLAN PPO	☐	ADD	☐	DROP
CLARITEV - INTEGRATED HEALTH PLAN WORKERS COMP	☐	ADD	☐	DROP
CLARITEV - MULTIPLAN AUTO	☐	ADD	☐	DROP
CLARITEV - MULTI PLAN MEDICARE ADVANTAGE PLANS	☐	ADD	☐	DROP
CLARITEV - MULTI PLANS PPO	☐	ADD	☐	DROP
CLARITEV - MULTIPLAN VALUE POINT ACCESS CARD PROGRAM	☐	ADD	☐	DROP
CLARITEV - MULTIPLAN WORKERS COMP.	☐	ADD	☐	DROP
CONTEGO HEALTH - THREE RIVERS PPO	☐	ADD	☐	DROP
CORVEL AUTO MEDICAL	☐	ADD	☐	DROP
CORVEL PPO	☐	ADD	☐	DROP
CORVEL WORKERS COMPENSATION	☐	ADD	☐	DROP
CURATIVE HEALTH	☐	ADD	☐	DROP
GALAXY HEALTHCARE PPO	☐	ADD	☐	DROP
GALAXY HEALTHCARE DISCOUNT CARD	☐	ADD	☐	DROP
GALAXY WORKERS COMP	☐	ADD	☐	DROP
HEALTH CHOICE AHCCCS – Contract only – Cred. through Health Choice	☐	ADD	☐	DROP
HEALTH CHOICE GENERATIONS MEDICARE - Contract only – Cred. through Health Choice	☐	ADD	☐	DROP
HEALTHSMART ACCEL	☐	ADD	☐	DROP
HEALTHSMART AUTO	☐	ADD	☐	DROP
HEALTHSMART HPO	☐	ADD	☐	DROP
HEALTHSMART PPO	☐	ADD	☐	DROP
HEALTHSMART WORKERS COMP	☐	ADD	☐	DROP

IMPERIAL – HEALTHCOSMOS MEDICAL GROUP	☐	ADD	☐	DROP
IMPERIAL - MARKETPLACE PLAN	☐	ADD	☐	DROP
IMPERIAL – MEDICARE	☐	ADD	☐	DROP
IMPERIAL – WELLPOINT	☐	ADD	☐	DROP
MCCP AUTO	☐	ADD	☐	DROP
MCCP PPO	☐	ADD	☐	DROP
MCCP WORKERS COMP	☐	ADD	☐	DROP
MOLINA - AHCCCS/MEDICARE – PCP ONLY NO LONGER ACCEPTS FACILITIES	☐	ADD	☐	DROP
NOMI HEALTH	☐	ADD	☐	DROP
PRIME HEALTH SERVICES IME PROGRAM	☐	ADD	☐	DROP
PRIME HEALTH SERVICE PERSONAL INJURY NETWORK	☐	ADD	☐	DROP
PRIME HEALTH SERVICE PPO, AUTO, WORKERS COMP.	☐	ADD	☐	DROP
PRIME HEALTH SERVICES TELEMEDICINE PROGRAM FOR WC	☐	ADD	☐	DROP
PRIME HEALTH SERVICES WTC	☐	ADD	☐	DROP
PROVIDER NETWORK OF AMERICA AUTO	☐	ADD	☐	DROP
PROVIDER NETWORK OF AMERICA PRIMARY	☐	ADD	☐	DROP
PROVIDER NETWORK OF AMERICA SUPPLEMENTAL	☐	ADD	☐	DROP
PROVIDER NETWORK OF AMERICA WORKERS COMP	☐	ADD	☐	DROP
PROVIDER SELECT INC.	☐	ADD	☐	DROP
SANA BENEFITS	☐	ADD	☐	DROP
UNITY PREFERRED NETWORK AUTO	☐	ADD	☐	DROP
UNITY PREFERRED NETWORK PPO	☐	ADD	☐	DROP
UNITY PREFERRED NETWORK WORKERS COMP	☐	ADD	☐	DROP
UPMC	☐	ADD	☐	DROP
USA AUTO	☐	ADD	☐	DROP
USA MANAGED CARE – PPO	☐	ADD	☐	DROP
USA WORKERS COMP	☐	ADD	☐	DROP
VELOCITY AUTO	☐	ADD	☐	DROP
VELOCITY PPO	☐	ADD	☐	DROP
VELOCITY WORKERS COMP	☐	ADD	☐	DROP
ZELIS HEALTHCARE AUTO	☐	ADD	☐	DROP
ZELIS HEALTHCARE MEDICAID	☐	ADD	☐	DROP
ZELIS HEALTHCARE MEDICARE	☐	ADD	☐	DROP
ZELIS HEALTHCARE PRIMARY PLAN	☐	ADD	☐	DROP
ZELIS HEALTHCARE SUPPLEMENTAL PLANS	☐	ADD	☐	DROP
ZELIS HEALTHCARE WORKERS COMP	☐	ADD	☐	DROP

PRINT PROVIDER NAME

PROVIDERS AHCCCS Number

PROVIDERS Medicare Number

PROVIDER SIGNATURE

DATE

PROVIDERS TAX ID

**** This form must have a provider's signature in order to be completed for processing. If no signature is present plans will not be notified of the above changes**

COMPLETED W-9 MUST BE ATTACHED. NOTE: YOUR ADDRESS ON YOUR W-9 MUST MATCH YOUR BILLING ADDRESS.

3030 N. Central Ave. Suite 1106, Phoenix, AZ 85012
www.azspa.com

Telephone: 602.265.2524
Fax: 623.999.1055 Updated 7-29-26

ARIZONA STATE PHYSICIANS ASSOCIATION

Provider Agreement Attachment

NEW ASPA PLAN CONTRACT

Effective 9/1/2024

Background:

ASPA has entered into a contract with Fusion Strategic Alliance for their new Arizona Network Offering.

Fusion Strategic Alliance is a carrier alternative providing access to care for self-funded employer groups in Arizona. Fusion Strategic Alliance is physician owned and operated with a mission to keep independent physician groups independent.

Carrier will reimburse as follows:

Reimbursement rates are 110% of the current year CMS fee schedule for Primary Care and 125% of CMS fee schedule for specialists.

For more information, please visit <https://fusionstrategicalliance.com> or email zmosman@alphaomegamedical.net.

Complete the information below for **each** provider and **fax to ASPA at 623-999-1055**. If you have any questions, please call ASPA 602-265-2524, ext. 210. **Please attach a current W-9 form.**

Yes _____ I want to Participate with **Fusion Strategic Alliance**

No _____ I do not want to Participate with **Fusion Strategic Alliance**

Provider Signature _____ Date _____

Please Print Name: _____ Tax ID # _____

Group NPI _____ Specialty _____

Contact Email: _____

3030 N. Central Ave., Suite 1106, Phoenix, Arizona 85012
(602) 265-2524 **FAX: 623-999-1055**

ARIZONA STATE PHYSICIANS ASSOCIATION

Physician Agreement Attachment

Gold Kidney Health Plan Serving CKD/ESRD patients in Arizona

Background:

Gold Kidney is a Special Needs Medicare Advantage health plan addressing the unmet needs of affordable and integrated kidney care coverage for Arizona with Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD).

Gold Kidney of Arizona is a Medicare Advantage health plan that is designated to provide wholistic care for patients with Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD). In addition to the standard Medicare Advantage provider network, Gold Kidney of Arizona will add access to high-quality Kidney Care services and Integrated Case Management Services. This is an affordable plan with zero premium, zero copay Nephrologist/PCP visit and zero coinsurance for select dialysis treatments and medications. This is offered in the following counties of Arizona. Maricopa, Yavapai, Gila, Coconino, Navajo, Pima and Pinal counties.

Reimbursement:

All Professional and Ancillary Services	100% of the CMS Fee Schedule after sequestration
Laboratory and Pathology Services	80% of the CMS Fee Schedule after sequestration
Radiology Services	75% of the CMS Fee Schedule after sequestration
J-codes	100% of the CMS Fee Schedule after sequestration
Durable Medical Equipment	100% of the CMS Fee Schedule after sequestration

Complete the information below for **each** provider in your practice, include a W-9 form and **fax to ASPA at 623-999-1055**.

Yes _____ I want to Participate with Gold Kidney Health Plan

No _____ I do not want to Participate with Gold Kidney Health Plan

Provider Signature _____ Date _____

Please Print Name: _____ Tax ID # _____

Specialty _____ County _____ NPI# _____

Office Contact _____

Email _____

**Arizona State Physicians Association (“ASPA”)
& Prospect Medical Group AZ, LLC (“Prospect”)
Provider Opt-In Attachment**

Pursuant to its agreement with ASPA, Prospect is pleased to announce an opportunity for you to participate in the Medicare Advantage Global Risk Health Plan Contract (“Contract”) between Prospect and SCAN Desert Health Plan, Inc. (“SCAN”), which took effect January 1, 2022.

Primary Care (PCP) Compensation Medicare Advantage Plan	\$70.00 PMPM
Primary Care Services & FFS Non-Capitated Primary Care Services	See attached Exhibit A
Specialist Physician Services	See attached Exhibit B
Specialist	95% Medicare fee-for-service
Urgent Care	90% Medicare fee-for-service
Radiology	85% Medicare fee-for-service
Physical Therapy/OT/Speech	\$45 Case Rate
Home Health, DME, Audiology, Nutrition	80% Medicare fee-for-service
Ambulatory Surgery Center	80% Medicare ASC fee schedule
Orthotic & Prosthetics	70% Medicare fee schedule

Should you agree to provide services under the Health Plan Contract as a Prospect Participating Provider, you will have access to Prospect's Provider Manual, and will be required to maintain compliance with the policies and procedures set forth therein, including policies governing the following areas:

- Eligibility Verification
- Licensing, Credentialing and Accreditation
- Referrals and Authorizations
- Claims, Encounters, and Disputes
- Records, Data Exchange, and Reporting
- Monitoring and Auditing
- Privacy and Confidentiality of Member Information; and
- Compliance with Health Plan materials and other federal regulatory requirements (e.g., Evidence of Coverage, Medicare Coverage and CMS Contracting and Downstream Entity rules)

☐ **Yes**, I agree to be a Participating Provider in the Medicare Advantage Contract between Prospect and the Health Plan listed in this document and understand I will be expected to be compliant with Prospect’s policies and procedures. (*Please include a separate sheet for each provider within your practice):

Note, if you have previously selected and are currently participating in a Health Plan or Health Plans, then that participation will continue notwithstanding your selection(s) on this opt-in form.

☐ **No**, I do not want to participate in Prospect’s SCAN Desert Health Plan, Inc. (“SCAN”), at this time. Prospect will reimburse ASPA Providers for services under the above Contract as follows:

If you would like detailed information on the primary care or specialty services governed by the Prospect/SCAN Contract, please contact ASPA at 602-265-2524, ext. 210 or email to Karen Ellington [at karen@azspa.com](mailto:karen@azspa.com).

Prospect and ASPA strongly encourage you to participate in this Medicare Advantage opportunity. Should you have any questions, please call ASPA at 602-265-2524, ext. 210 or contact us at 3030 N. Central Ave., Suite 1106, Phoenix, AZ, 85012. Otherwise, please complete the information below and **fax to ASPA at 623-999-1055, with the current W-9 form.**

PRINT PHYSICIAN NAME, TITLE

DATE

SPECIALTY

PHYSICIAN SIGNATURE

TAX ID

PHYSICIAN NPI#

PHYSICIAN CONTACT EMAIL



Dear Provider,

SCAN requires all members providing care for SCAN patients to complete the Annual Model Care (MOC) Training.

This training is a regulatory requirement and must be attested to by both primary care and specialty care providers, as they serve our Special Needs Plan (SNP) members. Additionally, the attestation is necessary for us to add providers to our system. Since the Health Plan (SCAN) conducts annual audits of contracted medical groups, having this completed form on file is an important compliance step.

Why Providers Must Complete the Annual Model of Care (MOC) Training

- The MOC training is a **CMS-required** annual training course for all providers caring for Special Needs Plan (SNP) members.
- It ensures we're all aligned in delivering **coordinated, high-quality, and person-centered care** to our most vulnerable populations.
- Completing the training helps improve **member outcomes**, strengthens **communication across the care team**, and keeps our network in **full compliance** with CMS requirements.
- The process is **quick and convenient** — typically under 20 minutes — and demonstrates your continued **commitment to excellence and partnership** in caring for our members.

PLEASE COPY AND PASTE THE LINK INTO YOUR BROWSER FOR THE TRAINING COURSE

<https://training.prospectmedical.com/Statics/docs/SCAN/2025-snp-moc-training.pdf> It is a pdf, approximately 10-15 minutes self-guided course. Only the CA FIDE-SNP section does not apply to the AZ providers.

Please send the attached back to me from each provider in your group. Should you have any questions please reach out to Karen at karen@azspa.com



2026 Attestation of Special Needs Plan Training

Thank you for completing the Special Needs Plan Model of Care training,

The Centers for Medicare & Medicaid Services (CMS) requires Health Plan employees, contractors and providers who serve Medicare Advantage Special Needs Plan (SNP) members to complete an annual SNP Model of Care (MOC) training (Refer to Chapter 42 of the Code of Federal Regulations, Part 422 (42 CFR 422.101 (f)(2)(ii)); Special Needs Plans).

The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees. The MOC is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices. The MOC provides the foundation for promoting SNP quality, care management and care coordination processes.

Please attest below that you have completed the required 2025 Special Needs Plan Model of Care training and **SAVE A COPY OF THIS ATTESTATION FOR YOUR OWN RECORDS:**

* Required

ATTESTATION:

Save a copy of this completed form for your files.

1. Job Title *

Enter your answer _____

2. First Name of Person Attesting *

Enter your answer _____

3. Last Name of Person Attesting *

Enter your answer _____

4. Work Email Address *

Enter your answer _____

5. Full Organization Name *

Enter your answer _____

6. Organization State: *

☐ California

☒ Arizona

☐ New Mexico

☐ Nevada

☐ Texas

7. I attest that I have reviewed training materials for SCAN Model of Care Training. *

☒ YES