



Beginning 02/01/2026, if your Provider has more than ONE Tax-ID, ASPA will charge a ONE-TIME fee of \$75.00 for each additional Tax-ID. The additional information WILL NOT be added until Payment has been received.

We are pleased that you have expressed an interest in becoming a member of the Arizona State Physicians Association (ASPAA). Enclosed are the following:

- ASPA Application
- ASPA Payor Participation Attachments
- Copy of Physician/Provider Affiliate Agreement (**Please sign page 10 and return with the application, please DO NOT date the Agreement**, a signed copy will be sent to you when the credentialing process is completed)
- **Please see attached Checklist on next page regarding items needed for your application.**

Please complete the application in full (**any items that pertain to you and your Specialty MUST be filled out**) (**See Attached, See CV, and CAQH applications will not be accepted**) return **ALL** enclosures with the documentation requested on the application.

Please review the application in full before sending in for the credentialing process begins. Any areas not filled out or are incorrect will be returned for additional/corrected information. As a practitioner you have the right for updates regarding your status, please send an email to angie@azspa.com for this update.

Upon receipt of the required information, your application will undergo the credentialing process. **This process takes between 90-120 days.** The contract shall be deemed executed when signed by an official representative of the Arizona State Physicians Association. At that time you will be notified regarding which plans you will be participating in through ASPAA.

Additionally, a site visit and chart audit will be required on ALL OB/GYN and Primary Care provider offices as well as Nurses in those same fields. Once your application has been submitted to our credentialing department, our QA Nurse will be calling to schedule a convenient time to come out to your office. We strongly advise you allow our nurse to come out to your office as soon as possible as your application will not be finalized and sent to committee for review until this component of the initial credentialing process has been complete.

As a Member, you may or may not have access to all ASPA's current contracted plans. Your name, specialty, and location(s) will be presented to our current contract plans for consideration of participation. ASPA nor the ASPA plans do not discriminate against race or ethnicity or languages.

DO NOT provide services to any contracted plans **UNTIL THE EFFECTIVE DATE WITH EACH OF THE PLANS HAS BEEN CONFIRMED.** Services prior to that effective date **WILL NOT BE COVERED.** **PLEASE NOTE** your effective date with the plans **WILL BE DETERMINED BY THE INDIVIDUAL PLAN, NOT ASPA.**

If, of course you already have a direct contract with any of the offered plans, you should continue under that contract until your ASPA contract is in effect, at which time you have a choice to either continue under your individual contract or utilize the contract available through ASPAA. We suggest you evaluate your contracts to determine which contract is better for your office. Once you have been approved as a Member you will have access to many other services offered by ASPAA.

If you require further clarification or have any questions regarding the application or credentialing processes you may contact Angie at angie@azspa.com or 602-265-2524 Ext. 222.

For questions regarding ASPA Contracted Plans and other ASPA services please contact Karen at karen@azspa.com



ASPA Initial Application Checklist

DUE TO NEW STATE REQUIREMENTS, ALL APPLICATIONS MUST BE FILLED OUT COMPLETELY OR IT WILL NOT BE PROCESSED. IF SOMETHING DOES NOT APPLY, PLEASE PUT N/A.

Payment is **REQUIRED BEFORE** the credentialing process can be started, please see fee structure below: (EFFECTIVE September 1st, 2026 all fees have been INCREASED to the following)

Specialty Physicians: \$700

Primary Care Physicians: \$600

ALL NURSES: \$485 (NP's, FNP's, CNM's, RN's, etc)

Allied Health Member \$465 (PA's, PT's, Ph.D.'s, DC's etc)

This fee includes your first year annual dues and Credentialing costs. **YOUR APPLICATION WILL NOT BE PROCESSED UNTIL THIS FEE HAS BEEN RECEIVED.** This fee should be sent in with the application or paid online at <http://azspa.com/pay-your-bill-online/> (with a copy of the receipt attached)

Please make sure the following items are attached upon completion and return of your ASPA Application (failure to provide these items will delay the processing of the application):

- o **Copy of DEA Certificate:** (if applicable) (**MUST** show **ARIZONA** address and **Current Expiration date**)
- o **Documentation of Arizona State License:** (showing **current expiration date**)
- o **Copy of Current Malpractice Facesheet:** (showing **current expiration date**) (Limits no less than \$1 Million/\$3Million)
- o **Copy of SAMs certificate:** (Sexual Misconduct and Molestation, statement located within your General Liability policy)
- o **Copy of Curriculum Vitae:** with minimum 5 years Work History. All dates (**Education and Work History**) **MUST** be in a Month/Year Format. (**MM/YYYY**)
- o **Physician Assistants: ALL PA's MUST BE NCCPA Certified AND** please provide a copy of your **Supervising Agreement** that is required by the Licensing Board.
- o **Proof of CME Hours:** (Chiropractors & Physical Therapist ONLY)
- o **ALL NURSES** must be **Board Certified**. ASPA does not accept Nurses that are not Board Certified. (**Please note this is not the same as being licensed with the State of Arizona**)
- o **A Current W9:** (the address listed **MUST MATCH** the address on the application or the Plans will not add the Provider)
- o **Current CLIA Certificate(s):** if applicable
- o **Please provide Current Fraud, Waste and Abuse Certificates for the applicant (See last page of Application)** (Please contact Karen with any questions, karen@azspa.com)
- o **NPI Assignment Letter(s)** (This can be from the **NPPES** website)
- o **AHCCCS ID Number Approval Letter**
- o **Medicare Approval Letter** (Letter from Noridian)

**ARIZONA STATE PHYSICIANS ASSOCIATION
STANDARD APPLICATION TO PARTICIPATE**

Please Type or Print Legibly. If more space is needed, use supplementary pages.
("SEE ATTACHED" "SEE CV", "SEE CAQH" ARE NOT ACCEPTED)

**DUE TO NEW STATE REQUIRMENTS, ALL APPLICATIONS MUST BE FILLED OUT COMPLETELY OR
IT WILL NOT BE PROCESSED. IF SOMETHING DOES NOT APPLY, PLUS PUT N/A.**

PERSONAL INFORMATION:

Title: _____ Last Name: _____ First Name: _____

Middle Name: _____ Suffix: _____ Salutations: Professional _____ Personal _____

Degree: _____ Date of Birth: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

Social Sec. # _____ - _____ - _____ E-Mail Address: _____

Primary Care: _____ Specialist: _____ Allied Health: _____ CAQH# _____ ASPA ID# _____

ALIAS:

Type: Maiden Name: _____ Other: _____

Title: _____ Last Name: _____ First Name: _____

Middle Name: _____ Suffix: _____ Start Date: _____ End Date: _____

Comment: _____

HOME AND PERSONAL INFORMATION:

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ Listed: _____ Telephone 2: _____ Listed: _____

Cell Phone: _____ Beeper: _____

Birthplace City: _____ State: _____ Country: _____

Languages(optional) _____ Write: _____ Read: _____ Speak: _____

Languages(optional): _____ Write: _____ Read: _____ Speak: _____

Citizenship: _____

If not a Citizen of the United States please indicate the status of your visa at the present time: _____

Ethnic/Race/Background(optional) _____ Date of Last Physical Exam: _____

Marital Status: _____ Spouse's Name: _____

CREDENTIALING CONTACT INFORMATION:

Contact Name: _____ Title: _____

Company Name: _____

Address: _____

Suite: _____ City: _____

State: _____ Zip Code: _____ Telephone: _____

Cell Phone: _____ Fax#: _____

E-Mail: _____

OFFICE INFORMATION: Beginning 02/01/2026, if your Provider has more than ONE Tax-ID, ASPA will charge a ONE-TIME fee of \$75.00 for each additional Tax-ID. The additional information WILL NOT be added until payment has been received.

Location #1 ☐ Primary Office ☐ Mailing Address ☐ Billing Address

Date started at this location: ____/____/____ Is Office Handicap Accessible?: Yes ____ No ____

Office Name: _____

Address: _____ Suite#: _____ City: _____

State: _____ Zip: _____ County: _____

Web Site: _____ E-mail: _____

EMR: YES NO EMR Company Name: _____ Electronic Claims: YES NO

Staff Languages: _____ Write: _____ Read: _____ Speak: _____

Staff Languages: _____ Write: _____ Read: _____ Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ Legal Name: _____

Legal Identity: ☐ PC ☐ PA ☐ LLC ☐ Other _____ Group NPI #: _____

Practice Status: ☐ Group ☐ Individual ☐ Partnership ☐ Employee Accepting New Patients: ____Yes ____No

Group Type: FQHC/RHC IC Multi Specialty Other (please explain)

CLIA Certificate #: _____ CLIA Certificate Expiration Date: _____
(Please provide copies for all practicing locations)

List Service you provide in this office: ____EKG ____GYN Exam ____Immunizations Other: _____

AGE LIMITS (Please check all that apply): ____ 0-18 ____ 18+ ____ All Ages

Days and Hours of Operation:

SUNDAY _____ THURSDAY _____

MONDAY _____ FRIDAY _____

TUESDAY _____ SATURDAY _____

WEDNESDAY _____

Office Contact:

Name: _____ Title: _____ Salutation: _____

Primary Contact: ____ Yes ____ No Type: ____ Office ____ Business ____ Insurance/ Billing ____ Administrator ____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other): _____

E-Mail: _____

#2 OTHER OFFICE LOCATION: ☐ Satellite Office ☐ Mailing Address ☐ Billing Address

Date started at this location: ____/____/____ Is Office Handicap Accessible?: Yes ____ No ____

Office Name: _____

Address: _____ Suite#: _____ City: _____

State: _____ Zip: _____ County: _____

Staff Languages: _____ Write: _____ Read: _____ Speak: _____

Staff Languages: _____ Write: _____ Read: _____ Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ Legal Name: _____

Legal Identity: ☐ PC ☐ PA ☐ LLC ☐ Other _____ Group NPI #: _____

Practice Status: ☐ Group ☐ Individual ☐ Partnership ☐ Employee Accepting New Patients: ____Yes ____No

CLIA Certificate #: _____ CLIA Certificate Expiration Date: _____
(Please provide copies for all practicing locations)

List Service you provide in this office: ____EKG ____GYN Exam ____Immunizations Other: _____

AGE LIMITS (Please check all that apply): ____ 0-18 ____ 18+ ____ All Ages

Days and Hours of Operation:

SUNDAY _____ THURSDAY _____

MONDAY _____ FRIDAY _____

TUESDAY _____ SATURDAY _____

WEDNESDAY _____

Office Contact:

Name: _____ Title: _____ Salutation: _____

Primary Contact: ____ Yes ____ No Type: ____ Office ____ Business ____ Insurance/ Billing ____ Administrator ____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other): _____

E-Mail: _____

3 OTHER OFFICE LOCATION: ☐ Satellite Office ☐ Mailing Address ☐ Billing Address

Date started at this location: ____/____/____ Is Office Handicap Accessible?: Yes ____ No ____

Office Name: _____

Address: _____ Suite#: _____ City: _____

State: _____ Zip: _____ County: _____

Staff Languages: _____ Write: _____ Read: _____ Speak: _____

Staff Languages: _____ Write: _____ Read: _____ Speak: _____

Telephone: _____ Back line: _____

Fax: _____ Answering Service: _____

Tax ID #: _____ Effective Date: _____ Legal Name: _____

 Legal Identity: ☐ PC ☐ PA ☐ LLC ☐ Other _____ Group NPI #: _____

 Practice Status: ☐ Group ☐ Individual ☐ Partnership ☐ Employee Accepting New Patients: ____Yes ____No

 CLIA Certificate #: _____ CLIA Certificate Expiration Date: _____
 (Please provide copies for all practicing locations)

List Service you provide in this office: ____EKG ____GYN Exam ____Immunizations Other: _____

AGE LIMITS (Please check all that apply): ____ 0-18 ____ 18+ ____ All Ages

Days and Hours of Operation:

SUNDAY _____ THURSDAY _____

MONDAY _____ FRIDAY _____

TUESDAY _____ SATURDAY _____

WEDNESDAY _____

Office Contact:

Name: _____ Title: _____ Salutation: _____

Primary Contact: ____ Yes ____ No Type: ____ Office ____ Business ____ Insurance/ Billing ____ Administrator ____

Consultant ____ Other: _____

Address if Different than Office: _____ Suite: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Phone: _____ Phone (Cell, other): _____

E-Mail: _____

LIST ADDITIONAL ADDRESS INFORMATION ON A SEPARATE SHEET OF PAPER

SUBMIT A W-9 FORM FOR EACH TAX ID NUMBER USED

SHARE CALL

List the names of physicians with whom you share call:

NAME: _____ Title: _____ Eff. date ____/____/____

Phone: _____ Fax: _____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/____/____

Phone: _____ Fax: _____

Hospital Privileges: _____

NAME: _____ Title _____ Eff. date ____/____/____

Phone: _____ Fax: _____

Hospital Privileges: _____

PHYSICIAN/PROVIDER SPECIALTIES: (ALL APPLICANTS HAVE A SPECIALTY)

My Primary Specialty: _____

Specialize or limit my Practice to: _____

Certified: YES NO Name of Board: _____

Cert. #: _____ Date: ____/____/____ Expires: ____/____/____ Original Cert Year _____

Re-Cert Year: _____ Not certified, are you eligible? ☐ YES ☐ NO Exam Date: _____Sub-Specialty: _____ Certified: ☐ YES ☐ NO

Cert. #: _____ Date: ____/____/____ Expires: ____/____/____ Original Cert Year _____

If not certified, are you eligible? ☐ YES ☐ NO Exam Date: _____HAVE YOU EVER BEEN EXAMINED BY ANY SPECIALTY BOARD, BUT FAILED TO PASS THE EXAMINATION?
☐ YES ☐ NO IF YES, EXPLAIN: _____****If you are a Physician Assistant, please provide the name(s) of your Supervising Physician(s):**

HOSPITAL / ADMIT LIST

PLEASE LIST ARIZONA HOSPITALS WHERE YOU HOLD PRIVILEGES INCLUDING ANY THAT ARE PENDING. IF MORE SPACE IS REQUIRED, ATTACH ADDITIONAL SHEET:

Are you a Hospital Based Provider: YES NO

HOSPITAL & ADDRESS DATES FROM & TO (Mo, day & Yr) PRIMARY HOSPITAL

#1 _____ / ____ / ____ TO ____ / ____ / ____ YES ____ NO ____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#2 _____ / ____ / ____ TO ____ / ____ / ____ YES ____ NO ____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#3 _____ / ____ / ____ TO ____ / ____ / ____ YES ____ NO ____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#4 _____ / ____ / ____ TO ____ / ____ / ____ YES ____ NO ____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#5 _____ / ____ / ____ TO ____ / ____ / ____ YES ____ NO ____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

#6 _____ / ____ / ____ TO ____ / ____ / ____ YES ____ NO ____

Phone: _____ Status _____ Any Gap in Privileges: _____ through _____

**IF YOU DO NOT HAVE HOSPITAL PRIVILEGES, PLEASE INDICATE WHO WILL BE ADMITTING FOR YOU
INCLUDE NAME OF ALL HOSPITALIST GROUPS USED:**

#1 Physician Name / Hospitalist Group Name: _____ **Title:** _____

Phone: _____ Fax: _____

Effective: ____ / ____ / ____ Through ____ / ____ / ____

#2 Physician Name / Hospitalist Group Name: _____ **Title:** _____

Phone: _____ Fax: _____

Effective: ____ / ____ / ____ Through: ____ / ____ / ____

**IF MORE THAN TWO PHYSICIANS OR GROUPS ARE USED, PLEASE SUPPLY THE SAME INFORMATION
ON A SEPARATE SHEET AND ATTACH.**

EDUCATIONAL BACKGROUND (Please provide ALL DATES in a MM/YYYY format)**MEDICAL/DENTAL COLLEGE**

University: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip code: _____ Attention: _____ Country: _____

From: ____/____/____ Through: ____/____/____ Date Graduated: ____/____/____

Degree Earned: _____ Specialty: _____

INTERNSHIP

University: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip code: _____ Attention: _____ Country: _____

From: ____/____/____ Through: ____/____/____ Date Graduated: ____/____/____

Degree Earned: _____ Specialty: _____

IF MORE THAN ONE INTERNSHIP WAS COMMENCED OR COMPLETED, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH

1 RESIDENCY

University: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip code: _____ Attention: _____ Country: _____

From: ____/____/____ Through: ____/____/____ Date Graduated: ____/____/____

Degree Earned: _____ Specialty: _____

#2 RESIDENCY

University: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip code: _____ Attention: _____ Country: _____

From: ____/____/____ Through: ____/____/____ Date Graduated: ____/____/____

Degree Earned: _____ Specialty: _____

IF MORE THAN TWO RESIDENCIES WERE COMMENCED OR COMPLETED, PLEASE SUPPLY THE ADDITIONAL INFORMATION ON A SEPARATE SHEET AND ATTACH.

FELLOWSHIP

University: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip code: _____ Attention: _____ Country: _____

From: ____/____/____ Through: ____/____/____ Date Graduated: ____/____/____

Degree Earned: _____ Specialty: _____

FELLOWSHIP #2

University: _____ Phone: _____

Address: _____ City: _____ State: _____

Zip code: _____ Attention: _____ Country: _____

From: ____/____/____ Through: ____/____/____ Date Graduated: ____/____/____

Degree Earned: _____ Specialty: _____

**IF MORE THAN ONE FELLOWSHIP WAS COMMENCED OR COMPLETED,
PLEASE SUPPLY THE ADDITIONAL INFORMATION ON A SEPARATE SHEET
AND ATTACH.**

PLEASE LIST ANY GAPS OF 180 DAYS OR MORE DURING EDUCATION:

FROM: ____/____/____ TO: ____/____/____ EXPLAIN: _____

FROM: ____/____/____ TO: ____/____/____ EXPLAIN: _____

FROM: ____/____/____ TO: ____/____/____ EXPLAIN: _____

FROM: ____/____/____ TO: ____/____/____ EXPLAIN: _____

FROM: ____/____/____ TO: ____/____/____ EXPLAIN: _____

FROM: ____/____/____ TO: ____/____/____ EXPLAIN: _____

If you need more space please attach information on a separate piece of paper.

LICENSE AND PROVIDER NUMBER INFORMATION

Provider NPI#: _____ Group NPI#: _____

Medicare Provider #: _____ Effective: _____

Accept Medicare Assignment? ☐ YES ☐ NO Group Medicare # _____

Medicaid/ AHCCCS Provider #: _____ Effective Date: _____

Medication Assisted Treatment Prescriber(MAT): YES NO

ECFMG Certificate #: _____ Issue Date: _____

DEA #: _____ DEA Expiration Date: _____

XDEA #: _____ X DEA Expiration Date: _____

Do You E-Prescribe: YES NO

Arizona License#: _____ Original Date Issued: _____ Effective: _____ Expires: _____

Original State Licensure: State: _____ Number: _____ Original Date issued: _____

List All Other State(s) And License Number(s) In Which You Are/Or Have Been Licensed To Practice:

_____ License #: _____ Effective Date: _____ EXPIRATION DATE: _____

_____ License #: _____ Effective Date: _____ EXPIRATION DATE: _____

_____ License #: _____ Effective Date: _____ EXPIRATION DATE: _____

_____ License #: _____ Effective Date: _____ EXPIRATION DATE: _____

_____ License #: _____ Effective Date: _____ EXPIRATION DATE: _____

LIABILITY CARRIERS:**Current: YES NO****Insurance Company Name:** _____

Address: _____ Suite: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Amount of Coverage: \$ _____ / _____ Policy #: _____

From: ____/____/____ To: ____/____/____ Certificate Holder: YES NO

Current: YES NO**Insurance Company Name:** _____

Address: _____ Suite: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Amount of Coverage: \$ _____ / _____ Policy #: _____

From: ____/____/____ To: ____/____/____ Certificate Holder: YES NO

FOR LIABILITY CARRIERS WITHIN THE PAST 10 YEARS – PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH. ATTACH COPIES OF YOUR CERTIFICATES FOR MALPRACTICE INSURANCE

REFERENCES

ON YOUR BEHALF, PLEASE HAVE THREE (3) LETTERS OF REFERENCE FORWARDED TO OUR OFFICE. **YOUR APPLICATION IS NOT CONSIDERED TO BE COMPLETE UNTIL THESE LETTERS ARE COMPLETED IN FULL BY YOUR PEER AND RECEIVED BY ASPA. PLEASE DO NOT HOLD THE APPLICATION WAITING FOR REFERENCES TO BE RETURNED TO YOU AS ASPA MAY HAVE ALREADY RECEIVED THEM.** REFERENCES WILL BE EVALUATED ACCORDING TO THE EXTENT OF THEIR DIRECT CLINICAL OBSERVATION OF YOUR WORK AND OTHER KNOWLEDGE OF YOU. LIST BELOW THE NAMES, ADDRESSES, AND PHONE NUMBERS OF THE **PHYSICIANS (OTHER THAN YOUR CURRENT ASSOCIATES) AND FORMER ASSOCIATES** WHO WILL BE SUPPORTING YOUR MEMBERSHIP IN ASPA. REFERENCE SHOULD BE FROM A PEER OF THE SAME SPECIALTY. **REFERENCES MUST BE FROM OTHER PHYSICIANS, MID LEVEL PROVIDERS(NURSES, PT'S, PA'S, ETC) ONLY DRS CAN FILL OUT FOR OTHER DRS AND MIDLEVELS. MID LEVELS CANNOT FILL OUT FOR DRS.** THE PEERS LISTED BELOW WILL BE USED ON PAGES 22-24 OF THIS APPLICATION.

Name: _____ Title: _____

Salutation: _____ Specialty: _____

Address: _____ Suite#: _____ City: _____

State: _____ Zip Code: _____ Country: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

☐ PROFESSIONAL

Name: _____ Title: _____

Salutation: _____ Specialty: _____

Address: _____ Suite # _____ City: _____

State: _____ Zip Code: _____ Country: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

☐ PROFESSIONAL

Name: _____ Title: _____

Salutation: _____ Specialty: _____

Address: _____ Suite # _____ City: _____

State: _____ Zip Code: _____ Country: _____ Phone Number: _____

Fax Number: _____ Email Address: _____

SOCIETIES, COLLEGES AND ACADEMIES

List Memberships In Professional Societies, Colleges, And Academies (Local, State Or National)

ORGANIZATION: _____ MEMBER SINCE: _____ THROUGH: _____

Elected or Appointed Position Held: _____

Elected or Appointed Position Held: _____

Elected or Appointed Position Held: _____

*******PLEASE ATTACH CURRICULUM VITAE WHICH INCLUDES YOUR WORK HISTORY*****
(Dates MUST BE in a MM/YYYY Format)*******

WORK HISTORY

Please list your work history starting with your current position of who you are being credentialed with. **Please provide dates in a MONTH/YEAR format.** If you need more room, please attach a separate piece of paper with the following information
("SEE CV" WILL NOT BE ACCEPTED)

#1 Name of Company _____ Dates From: ____/____/____ To: ____/____/____

Address: _____ Suite _____ City: _____ State: _____

Zip Code: _____ Country: _____ Phone: _____ Fax: _____

Position Held: _____ Primary Activity: _____

Contact Name: _____ Title: _____ Contact Phone: _____

#2 Name of Company _____ Dates From: ____/____/____ To: ____/____/____

Address: _____ Suite _____ City: _____ State: _____

Zip Code: _____ Country: _____ Phone: _____ Fax: _____

Position Held: _____ Primary Activity: _____

Contact Name: _____ Title: _____ Contact Phone: _____

#3 Name of Company _____ Dates From: ____/____/____ To: ____/____/____

Address: _____ Suite _____ City: _____ State: _____

Zip Code: _____ Country: _____ Phone: _____ Fax: _____

Position Held: _____ Primary Activity: _____

Contact Name: _____ Title: _____ Contact Phone: _____

#4 Name of Company _____ Dates From: ____/____/____ To: ____/____/____

Address: _____ Suite _____ City: _____ State: _____

Zip Code: _____ Country: _____ Phone: _____ Fax: _____

Position Held: _____ Primary Activity: _____

Contact Name: _____ Title: _____ Contact Phone: _____

PLEASE LIST ANY GAPS IN TIME (EMPLOYMENT) FOR SIX MONTHS OR MORE:

FROM: ___/___/___ TO: ___/___/___ EXPLAIN: _____

FROM: ___/___/___ TO: ___/___/___ EXPLAIN: _____

FROM: ___/___/___ TO: ___/___/___ EXPLAIN: _____

FROM: ___/___/___ TO: ___/___/___ EXPLAIN: _____

If you need more space please attach information on a separate piece of paper.

PHYSICIAN PHILOSOPHY:

1. DO YOU UNDERSTAND THE CONCEPT OF MANAGED HEALTH CARE AND ARE YOU WILLING TO WORK WITHIN THE GUIDELINES ESTABLISHED BY CONTRACTED HEALTH PLANS? ☐ YES ☐ NO

2. DO YOU RECOGNIZE AND ACCEPT THAT UTILIZATION REVIEW AND PEER REVIEW ARE FUNDAMENTAL PRINCIPLES OF THIS ORGANIZATION? ☐ YES ☐ NO

3. DO YOU AGREE THAT MEDICAL RECORDS/CHARTS WILL BE AVAILABLE FOR UTILIZATION/QUALITY ASSURANCE REVIEW? ☐ YES ☐ NO

4. ARE YOU WILLING TO ACTIVELY PARTICIPATE ON ANY COMMITTEES REPRESENTING THIS ORGANIZATION (i.e., CREDENTIALING, QA/UR, BOARD OF DIRECTORS)? ☐ YES ☐ NO

5. WOULD YOU BE AVAILABLE TO PROVIDE EDUCATIONAL PROGRAMS IN YOUR SPECIALTY FOR MEMBERS OF THIS ORGANIZATION? ☐ YES ☐ NO

FAILURE TO ANSWER THE FOLLOWING QUESTIONS TRUTHFULLY WILL RESULT IN DENIAL OF MEMBERSHIP IF YOU ANSWER "YES" TO ANY OF THE QUESTIONS IN THIS SECTION, PLEASE GIVE A FULL EXPLANATION OF THE DETAILS ON A SEPARATE SHEET AND ATTACH HERETO.	YES	NO
1. ASIDE FROM THE ROUTINE CREDENTIALS SCRUTINY (INCLUDING ROUTINE REVIEW OF A SAMPLING OF YOUR CHARTS) WHICH OCCURRED AT YOUR INITIAL APPOINTMENT OR YOUR REAPPOINTMENT TO THE MEDICAL STAFFS OF HOSPITALS AT WHICH YOU HAVE OBTAINED CLINICAL PRIVILEGES, HAVE YOU EVER BEEN THE SUBJECT OF A PEER REVIEW PROCEEDING, INQUIRY OR INVESTIGATION? THIS INCLUDES, BUT IS NOT LIMITED TO, THE COMMENCEMENT OF A PROCEEDING BEFORE A MEDICAL STAFF REQUESTING ANY FORM OF CORRECTIVE ACTION INCLUDING REPRIMAND SUSPENSION OF PRIVILEGES, OR REVOCATION OF MEDICAL STAFF MEMBERSHIP, AND COVERS ALL SUCH PROCEEDINGS REGARDLESS OF THE FINAL OUTCOME.		
2. SINCE MEDICAL SCHOOL, HAVE YOU RESIGNED FROM A HOSPITAL OR RELINQUISHED CLINICAL STAFF PRIVILEGES TO AVOID DISCIPLINARY ACTIONS?		
3. HAVE YOU SUBMITTED AND SUBSEQUENTLY WITHDRAWN AN APPLICATION FOR MEDICAL STAFF MEMBERSHIP SINCE MEDICAL SCHOOL?		
4. HAVE ANY INVESTIGATIVE ACTIONS PAST OR PRESENT BEEN INITIATED OR ARE ANY PENDING AGAINST YOU BY ANY STATE LICENSURE BOARD?		
5. HAS ANY STATE LICENSURE BOARD ISSUED ANY LETTERS OF CONCERN/ADVISORY LETTERS TO YOU SINCE MEDICAL SCHOOL?		
6. SINCE MEDICAL SCHOOL HAVE YOU VOLUNTARILY SURRENDERED OR HAD YOUR LICENSE TO PRACTICE MEDICINE DENIED, REFUSED, RESTRICTED, SUSPENDED, REVOKED OR CENSURED IN THIS OR ANY OTHER JURISDICTION?		

7. SINCE MEDICAL SCHOOL, HAVE YOU HAD YOUR MEMBERSHIP IN ANY PROFESSIONAL OR SPECIALTY ORGANIZATION, HMO, PPO, MEDICARE, AHCCCS/MEDICAID OR OTHER PREPAID HEALTH PLAN PARTICIPATION, OR HOSPITAL STAFF DENIED, REFUSED, SANCTIONED, SUSPENDED OR REVOKED?		
8. SINCE MEDICAL SCHOOL, HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION BY ANY PRIVATE, FEDERAL, OR STATE AGENCY CONCERNING YOUR PARTICIPATION IN ANY PRIVATE, FEDERAL, OR STATE HEALTH INSURANCE PROGRAM?		
9. SINCE MEDICAL SCHOOL, HAVE YOU HAD YOUR LICENSE TO PRESCRIBE OR DISPENSE NARCOTICS REFUSED, SUSPENDED OR REVOKED?		
10. IS YOUR NARCOTICS REGISTRATION CERTIFICATE CURRENTLY BEING CHALLENGED?		
11. SINCE MEDICAL SCHOOL HAVE YOU BEEN NAMED AS A DEFENDANT IN ANY CRIMINAL PROCEEDING?		
12. SINCE MEDICAL SCHOOL HAVE YOU BEEN CONVICTED OF A FELONY OR ANY CRIME OTHER THAN A TRAFFIC OFFENSE?		
13. HAVE YOU HAD A JUDGMENT RENDERED AGAINST YOU IN ANY COURT ON A CLAIM ALLEGING PROFESSIONAL MALPRACTICE OR PROFESSIONAL NEGLIGENCE SINCE MEDICAL SCHOOL?		
14. AT ANY TIME SINCE MEDICAL SCHOOL, HAS ANYONE ASSERTED (REGARDLESS OF OUTCOME) A CLAIM AGAINST YOU ALLEGING PROFESSIONAL MALPRACTICE OR PROFESSIONAL NEGLIGENCE?		
15. HAVE YOU ANY MENTAL ILLNESS, CHRONIC ILLNESS, OR PHYSICAL DEFECT THAT MAY ADVERSELY AFFECT YOUR ABILITY TO PRACTICE MEDICINE?		
16. HAVE YOU TESTED POSITIVE FOR ANY CONTAGIOUS HEALTH CONDITION THAT WOULD ENDANGER PATIENTS YOU ARE TREATING?		
17. DO YOU NOW OR HAVE YOU EVER HAD AN ALCOHOL OR DRUG DEPENDENCY?		
18. DO YOU CURRENTLY USE ILLEGAL DRUGS?		
19. ARE YOU CURRENTLY TAKING ANY MEDICATION THAT MAY AFFECT EITHER YOUR CLINICAL JUDGMENT OR MOTOR SKILLS?		
20. DO YOU HAVE ANY LIMITATIONS ON YOUR HEALTH, LIFE OR DISABILITY INSURANCE?		
21. SINCE MEDICAL SCHOOL, HAVE YOU BEEN DENIED HEALTH, LIFE, OR DISABILITY INSURANCE?		
22. ARE YOU CURRENTLY UNDER ANY LIMITATIONS CONCERNING YOUR ACTIVITIES OR WORKLOAD?		
23. HAS YOUR PROFESSIONAL LIABILITY INSURANCE COVERAGE BEEN TERMINATED BY ACTION OF THE INSURANCE COMPANY SINCE MEDICAL SCHOOL?		
24. HAVE YOU BEEN DENIED PROFESSIONAL LIABILITY INSURANCE?		
25. HAS YOUR PRESENT PROFESSIONAL LIABILITY INSURANCE CARRIER EXCLUDED ANY SPECIFIC PROCEDURES FROM YOUR COVERAGE?		

POSITIONS AND MEMBERSHIPS

FACILITY POSITIONS: (DOES NOT INCLUDE STAFF MEMBERSHIPS, I.E. HOSPITALS, MED SCHOOLS, ETC.)

NAME OF FACILITY: _____

FROM ____/____/____ TO ____/____/____

POSITION: _____

NAME OF FACILITY: _____

FROM ____/____/____ TO ____/____/____

POSITION: _____

IF NEEDED FOR ADDITIONAL POSITIONS, PLEASE SUPPLY THE SAME INFORMATION ON A SEPARATE SHEET AND ATTACH HERETO.

HAVE YOU SERVED OR ARE YOU CURRENTLY SERVING IN THE US MILITARY? ☐ YES ☐ NO
 (PLEASE INCLUDE DISCHARGE PAPERS.)

I verify that the information contained in this application is accurate and complete to the best of my knowledge. I understand that: it is my responsibility and to produce adequate information in a timely manner; any omissions or misrepresentations may result in an automatic denial of application or termination of ASPA membership; and that this application will not be processed until application is deemed complete by ASPA, and that it is my responsibility to provide all information requested to make a complete application.

Signature: _____

DATE: _____

PRINT NAME HERE: _____

BEHAVIORAL HEALTH PROVIDERS ONLY (COMPLETE PAGES 15 THROUGH 17)

PLEASE ATTACH A COPY OF YOUR CERTIFICATES

EDUCATION AND HIGHEST DEGREE:

HIGHEST DEGREE IN SOCIAL WORK/COUNSELING YOU HAVE ATTAINED (CHECK ONE):

☐ ASSOCIATE OF ARTS ☐ BACHELOR'S DEGREE ☐ MASTER'S DEGREE ☐ DOCTORAL DEGREE

HIGHEST DEGREE EARNED IN (CHECK ONE):

☐ Ph.D ☐ Ed.D ☐ Psy.D ☐ Other (Specify) _____

INDICATE THE SPECIFIC PROGRAM/TRACK, DEPARTMENT AND INSTITUTION GRANTING THIS DEGREE:

NAME & ADDRESS OF INSTITUTION:

NAME OF DEPARTMENT/SCHOOL: _____

NAME OF SPECIFIC PROGRAM/TRACK: _____

YEAR IN WHICH DEGREE WAS CONFERRED: _____

DID YOU COMPLETE A FORMAL RESPECIALIZATION PROGRAM IN CLINICAL COUNSELING OR SCHOOL PSYCHOLOGY AFTER COMPLETION OF DOCTORAL DEGREE IN PSYCHOLOGY? ☐ YES ☐ NO

IF YES, WAS THIS RESPECIALIZATION PROGRAM OFFERED BY A DOCTORAL PROGRAM THAT WAS ACCREDITED BY APA? ☐ YES ☐ NO NAME OF PROGRAM: _____

PSYCHOLOGIST:

WAS YOUR FORMAT INTERNSHIP OR ORGANIZED HEALTH SERVICE TRAINING PROGRAM:

☐ FULL-TIME BASIS ☐ PART-TIME BASIS

WAS THIS TRAINING AT: ☐ ONE SITE ☐ TWO OR MORE SITES

INDICATE TOTAL NUMBER OF HOURS SUPERVISED EXPERIENCED THAT YOU RECEIVED IN EACH INTERNSHIP:

SITE ONE _____ SITE TWO _____ OTHER SITES _____ TOTAL HOURS _____

INTERNSHIP SITE ONE:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF INTERNSHIP: FROM: _____ TO: _____

HOURS SPENT PER WEEK IN INTERNSHIP: _____

YOUR TITLE IN INTERNSHIP: _____

NAME OF TRAINING DIRECTOR: _____

NAME & TITLE OF DIRECT SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

DID YOUR DIRECTOR OF DOCTORAL TRAINING APPROVE THE INTERNSHIP AS PART OF THE REQUIREMENTS OF THE DEGREE? ☐ YES ☐ NO

INTERNSHIP SITE TWO:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF INTERNSHIP: FROM: _____ TO: _____

HOURS SPENT PER WEEK IN INTERNSHIP: _____

YOUR TITLE IN INTERNSHIP: _____

NAME OF TRAINING DIRECTOR: _____

NAME & TITLE OF DIRECT SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

DID YOUR DIRECTOR OF DOCTORAL TRAINING APPROVE THE INTERNSHIP AS PART OF THE REQUIREMENTS OF THE DEGREE? ☐ YES ☐ NO

INDICATE TOTAL NUMBER OF HOURS SUPERVISED POST-DOCTORAL EXPERIENCED THAT YOU RECEIVED IN EACH SITE:

SITE ONE _____ SITE TWO _____ OTHER SITES _____ TOTAL HOURS _____

POSTDOCTORAL SITE ONE:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF POST-DOCTORAL EXPERIENCE: FROM: _____ TO: _____

HOURS SPENT PER WEEK: _____

YOUR TITLE IN THIS SETTING: _____

NAME OF SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

POSTDOCTORAL SITE TWO:

NAME OF FACILITY _____

ADDRESS _____

TYPE OF EMPLOYMENT SETTING _____

DATES OF POST-DOCTORAL EXPERIENCE: FROM: _____ TO: _____

HOURS SPENT PER WEEK: _____

YOUR TITLE IN THIS SETTING: _____

NAME OF SUPERVISOR: _____

HOURS OF INDIVIDUAL, DIRECT SUPERVISION RECEIVED PER WEEK: _____

SOCIAL WORKER/COUNSELOR:

NAME OF FACILITY/EMPLOYMENT: _____

ADDRESS: _____

NAME OF SUPERVISOR: _____

DEGREE: _____ TELEPHONE: _____ DATES FROM/TO: _____

☐ FULL-TIME ☐ PART-TIME ☐ HALF-TIME OR MORE

DESCRIBE NATURE OF WORK: _____

NAME OF FACILITY/EMPLOYMENT: _____

ADDRESS: _____

NAME OF SUPERVISOR _____

DEGREE: _____ TELEPHONE: _____ DATES FROM/TO: _____

☐ FULL-TIME ☐ PART-TIME ☐ HALF-TIME OR MORE

DESCRIBE NATURE OF WORK: _____

STATEMENT OF INFORMATION RELEASE

All information in this application is true to my best knowledge and belief. I understand that any misleading statement or material omission in this application may constitute cause for denial or cancellation of membership.

By applying to, and/or continuing participation as a member in the Arizona State Physicians Association (ASPA), I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including ASPA and its agent(s), engaged in quality assessment, peer review and credentialing on behalf of ASPA, and all persons and entities providing credentialing information to such representatives of ASPA, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in ASPA, to the extent that those acts and/or communications are protected by state or federal law.

I authorize any third parties (including, but not limited to, individuals, agencies, medical groups, corporations, companies, employers, hospitals, health plans, licensing agencies, insurance companies, medical societies, etc.) to release information concerning my qualifications, credentials, clinical competence, quality insurance data, information pertaining to character, physical or mental health condition, behavior, ethics, claims history, disciplinary action, or any other matter reasonably having a bearing on his or her qualifications. I further authorize ASPA to release my completed credentialing file to any organization where I have applied for membership or participation and ASPA is the delegated credentialing entity.

A photocopy of this waiver shall be as effective as the original when so presented and shall be considered valid for a minimum of three (3) years from the date of signing.

NAME: _____

SIGNATURE: _____ DATE: _____

MEMORANDUM OF UNDERSTANDING

Arizona State Physicians Association (ASPA) is a physician initiated and controlled organization which seeks to form an economic unit to promote delivery to the public of high quality, cost effective medical care through managed care and peer review techniques. Membership rights should not be considered an investment for profit and will not be transferable. Membership is limited to licensed health care providers who reside in Arizona and practice their profession in Arizona.

The ultimate accomplishment of the goals of ASPA cannot be guaranteed and membership as a physician provider does not ensure your participation in all ASPA contracts.

An Application for Participation in ASPA is attached. With the accompanying completed application for participation, please enclose the appropriate non-refundable credentialing processing fee indicated on attached instructional letter. By signing below, you agree that this fee is reasonable and it implies no obligation by ASPA to accept you as a member in ASPA.

Upon signing and returning this memorandum, together with the non-refundable processing fee (payable to ASPA), and application, the credentialing process will begin. You will maintain the right to review all information obtained by ASPA to evaluate the credentialing application. This review excludes confidential references, recommendations, or other information that is Peer Review Protected. Your completed application and other information will be reviewed by the Central Credentialing Committee composed of members from each Operating Division, or Arizona State Physicians Associations designee. Approval must be gained from this committee or designee, the Utilization and Quality Review Committee and the Board of Directors of ASPA. Such evaluation constitutes a peer review action under the Health Care Quality Improvement Act of 1986. Accordingly, any adverse decision based upon your competence or professional conduct is required to be reported to the State Board of Medical Examiners or the State Board of Osteopathic Examiners, or other appropriate State Authorities. By execution and delivery to Arizona State Physicians Association of this application, you hereby acknowledge receipt of this notice.

Print Name: _____

SIGNATURE:

DATE:

Arizona State Physicians Association
3030 North Central Avenue, Suite 1106
Phoenix, AZ 85012 / 602-265-2524
REVISED 01/28/2020

Arizona State Physician's Association License Actions Report

PHYSICIAN NAME: _____

Please supply the following information for each Open or Dismissed Investigation; Advisory Letter; Letter of Reprimand; Decree of Censure; Suspension of License; Loss of License; Loss or Restriction of DEA License; or Probation, made in the past ten (10) years to allow proper review and evaluation by the credentials committee. If more than one license action exists, please photocopy this page and submit information for each. A full disclosure of the following details is necessary prior to completion of credentialing. All information will be kept in strict confidence. Attach any related correspondence, including letters of dismissal, etc. **PLEASE DO NOT INCLUDE ANY PATIENT NAMES IN REPORT(S)**

Allegation: _____

Condition and diagnosis at time of incident: _____

Treatment and procedures provided: _____

Patient condition subsequent to treatment: _____

Final outcome of the action: _____

Your relationship to Patient: ☐ PCP ☐ Surgeon ☐ Assistant Surgeon ☐ Consultant

Other: _____

Incident Location: _____ Date: _____

TYPE of ACTION: Open Investigation ☐ Dismissed Complaint ☐ Advisory Letter ☐

Letter of Reprimand ☐ DeCree of Censure ☐ Probation ☐ Loss of License ☐

Restricted License ☐ Other ☐ _____

I understand information submitted herein becomes part of my application as submitted.

Signature: _____ Date: _____

Arizona State Physician's Association
Malpractice Claim Report

PHYSICIAN NAME: _____

Please supply the following information for each malpractice claim made or settled in the past five (5) years to allow proper review and evaluation by the credentials committee. If more than one malpractice action exists, please photocopy this page and submit information for each. A full disclosure of the following details is necessary prior to completion of credentialing. All information will be kept in strict confidence. **PLEASE DO NOT INCLUDE ANY PATIENT NAMES IN REPORT(S)**

Allegation: _____

Condition and diagnosis at time of incident:

Treatment and procedures provided: _____

Patient condition subsequent to treatment:

Final outcome of the claim: _____

Your relationship to Patient: ☐ PCP ☐ Surgeon ☐ Assistant Surgeon ☐ Consultant

Other: _____

Incident Location: _____ Date: _____ Insurance Carrier: _____

YOUR STATUS: ☐ Primary Defendant ☐ Co-defendant ☐ Other (Describe) _____

Claim Disposition: ☐ Open ☐ Closed by Dismissal ☐ Closed Date Closed: _____

Amount of settlement / Judgment: _____ Amount paid on YOUR behalf: _____

I understand information submitted herein becomes part of my application as submitted.

Signature: _____ **Date:** _____

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name): _____

FROM: _____ (Please Print) TITLE: _____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ SPECIALTY: _____

ADDRESS: _____

CITY, STATE ZIP: _____ PHONE: _____ FAX: _____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
Sense of Responsibility			Clinical Competence		
Technical Skill			Medical Record Completion		
Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation - Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS: _____

ADDITIONAL COMMENTS ARE APPRECIATED: _____

PHYSICAL SIGNATURE OF RECOMMENDING PHYSICIAN

(typed in signatures will not be accepted, peer MUST physically sign)

DATE: _____

Return to: ARIZONA STATE PHYSICIANS ASSOCIATION, INC
 3030 North Central Avenue, Suite 1106, Phoenix, AZ 85012
 602-265-2524/800-522-9619
 Direct Fax: 623-999-1054
 Email: angie@azspa.com

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name): _____

FROM: _____ (Please Print) TITLE: _____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ SPECIALTY: _____

ADDRESS: _____

CITY, STATE ZIP: _____ PHONE: _____ FAX: _____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
Sense of Responsibility			Clinical Competence		
Technical Skill			Medical Record Completion		
Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation - Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS: _____

ADDITIONAL COMMENTS ARE APPRECIATED: _____

PHYSICAL SIGNATURE OF RECOMMENDING PHYSICIAN

(typed in signatures will not be accepted, peer MUST physically sign)

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 Email: angie@azspa.com

PEER REFERENCE MUST BE FROM PEER NOT AFFILIATED WITH YOUR PRACTICE

Re: Reference for (Applicant Name): _____

FROM: _____ (Please Print) TITLE: _____

ARE YOU A MEMBER OF ASPA? YES ☐ NO ☐ SPECIALTY: _____

ADDRESS: _____

CITY, STATE ZIP: _____ PHONE: _____ FAX: _____

EMAIL ADDRESS: _____

Please base your evaluation of the following factors on the applicant's demonstrated performance compared to that reasonably expected of a physician with a similar level of training, experience, and background.

	FAVORABLE	UNFAVORABLE		FAVORABLE	UNFAVORABLE
Basic Medical Knowledge			Professional Judgment		
Sense of Responsibility			Clinical Competence		
Technical Skill			Medical Record Completion		
Quality of Medical Records			Patient Management		
Physician/Patient Relationship			Relationship with Nursing Staff		
Cooperation - Ability to Work with Others			Ability to Understand, Speak and Write English		

RECOMMEND WITHOUT RESERVATION? YES ☐ NO ☐ DO NOT RECOMMEND: YES ☐ NO ☐

RECOMMEND WITH THE FOLLOWING RESERVATIONS: _____

HOW MANY YEARS HAVE YOU KNOWN THE APPLICANT? _____

WHAT IS YOUR RELATIONSHIP TO THE APPLICANT? _____

MY GENERAL IMPRESSION OF THE APPLICANT IS: _____

ADDITIONAL COMMENTS ARE APPRECIATED: _____

PHYSICAL SIGNATURE OF RECOMMENDING PHYSICIAN

(typed in signatures will not be accepted, peer MUST physically sign)

DATE: _____

Return to: ARIZONA STATE PHYSICIANS ASSOCIATION, INC
 3030 North Central Avenue, Suite 1106, Phoenix, AZ 85012
 602-265-2524/800-522-9619
 Direct Fax: 623-999-1054
 Email: angie@azspa.com



Practitioner/Provider Name: _____

Additional Items: (please answer the following questions) (These questions are now being REQUIRED by ALL ASPA Plans)

1. Do you provide services to individuals with Physical Special Needs/Chronic Conditions?

YES NO

2. Do you Provide Services to individuals with Developments Special Needs/Chronic Conditions?

YES NO

3. Do you provide services to individuals with Behavioral Special Needs/Chronic Conditions?

YES NO

4. Do you provide services to individuals with Emotional Special Needs/Chronic Conditions?

YES NO

5. Do you provide services to individuals who have Difficulty with Communication or Cooperating (ie: Autism or Intellectual Disabilities)?

YES NO

6. Do you provide services to individuals with Mobility Limitations (ie: Wheelchair bound)?

YES NO

7. Do you treat Anxiety?

YES NO

8. Do you treat ADHD?

YES NO

9. Do you treat Depression?

YES NO

10. Do you Treat HIV:

YES NO

11. Do you treat Substance Abuse?

YES NO

12. PCP's and OB/GYN's ONLY: You do provide EPSDT Services?

YES NO

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

YES NO

14. Do you participate in VFC (Vaccines for Children under 18)

YES NO (if YES), please provide your VFC Pin Code _____

15. CAQH# _____

16. Do you offer Telemed Services

YES NO

17. Line of Business: (choose all that apply):

Medicaid Medicare Commercial

18. Are you a Medication Assisted Treatment Prescriber (MAT)?

YES NO

19. Do you have a XDEA? (if yes, please provide certificate)

YES NO

20. Do you E-Prescribe?

YES NO



www.azspa.com

Fraud Waste and Abuse Training and General Compliance

ASPA is contracted with plans that have Medicare and AHCCCS products. It is a requirement of ASPA through our delegation with our contracted plans, we show proof that our Members are in compliance with all training and policy requirements under CMS and AHCCCS. Going forward ASPA will require this attestation to be completed, and kept in our records.

2026

Here are FOUR options to complete the compliance training requirements. Please select the method by which your practice chose to comply (check one):

- ☐ Completed the General Compliance and/or FWA training modules located on the CMS MLN. Once an individual completes each of the modules, the MLN system will generate a certificate of completion.
- ☐ Downloaded and incorporated the content of the CMS standardized training modules from the CMS website into your Practices existing compliance training materials/systems.
- ☐ Incorporated the content of the CMS training modules into written documents for the practice (e.g. provider guides, participation manuals, business association agreements, etc.
- ☐ **THIS PRACTICE DOES NOT TREAT/PARTICIPATE WITH ANY MEDICARE OR AHCCCS PRODUCTS/PATIENTS**

CMS Compliance Program requirements are located in Chapter 9 and 21 of the Medicare Care Manual.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html>

AHCCCS Compliance Program is located in the AHCCCS Contractor Operations Manual (Policies 103, 104, and 438); the AHCCCS Medical Policy Manual (AMPM): <https://azahcccs.gov/PlansProviders/GuidesManualsPolicies/index.html>

Copies of Compliance Programs of our contracted plans will be posted on the ASPA Web site www.azspa.com

Attestation and Participation Acknowledgement

By signing below I attest that the practice identified below, and any participating providers, employees and contractor (including temporary employees and volunteers) therein, comply with the Medicare/AHCCCS Compliance and FWA training requirements for **2026** as marked above.

Practice Name: _____

Signature (of individual with legally finding authority): _____ Date _____

Print Name and Title: _____

Tax ID: _____ Group NPI: _____ Phone: _____

Email _____

Attach a list of all employees including providers, training certificates and a current W9.

Questions: tonya@azspa.com