2700 N. Central Ave. |Ste. 810| Phoenix, AZ 85004
602-252-4042 or 800-624-4277 | providerrelations@azfmc.com
Fax; 602-495-8684

Provider Change Form

Please note: Provider is entirely responsible for keeping Arizona Foundation informed about current practice information.

If Arizona Foundation does not receive updated information from the provider in writing, we will continue to send correspondence to the address currently in our database. Arizona Foundation will not be responsible for lost or returned mail if we do not receive this completed form from the provider at least five (5) days prior to the effective date of change.

Please complete all applicable information, including REQUIRED fields (required fields are in red). Failure to complete required fields may result in the request not being processed. Please allow 5-7 business days for this request to be processed. If you should have any questions, please contact Arizona Foundation's Provider Relations Team at 800-624-4277.

Type of Change: _____

If you select other, please list your type of change here: _____

Provider Name- Please List Current Provider Information

Last Name: _____ M _____ First Name: _____

Tax ID#: _____ Corp. Name: _____

AZ. License #: _____ Email: _____

Specialty Change

Primary: _____ Board Certified: ☐ Yes (Req Documentation) ☐ No

Secondary: _____ Board Certified ☐ Yes (Req Documentation) ☐ No

Tax ID Change

Termed TIN: _____ Effective Date: _____

New/Replacement TIN: _____ Effective Date: _____

New/Additional TIN: _____ Effective Date: _____

Reason for TIN: _____

Address – Please make sure to list phone and fax numbers. Also, please note that as of September 1, 2010, AFMC requires that all addresses have a full zip code, including Zip +4. Each physician must also have at least one physical address. Therefore, PO Box will no longer be accepted as a physician's only active address.

Tax ID: ______________________ Address: ______________________

City: ______________________ State: ____________ Zip Code +4: ____________

Phone Number: ____________ Fax Number: ____________ Email: ____________

☐Term ☐Add ☐Office ☐Mailing ☐Billing

Tax ID: ______________________ Address: ______________________

City: ______________________ State: ____________ Zip Code +4: ____________

Phone Number: ____________ Fax Number: ____________ Email: ____________

☐Term ☐Add ☐Office ☐Mailing ☐Billing

Tax ID: ______________________ Address: ______________________

City: ______________________ State: ____________ Zip Code +4: ____________

Phone Number: ____________ Fax Number: ____________ Email: ____________

☐Term ☐Add ☐Office ☐Mailing ☐Billing

Tax ID: ______________________ Address: ______________________

City: ______________________ State: ____________ Zip Code +4: ____________

Phone Number: ____________ Fax Number: ____________ Email: ____________

☐Term ☐Add ☐Office ☐Mailing ☐Billing

Signature: ______________________________

Date: ____________________

To Fax this form to Arizona Foundation, please follow these easy steps:

1. Fill out the form.
2. Print Form
3. Sign the form and fax to: Arizona Foundation Provider Relations Team at 602-495-8684

Last updated 09.25.17