Credentialing Application / Information Form
for AZ Network Medical Practitioners

Thank you for your interest in becoming a contracted provider. In order to complete the contracting process with the P3 Health Partners Network, you must sucessfully complete the credentialing process.

REQUIRED: **Professional providers are required to register with CAQH and complete a provider profile to be used for initial credentialing and subsequent renewals.**

1) **Register with CAQH and complete your provider profile** - Register for free and complete your profile online at: *ProView.CAQH.org*
2) **Authorize P3 Health Partners to access information -** Use the "Authorize" section in ProView to authorize P3 to access your information
3) **Provide your CAQH provider ID number -** Enter your CAQH provider ID number in the firsh field of the form below
4) **Complete the P3 Application Form** - Complete the entire form below and then save, attach and email the form to: **P3Credentialing@p3hp.org**
5) **Update CAQH regularly -** Review, update with changes and re-attest your CAQH provider file as required quarterly.

The completion of this application / information form does not guarantee network participation. Additional documentation may be required to validate and provide detail on some responses.

NOTE: Any missing items or incomplete required fields may cause significant delays.

Section	Fields			
CAQH Provider ID *(Required)*	CAQH Provider ID Number			
PROVIDER NAME and DEGREE *attach a copy of your Degree(s)* *(Required)*	Last	First	MI	Degree (MD, DO, Etc)
	Gender	Date of Birth (mm/dd/yyyy)	SSN	Birth Place (City & State)
OTHER NAME(S) USED	Last	First	MI	
INDIVIDUAL NPI *(Required)*	Individual NPI	Effective Date (mm/dd/yyyy)		
MEDICAL LICENSE *attach a copy of you medical license* *(Required)*	License Number	Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	
OTHER ID NUMBERS *attach copy(s) of all licensure* *(Required)*	DEA # ______________________	Expiration Date: _____ / _____ / __________		
	Pharmacy/CS # ______________________	Expiration Date: _____ / _____ / __________		
	Medicare PTAN # ______________________			
	Medicaid # & State ______________________			
ARE YOU ACCEPTING NEW PATIENTS? *(Required)*	☐ YES	☐ NO		
GROUP NAME Claim payments may be made to the Group Name / NPI Number *(Required)*	Group Legal Name - as on file with the IRS			
	Group DBA (Doing Business As) Name			
	Group / Organization NPI			
TAX ID and START DATE *(Required)*	Tax ID Number	Date when group started billing with this Tax ID #		
OFFICE CONTACT *(Required)*	Name	Title		
	Office Contact Email Address	Phone	Fax	

SPECIALTY / TAXONOMY			
Please note, what you indiciate as your practicing specialty(s) will be how you are listed in the P3 Health Partners directories *(Required)*	Check applicable box	☐ Hospital Based	☐ Office Based
	Primary Practicing Specialty		
	Other Practicing Specialty(s) as applicable		
	Individual Taxonomy		

SPECIALTY BOARD CERTIFIED If YES, please attach a copy of Board Certificate *(Required)*			
	Board Certified?	☐ YES	☐ NO
	Name of Specialty Board		Certificate #
	Certified (mm/dd/yyyy)	Recertified (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

ADDITIONAL SPECIALTY BOARD CERTIFIED If YES, please attach a copy of Board Certificate *(Required)*			
	Board Certified?	☐ YES	☐ NO
	Name of Specialty Board		Certificate #
	Certified (mm/dd/yyyy)	Recertified (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)

INDIAN HEALTH CARE *(Required)*	Are you an Indian Health Care Provider?
	☐ YES ☐ NO

OTHER LANGUAGES SPOKEN BY PROVIDER	1)	2)	3)

HOSPITAL/SNFs/SURGERY FACILITY PRIVILEGES *(Required)* If space for additional facilities is needed, please attach a separate sheet.

FACILITY NAME:	**PRIVILEGE TYPE:**
FACILITY ADDRESS	**FACILITY PHONE:**
FACILITY NAME:	**PRIVILEGE TYPE:**
FACILITY ADDRESS	**FACILITY PHONE:**
FACILITY NAME:	**PRIVILEGE TYPE:**
FACILITY ADDRESS	**FACILITY PHONE:**
FACILITY NAME:	**PRIVILEGE TYPE:**
FACILITY ADDRESS	**FACILITY PHONE:**

BUSINESS WEBSITE *(Required)*	Website:

BUSINESS EMAIL *(Required)*	Provider Business Email (contracts and coorespondence must be sentnto the provider, not to a billing company or a consultant)

PRIMARY ADDRESS
Primary address must be a physical location where services are performed. *If there are additional locactions, attach a separate sheet.*
(Required)

Street Address		Suite
City	State	Zip
Phone	Fax	

Office Hours	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Start time							
End Time							

BILLING ADDRESS
Contracted provider payments will be sent to this address
(Required)

Street Address		Suite
City	State	Zip
Phone	Fax	

MAILING ADDRESS If no address is specified, correspondence will be sent to the billing address	Street Address		Suite
	City	State	Zip
	Phone	Fax	
CREDENTIALING COORESPONDENCE If no address is specified, correspondence will be sent to the billing address	Street Address		Suite
	City	State	Zip
	Phone	Fax	
MEDICAL RECORDS If no address is specified, correspondence will be sent to the billing address	Street Address		Suite
	City	State	Zip
	Medical Records Email	Phone	Fax

ADDITIONAL INFORMATION / COMMENTS:

Authorized Provider Signature: I, ____ (name & title), and I verify that the information provided on this form and in CAQH is current and accurate. I agree that by signing my name in the field below, I am verifying the information as provided.

____ ______________________________

Provider Signature **Date**

EMAIL THE ENTIRE FORM *and* ATTACHMENTS TO: P3Credentialing@p3hp.org