



Our first care is your health care

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Janet Napolitano, Governor
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Provider Address Update Form (Completed W-9 Must Be Included)

NAME (Last, First, M.I.): _____	NPI # _____
AHCCCS PROVIDER ID#: _____	SOCIAL SECURITY #: _____

CHECK ONE:

ADD ADDITIONAL INFORMATION

REPLACE EXISTING INFORMATION

NOTE: Form will be returned if not completed.

CORRESPONDENCE ADDRESS

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () _____ - _____ EMERGENCY PHONE: () _____ - _____

ATTENTION TO: _____

PAY-TO ADDRESS (SITE 01)

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () _____ - _____ EMERGENCY PHONE: () _____ - _____

ATTENTION TO: _____

EMPLOYER TAX ID# _____ BEGIN DATE: _____ END DATE: _____

SERVICE ADDRESS (SITE 01) *Must be a Street Address*

STREET LINE #1: _____

STREET LINE #2: _____

CITY: _____ STATE: _____ ZIP: _____

BUSINESS PHONE: () _____ - _____ EMERGENCY PHONE: () _____ - _____

FAX PHONE: () _____ - _____ ATTENTION TO: _____

BEGIN DATE: _____ END DATE: _____ PAY-TO LOC. CODE:* _____

(*=Please indicate the locator code for the pay-to address that applies to this service address.)

I affirm under penalty of law that the information on this form is true, accurate, and complete to the best of my knowledge.

SIGNATURE:** _____ TITLE: _____ DATE: _____

****Must be signature of Provider or Authorized Signor on file with AHCCCS**