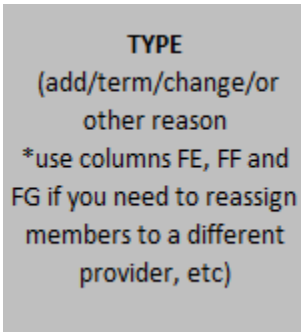
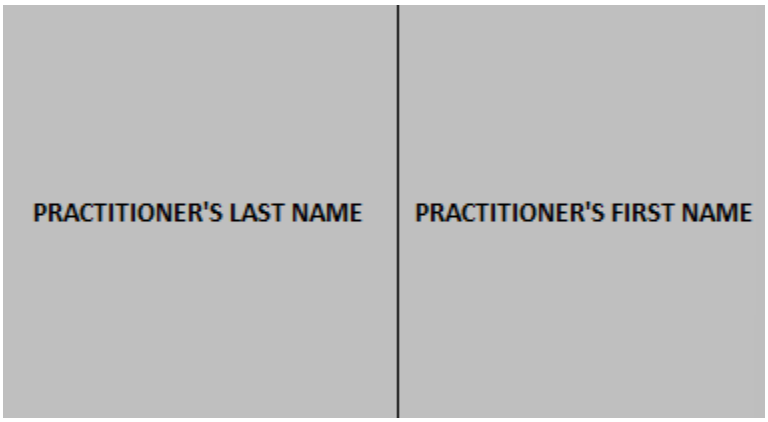
Non Delegated Group AzAHP Roster – Tip Sheet

1. Input the **Request Type** in the associated field.



2. Record the **First and Last name** in the matching fields.



3. Insert the **Degree Type/Title** in the related field.

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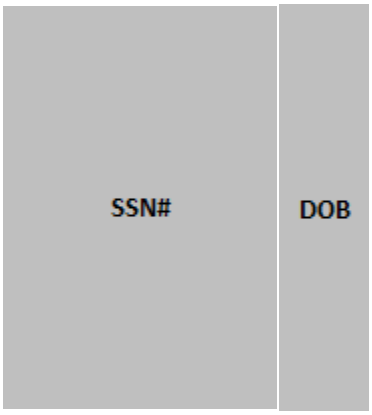
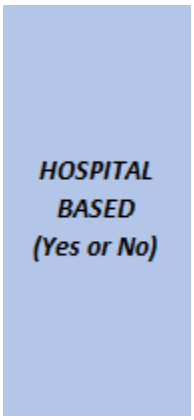
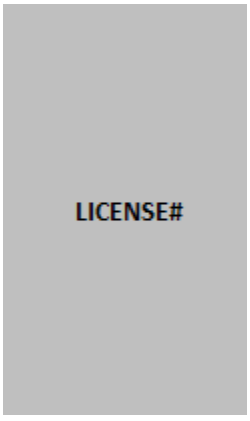
4. Provide the practitioner's complete **Social Security Number (SSN)** and **Date of Birth (DOB)**.



5. Select "Yes" only if you serve as a **hospitalist** or are employed directly by a hospital facility.



6. Supply the applicable **License #** in the respective field.



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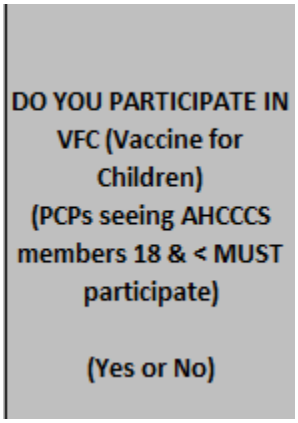
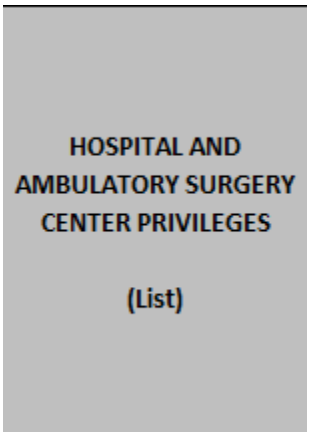
7. Indicate whether you have any **PCP panel size restrictions**.

8. If you are a PCP, please specify your participation status in the **VFC program**.



9. List all **hospitals and ambulatory surgery centers** where you maintain clinical privileges, if applicable.



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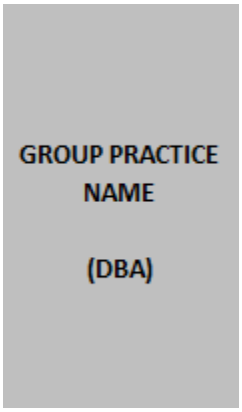
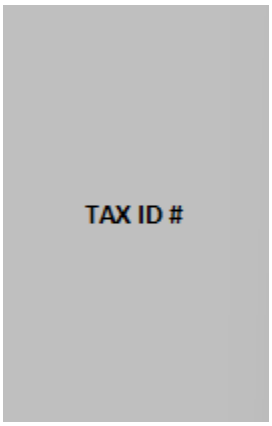
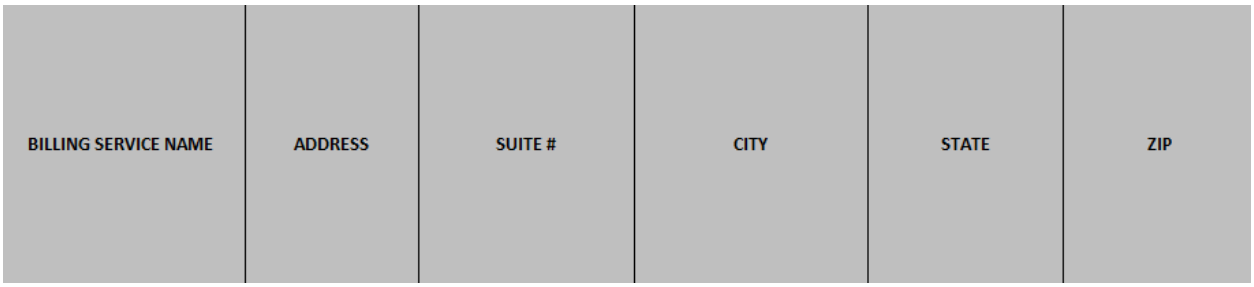
10. Please enter the **Group Practice Name** in the designated field.



11. Please include **Group Federal Tax ID#** in the corresponding field.



12. **Billing Service** address must be a physical street address. PO Box addresses are not acceptable, as physical addresses are required for claims processing.



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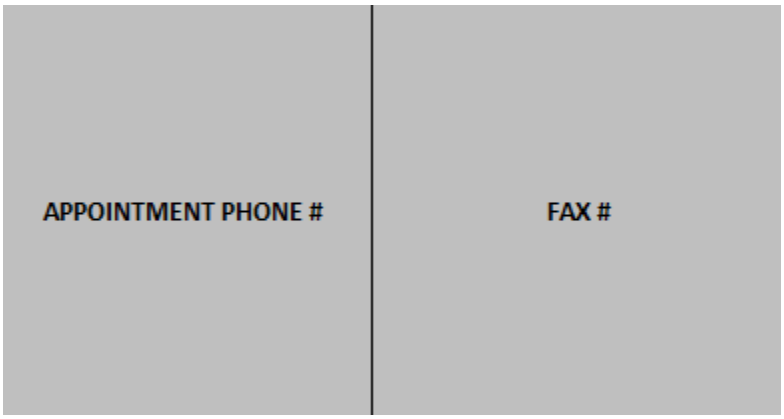
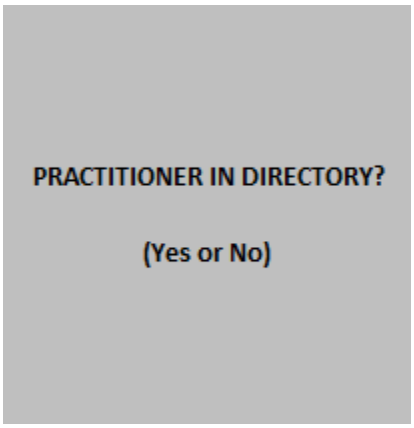
13. Include current facility **phone number** and **fax number**.



14. Always confirm whether you wish to be listed in the **provider directory for each practice location**.



15. Please make sure to send in all mandatory information in the Delegated Group AzAHP Roster for timely processing.