Panel Addition Request Form
Fax to (480) 212-5860
Or email to
HCH.EligibilityTeam@healthchoiceaz.com

Date: ______________________________ Request Made By: ___________________________________

Provider ID number: _____________________________ Provider Name: ______________________

Name & Address of Facility: ________________________ Telephone Number: _________________

____ Fax Number: _______________________

AHCCCS ID NUMBER	Member's Name	Member's Date of Birth	Date of Service MM/DD/YY	For Office Use Only
				Approved ☐ Denied ☐
				Approved ☐ Denied ☐
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				Approved ☐ Denied ☐
				Approved ☐ Denied ☐

PCP or Office Manager Signature: _______________________ Date: ____________________

If you have any questions please contact your Network Services Representative at 1.800.322.8670

Comments:

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