

CONTACT Potential Provider Application

Please return this form to:
CONTACT Provider Relations Department
PO Box 60965, Phoenix, AZ 85082-0965
Fax: 1-800-561-2361

Applicant Name:	
Corporate Name:	Telephone Number:
Primary Office Location:	
Additional Office Location:	
Additional Office Location:	
Mailing Address (if different than Primary Location):	
Availability for new patients: Are you willing to take emergent/urgent requests? _____ Do you have intake appointment times available each week? _____ Do you have evening hours? _____ Do you have Saturday hours? _____	
License/Certification Number:	Foreign Languages spoken (fluent only):
Number of years practicing:	Number of years practicing in Arizona:
Medical Records Review: Accepted applicants may be required, prior to contracting, to have a medical records review of 3-5 files and pass with minimum of 80%. Files can be "blinded" for confidentiality. Procedures regarding the review will be included with the formal application. I agree to allow CONTACT to review 3-5 separate patient files:	
YES <input type="checkbox"/> NO <input type="checkbox"/> Not Applicable – Practice located outside of Arizona <input type="checkbox"/>	
Practice Focus: Do you treat children? _____ Do you treat adolescents? _____ Do you treat the elderly? _____ Please list your clinical specialties and/or preferences: _____ _____	
For Board Certified Psychiatrists Only:	
Board Certification Number:	Type of Certification:

You will be notified in writing of the outcome within 30 days after CONTACT receives this documentation.