ONECARE

CARE1ST HEALTH PLAN ARIZONA

Provider Directory Correction Request Form

CONTACT INFORMATION:

Please provide the information requested below. Omission of critical information may result in your request being delayed.

Date of Request	
Requestor/Contact Name	
Phone Number	
Email Address	
Group Practice (if applicable)	
Group/Physician Tax Identification Number	
Physician Name (First, MI, Last, Suffix, Degree)	

INFORMATION REQUIRING CORRECTION:

Please complete the appropriate field(s) in both columns and fax to Provider Network Operations at the number below.

	Information as displayed in Provider Listing (Please note the inaccuracy or attach a copy of the listing circling the inaccurate information)	**Correction Required** (Please indicate how the information should be displayed in the listing)
Physician First Name		
Physician Middle Initial		
Physician Last Name		
Physician Suffix (Sr., Jr. III, etc.)		
Physician Degree (MD, DO, etc)		
Specialty		
Entity Name (Ancillary & Facility providers)		
Office/Location Address		
Suite Number		
City		
County		
Zip Code		
Phone Number (xxx-xxx-xxxx)		
Fax Number (xxx-xxx-xxxx)		
Languages Spoken		
Hospital Privileges		
PCP or Specialist Designation		
Participation Status		

Physician Signature _____ Date _____

Care1st Network Management
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