Arizona Complete Health
Demographic Update Form

Please complete the applicable information and email form to
AzCHProviderData@azcompletehealth.com

Request Type:	☐ Address Change	☐ Name Change	☐ Term Request	☐ Billing Update

Provider Information:	Group Name:
	Federal Tax ID #:

Address Change:	**Address 1**	☐ **Add**	☐ **Delete**
	Street:		Suite #:
	City:	State:	Zip Code:
	Telephone:	Fax:	
	Office Hours: (ex. M-F 8am-5pm)		
	Group NPI:		
	Address 2	☐ **Add**	☐ **Delete**
	Street:		Suite #:
	City:	State:	Zip Code:
	Telephone:	Fax:	
	Office Hours: (ex. M-F 8am-5pm)		
	Group NPI:		

Practitioner Name Change:	Practitioner NPI:	Effective Date:
	Current Name:	
	Revised Name:	
Note:	*For any name changes, a copy of Practitioners current license reflecting the change is required.*	

Billing/Remit Address Update:	☐ **Billing/Remit Address**		
	Street:	Suite #:	
	City:	State:	Zip Code:
	Telephone:	Fax:	
	Effective Date:		
Note:	*For any billing address updates, a current W9 is required.*		

Practitioner Term Request:	Terming Practitioner Name:	Terming Practitioner NPI:
	PCP Member Reassignment? ☐ Yes ☐ No	Effective Date of Term:
	Reassigned Practitioner Name:	Reassigned Practitioner NPI:
	Reason for Term:	

Request Submitted by Provider:	Name:	Title:
	Date:	Signature:
	Phone:	Email: