

Provider Data Update Form



Please read before completing this form

- This form is for MCC of AZ **contracted providers only**. To join the network, please visit our websites at <https://dsnp.mccofaz.com/providers/join-our-network/> or <https://www.mccofaz.com/provider/provider-tools/forms/>.
- If you are a provider group and need to add a provider, please complete the provider information form. This can be found on our website at <https://dsnp.mccofva.com/providers/provider-materials/> or at <https://www.mccofaz.com/provider/provider-tools/forms/>.
- For large groups/facilities, please contact MCCAZProvider@MagellanHealth.com and request a roster template for your data changes.

Group/agency name:	Individual practitioner name:	Provider TIN:
Group/agency NPI:	Practitioner NPI:	

Type of change

- Add
 Change
 Delete

Change category

<input type="checkbox"/> Address update/change	<input type="checkbox"/> Name update/change	<input type="checkbox"/> Specialty update/change
<input type="checkbox"/> Physical address	<input type="checkbox"/> NPI update/change	<input type="checkbox"/> Phone # update/change
<input type="checkbox"/> Payment address	<input type="checkbox"/> TIN update/change	<input type="checkbox"/> Open or close panel (give detail below – e.g. no longer accepting members)
<input type="checkbox"/> Mailing address	<input type="checkbox"/> Medicaid # update/change	
*For address changes, check all that apply	<input type="checkbox"/> Medicare # update/change	

Enter new/updated demographic information (only enter the information that you want us to update):

Name:	Address:	
City:	State:	ZIP code:
Phone #:	Fax #:	
NPI #:	TIN #:	
Medicaid #:	Medicare #:	

Specialty:

Enter additional details about your change below:

Please complete the below contact information so we can contact you if additional information is needed

Contact name and title: _____

Contact phone: _____

Contact email: _____

Please email this completed form to MCCAZProvider@MagellanHealth.com or fax it to 1-888-656-5098.