Panel Addition Request Form
Fax to (480) 212-5860
Or email to eligibilityteam@iasishealthcare.com
Please allow up to 72 hours for processing

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 HCA/HCG Use only
				Approved ☐ Denied ☐
				Approved ☐ Denied ☐
				Approved ☐ Denied ☐
				Approved ☐ Denied ☐
				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

FOR HCA/HCG USE ONLY

Confirmation Sent to Provider: ☐ Yes ☐ No Date Sent: _____

Comments:

_____

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