BCBSAZ PCMH Program Interest Form

An Independent Licensee of the Blue Cross and Blue Shield Association

Use this form to let us know of your interest in participating in the BCBSAZ Patient Centered Medical Home program. Participation criteria include:

- Providers must be contracted with BCBSAZ.
- Physician's current practicing specialty must be Internal Medicine, Family Practice, General Practice, Pediatrics, or OB/GYN.
- Providers must be seeing patients in an office setting.
- Providers must agree to implement strategies to increase (or maintain expanded level of) member access and availability.
- Providers must agree to meet and maintain the required percentile in individual scoring of HEDIS(R) Effectiveness of Care measures.

Date	I am interested in:
	☐ The BCBSAZ Primary Care PCMH Program ☐ The BCBSAZ OB/GYN PCMH Program

PRACTICE INFORMATION		
Practice Name	Tax ID	
Primary Clinical Contact		
Practice Street Address		Suite
City	State	Zip Code
Phone	Fax	
Number of Physicians	Number of Mid-level Providers	

PRACTICE ADMINISTRATION			
PRACTICE ADMINISTRATOR (NAME)	Practice Administrator's Name (preferred method of contact ☐ phone ☐ email)		
	Email Address	Phone Number	Best Time to Contact
OFFICE MANAGER (IF DIFFERENT)	Office Manager's Name (preferred method of contact ☐ phone ☐ email)		
	Email Address	Phone Number	Best Time to Contact
IT CONTACT (OPTIONAL)	IT Contact's Name (preferred method of contact ☐ phone ☐ email)		
	Email Address	Phone Number	Best Time to Contact

Complete, save, and return the form to the BCBSAZ PCMH Department by email at PCMHprogram@azblue.com or by fax: (602) 544-5609

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