BANNER HEALTH
PROVIDER CERTIFICATE REQUEST FORM

REQUESTOR INFORMATION		RETURN COMPLETED REQUEST FROM TO:
REQUESTED BY:		Banner Health Attn: Risk Management 2901 N Central Avenue Suite #160 Phoenix, AZ 85012 Tel: 602 747-4799 E-mail Address Link: Certificates
DATE REQUESTED:		
PHONE:		
E-MAIL:		
FAX:		

PROVIDER DETAILS		
PROVIDER NAME:		
PROVIDER TYPE:	☐ MD ☐ DO ☐ NP ☐ PA ☐ Other:	
	Currently Employed Provider?	☐ Yes ☐ No
	New Provider?	☐ Yes ☐ No
		Start Date:
	Previously Employed Provider?	☐ Yes ☐ No
	University of Arizona or UAHN Provider?	☐ Yes ☐ No
PROVIDER STATUS:	☐ Full Time ☐ Part Time ☐ Resident ☐ Contracted ☐ Other:	
	CONTRACTED PROVIDER INFORMATION	
	CONTRACT NAME:	
	CONTRACT NUMBER:	
	ADDITIONAL NOTES:	

REQUESTED DOCUMENTATION	
	☐ Current Year Certificate: ☐ Yes ☐ No
	☐ Prior Years/Loss Run From Year: to Year: