Arizona Foundation

New Business Transmittal Advisory

Print Form

Enrollment information must be submitted with the New Business Transmittal Form (prior to the effective date of the group.) Please fill out this form completely to ensure group's access to Arizona Foundation for Medical Care's (AFMC) networks.

This form may be filled out electronically. Upon completion, print and fax to: 602-417-2871 or email accountmanagement@azfmc.com.

Submitted by: _____ Phone: _____ Date: _____

GROUP INFORMATION

Employer Group (include dbas): _____

Address: _____ City/State/Zip Code: _____

Contact Person/Title: _____ Phone: _____ E-mail: _____

Are there additional office locations? ☐ Yes ☐ No If yes, where?: _____

Funding Arrangement: ☐ Fully Insured ☐ Self-funded Proposed Effective Date: _____

Number of Employees (must match enrollment): _____ Group/Policy Number: _____

Prior Plan Administrator/Carrier: _____ Group Renewal Date: _____

PRODUCER INFORMATION

Consultant/Broker Name: _____ Agency Name: _____

Address: _____ City/State/Zip Code: _____

Phone: _____ E-mail: _____ Fax: _____

AFMC REQUESTED SERVICES

Basic Medical Services (please check all that apply):

	AFMC
☐ PPO: Traditional	
☐ POS: Best Value	
☐ Foundation Regional	
☐ Foundation National	

Ancillary Network (please check all that apply):

	AFMC
☐ Chiropractic Cost Containment System (CCCS) - Not included with medical network	
☐ Foundation Comp Workers' Compensation Network Plan	

Comments:

Medical Management Options (please check all that apply):

	AFMC
☐ CHOICE (Utilization Management)	
☐ Case Management	
☐ Disease Management	
☐ Demand Management	
☐ Maternity Management	
☐ Wellness Program	

ADMINISTRATIVE INSTRUCTIONS

Mail Repriced Claims To: Contact: _____ Company: _____

Address (include city, state and zip code): _____

Phone: _____ Fax: _____ E-mail: _____

Send Billing To: Contact: _____ Company: _____

Address (include city, state and zip code): _____

Phone: _____ Fax: _____ E-mail: _____

Send Savings Report To: Contact: _____ Company: _____

Address (include city, state and zip code): _____

Phone: _____ Fax: _____ E-mail: _____

Run-off Instructions: Prior Carrier to pay: _____ New Carrier to pay: _____

AFMC ONLY Admin Recv'd: _____ Admin Date: _____ Date Entered: _____