



**GROUP BILLING AUTHORIZATION**

Complete one authorization form for each provider and group.

I understand that I must notify AHCCCS, Provider Registration of any changes to the group billing arrangements 30 days in advance. Notification must include the effective date of change.

**PLEASE TYPE OR PRINT IN INK.**

1. I hereby authorize \_\_\_\_\_  
 (Group Name)

\_\_\_\_\_ to bill on my behalf for services provided to AHCCCS members  
 (Group ID Number/NPI Number)

for claims with dates of service on or after \_\_\_\_\_.  
 (Date of Group Affiliation)

\_\_\_\_\_  
 (Signature)

\_\_\_\_\_  
 (Date)

\_\_\_\_\_  
 (Printed Name)

\_\_\_\_\_  
 (Provider ID Number)

\_\_\_\_\_  
 (NPI Number)