



BABY ARIZONA PARTICIPATING PROVIDER AGREEMENT

I wish to participate in the Baby Arizona program. The following office staff will take part in the training session provided by the Baby Arizona Web located at:
www.babyarizona.gov

Name(s) _____

I understand that I may withdraw my practice from this program at any time upon written notice to: AHCCCS, Attention: Maternal and Child Health Coordinator, 701 East Jefferson – MD 6700, Phoenix, Arizona 85034

I further understand that by practicing in the program I agree to the following:

- My name, practice address, and phone number may be given to a potential patient by the ADHS Pregnancy Information Hotline and/or other participating referral systems.
- When contacted by a referred patient or the hotline, my office will schedule an appointment to assist with the S.O.B.R.A. eligibility process pursuant to the training we have received.
- My office will perform the same clinical services for a referred patient on the initial visit that we provide patients referred from other sources.
- If a patient is subsequently determined not to be S.O.B.R.A. eligible, we will continue her care based upon a reasonable payment schedule developed between my office and the patient.
- If a patient determined eligible is assigned to another provider or opts to receive care from another provider, we will transfer her records to that provider within ten (10) working days of receiving a signed release from the patient.

Physician/Designee

Date

Practice Name (if different)

Address

Phone Number