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AMERICAN INDIAN MEDICAL HOME
APPLICATION REQUEST FORM

♦ ***Mandatory Fields must be completed or information will be returned.***

♦ TYPE OF APPLICATION REQUEST

AIMH Application

☐ Initial Application
☐ Renewal Application

♦ PROVIDER NAME: _____

♦ PROVIDER ID # (6 digits): ☐☐☐☐☐☐

♦ PROVIDER PHONE #: _____

♦ PROVIDER FAX #: _____

♦ CONTACT NAME: _____

♦ CONTACT PHONE #: _____

Return Fax # American Indian Medical Home 602-256-4667

***If this fax was received in error, please contact the Provider immediately at the Provider phone number above**