



## Transplant Stage Invoice Cover Sheet

Mail or deliver to:  
 AHCCCS /DHCM/Reinsurance Unit  
 701 East Jefferson Street  
 Mail Drop 6100  
 Phoenix, Arizona 85034  
 Fax 602-417-4725

Date:

Contractor Name (Health Plan or Program Contractor)		
AHCCCS ID # for Contractor and Facility		
Submitted By		
Contact Phone Number		
E-mail address		
Recipient Name		
Recipient AHCCCS ID #		
AHCCCS Transplant Case Number		
Stage Description		
Stage Number & Stage Name		
Stage Dates of Service	-	-
Total Billed Charges for Stage		
Contractor Paid Amount		

<b>Box A1</b> Listing of Non-payable charges due to OPFS: CRN(s) listed in numerical order by form type	<b>Box A2</b> Listing of Denied Services CRN(s) listed in numerical order by form type	<b>Reinsurance Action Request Form Attached</b> Yes <input type="checkbox"/> or No <input type="checkbox"/>
<b>Total \$</b>	<b>Total \$</b>	
<b>Spread Sheet Attached</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		

<b>Submissions must include the following:</b> Facility Invoice, Proof of Payment, Facility Claims (totaled by form type), Letter of Agreement (if place of service is a non-contracted facility)			
<b>Box B minus Box A2 must equal Box C</b>			
<b>Box B TBC from Attached Claims</b>		<b>Box C TBC from PMMIS Screen</b>	
Attached Form I Total \$		RI115 Form I Total \$	
Attached Form O Total \$		RI115 Form O Total \$	
Attached Form A Total \$		RI115 Form A Total \$	
Attached Form C Total \$		RI115 Form C Total \$	