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| AHCCCS logo | **AMERICAN INDIAN HEALTH PLAN****CHANGE REQUEST FORM** |  |
|  |
| **Facility Name Submitting Request:** | **Facility Phone Number:** |
| **Facility Address:** | **NPI or Provider ID:** |

 *(If your facility is not registered, you cannot use this form. Contact AHCCCS Provider Registration for questions or assistance (602)-417-7670/ (800) 433-0425). Should your facility not be registered refer the member to contact AHCCCS Enrollment to make their health plan change.*

**To:** AHCCCS Administration\DMS\OCARE\Enrollment

**Fax:** (602) 252-6536 **Phone Number:** (602) 417-7100/ (800) 334-5283

**A. The household member(s) listed below are enrolled in an AHCCCS Complete Care Health Plan. These member(s) wish to change their Health Plan to American Indian Health Program 999998.**

|  |  |  |  |
| --- | --- | --- | --- |
|  **First Name** | **Last Name** | **AHCCCS ID** | **DOB** |
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**B. The household member(s) listed below are enrolled in American Indian Health Plan 999998. These member(s) wish to change their Health Plan to AHCCCS Complete Care Health Program**

**.**

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name** | **Last Name** | **AHCCCS ID** | **DOB** |
|  |  |  |  |
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**I,       hereby request that AHCCCS take actions as requested in section(s) A or B.**

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**Member, Guardian or Parent Printed Name Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member, Guardian or Parent Signature Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IHS Benefit Coordinator Printed Name Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IHS Benefit Coordinator Signature Date**