AMERICAN INDIAN HEALTH PROGRAM
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. Should your facility not be registered refer the member to contact AHCCCS Enrollment to make their health plan change (602) 417-7100/ (800) 334-5283.

Return this form to:
To: AHCCCS Administration\DMPS\OCARE\Enrollment
Fax: (602) 252-6536 or
Email: mcdumemberescalation@azahcccs.gov

To register as an AHCCCS provider visit the Provider Enrollment website for the Provider Application at http://azahcccs.gov/APEP or contact AHCCCS Provider Enrollment to speak with a Provider Assistance Representative to help with general questions.
Phone: (602) 417-7670 or (800) 433-0425

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

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

First Name	Last Name	AHCCCS ID	DOB

I, hereby request that AHCCCS take actions as requested in section(s) A or B.

Member, Guardian or Parent Printed Name	**Date**
Member, Guardian or Parent Signature	**Date**
IHS Benefit Coordinator Printed Name or Urban Indian Org Family Health Advocate Printed Name	**Date**
IHS Benefit Coordinator Signature or Urban Indian Org Family Health Advocate Signature	**Date**