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| Transplant Stage Invoice Cover Sheet |

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

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|  |       |

Date:

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| 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 |       |

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| **Box A1**Listing of Non-payable charges due to OPFS: CRN(s) listed in numerical order by form type | **Box A2**Listing of Denied Services CRN(s) listed in numerical order by form type | Reinsurance Action Request Form AttachedYes [ ]  or No [ ]  |
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| **Total $** |  | **Total $** |  |
| **Spread Sheet Attached Yes** **[ ]**   **No** [ ]  |

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|  **Submissions must include the following:**Facility Invoice, Proof of Payment, Facility Claims (totaled by form type), Letter of Agreement (if place of service is a non-contracted facility) |
| **Box B minus Box A2 must equal Box C** |
| **Box B TBC from Attached Claims** | **Box C TBC from PMMIS Screen** |
| 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 $ |  |