Transplant Stage Invoice Cover Sheet

Date:

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

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	

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 Attached Yes ☐ or No ☐
Total $	**Total $**	
Spread Sheet Attached Yes ☐	**No ☐**	

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 $	