EXHIBIT 1120-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INITIAL DIALYSIS CASE CREATION FORM
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I am the treating physician for _______________________________, _______________________,
(PRINT MEMBER NAME) (DATE OF BIRTH)
___________________ who has been diagnosed with End-Stage Renal Disease (ESRD).
(AHCCCS ID #)

It is my opinion that in the absence of the following dialysis treatments per week, the member’s
ESRD would reasonably be expected to result in:
· Placing the member’s health in serious jeopardy;
· Serious impairment of bodily function; or
· Serious dysfunction of a bodily organ or part.

It is my medical opinion that _______________________________ requires ______ dialysis
treatments per week.

__________________________________________  ______________________
SIGNATURE                                     DATE

________________________  ______________________
AHCCCS PROVIDER ID #:

________________________
DIALYSIS START DATE
(only for initial certification)

________________________
DIALYSIS FACILITY

PLEASE SUBMIT THIS FORM TO AHCCCS FOR ALL NEW DIALYSIS PATIENTS.
FAX: (602) 256-6591

FOR QUESTIONS CALL (602) 417-4400 EXT. 67548