

FACILITY NAME: _____ CONTRACTOR NAME: _____

MEMBER NAME: _____ AHCCCS ID: _____

THE FOLLOWING BILLING/MEMBER LEVEL OF CARE CHANGE(S) HAVE OCCURRED

		RATE:	EFFECTIVE:
I. FACILITY REIMBURSEMENT:	LOC _____	\$ _____	_____
II. LEVEL OF CARE (LOC) CHANGED TO:	_____	\$ _____	_____
III. MEMBER ROOM & BOARD RESPONSIBILITY		\$ _____	_____

I HAVE READ AND AGREE WITH THE ABOVE CHANGES.

FACILITY REPRESENTATIVE:

PRINTED _____ TITLE: _____

SIGNATURE _____ DATE: _____

MEMBER / REPRESENTATIVE: (ONLY REQUIRED FOR CHANGES IN ROOM & BOARD)

PRINTED _____ RELATIONSHIP: _____

SIGNATURE _____ DATE: _____

CASE MANAGER:

PRINTED _____

SIGNATURE _____ DATE: _____

**A SIGNED COPY MUST BE PROVIDED TO THE CONTRACTOR'S CASE MANAGER
FOR THE MEMBER'S FILE**