|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **INSTRUCTIONS:**  **ALL SECTIONS MUST BE COMPLETED OR MARKED N/A** | | | | | | | | | |
|  | **Member Name** | | | **AKA** | | | **Telephone** | | |
|  | **AHCCCS ID #** | | | | | **DOB** | | | **Male  Female** |
|  | **Rate Code** | | | **County Name & #** | | | | | |
|  | **Relinquishing Contractor** | | | | | | | | |
|  | **Receiving Contractor** | | | | | | | | |
|  | **Medicare Part A  Part B  N/A** | | | **Other Insurance** | | | **Plan ID #** | | |
|  | **ALTCS/Tribal ALTCS Application Pending Yes  No** | | | | | **Date** | | | |
|  | **Diagnosis** | | | | | **Secondary Diagnosis** | | | |
|  | **PCP Name** | | | | | | **Telephone** | | |
|  | **High Risk Pregnancy Yes  No** | | | | **Explain Risk** | | | | |
|  | **Pregnancy Estimated Date of Confinement** | | | **Maternity Provider** | | | **Telephone** | | |
|  | **Medications** | | | | | | **Injectable Yes  No**  **Provider Administrating:** | | |
|  | **Transplant Yes  No** | | **Type** | | | **Date** | | | **Facility** |
|  | **Catastrophic Reinsurance Yes  No** | | | | **Diagnosis/High Cost Specialty Drug: Yes No** | | | | |
|  | **Specialist Name** | | | **Type** | | | **Telephone** | | |
|  | **Out-of-Area-Appt Yes  No** | | | **Provider** | | | **Telephone** | | |
|  | **Outpatient Services Yes  No** | | | **Provider** | | | **Telephone** | | |
|  | **Outpatient Adult PT/OT Yes  No** | | | **# of Visits in Current Contract Year** | | | | | |
|  | **Home Health Yes  No** | | **Provider** | | | | **Telephone** | | |
|  | **Home Health Services** | | | | | | | | |
|  | **Case Management Yes  No** | | | **Please Explain** | | | | | |
|  | **Case Manager Name/DCS Case worker** | | | | | | **Telephone** | | |
|  | **Contractor/FFS program Care Manager Name** | | | | | | **Telephone** | | |
|  | **Inpatient Yes  No** | **Facility Name** | | | | | **Telephone** | | |
|  | **SNF Yes  No** | **Facility Name** | | | | | **Telephone** | | |
|  | **# of Skilled Nursing Facility (SNF) Days used/benefit year** | | | | | | | | |
|  | **Residential Yes  No** | **Facility Name** | | | | | **Telephone** | | |
|  | **Admitting Diagnosis** | | | | | | | | |
|  | **Admission Date Expected Discharge Date** | | | | | **Expected Discharge Date** | | | |
|  | **Dental Benefit Used ($)**  **ALTCS \_\_\_\_\_\_ Adult Dental Emergency Benefit \_\_\_\_\_\_\_\_\_** | | | | |  | | | |
|  | **High Needs/High Cost (HNHC) Yes  No  Criteria for inclusion in HNHC** | | | | | | | | |
|  | **CRS Diagnosis(s) MSIC provider** | | | | | | | | |
|  | **Behavioral Health Yes  No** | | | **Provider** | | | **Telephone** | | |
|  | **Court Ordered Treatment**  **Yes  No**  **Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_**  **COT Oversight Provider** | | | **Court of Jurisdiction** | | | | | |
|  | **Member on conditional release from Arizona State Hospital Yes  No** | | **Care Manager** | | | | | **Telephone** | |
|  | **Special Assistance (SMI) Yes  No** | | | **Contact Name & Relation** | | | | **Telephone** | |
|  | **(SMI) Designation Yes  No** | | | **(SMI) Opt Out Yes  No** | | | | | |
|  | **Member enrolled in CHP in the last 12 months Yes  No** | | | | | | | **If yes, termination date** | |
|  | **HCDM/DR Yes  No** | | | | | **Name** | | **Telephone** | |
|  | **Respite Hours Used** | | | | | | | | |
|  | **Medical Equipment Vendor** | | | | | **Telephone** | | **Date** | |
|  | **Type of Medical Equipment** | | | | | | | **Own  Rent  N /A** | |
|  | **Medical Foods Yes  No** | | | **Vendor** | | | | **Telephone** | |
|  | **End of Life Care Services Yes  No** | | | | | | |  | |
|  | **Exclusive Pharmacy Yes  No** | | **Pharmacy** | | | | **Telephone Begin Date** | | |
|  | **Exclusive Prescriber Yes  No** | | **Prescriber** | | | | **Telephone Begin Date** | | |
|  | **Medication Assisted Treatment (MAT) Yes  No** | | **Prescriber** | | | | **Telephone:** | | |
|  | **Other Care Needs** | | | | | | |  | |
|  | **Non-Emergency Medical Transportation Yes  No** | | | | | **Mode** | | | |
|  | **Date Transportation Needed** | | | **Destination** | | | | | |
|  | **Person Completing Form** | | | | | | **Telephone/Email** | | |
|  | **Date of Notification to Receiving Contractor** | | | | | | | | |
|  | | | | | | | | | |
| **Comments or additional information**: | | | | | | | | | |

This information is considered CONFIDENTIAL and disclosure is governed by applicable Federal, State, and Agency regulations. Information on this Form is current as of this notification date. This Form must be completed for all members requiring transition services in accordance with AHCCCS policies: No changes or revisions to this Form are permitted without written approval from AHCCCS.