



AMPM CHAPTER 500, CARE COORDINATION REQUIREMENT

AMPM POLICY 520, ATTACHMENT A,

ENROLLMENT TRANSITION

INFORMATION (ETI) FORM

EXHIBIT 520-1

ACUTE CARE

ENROLLMENT TRANSITION INFORMATION FORM¹

¹ [Exhibit revised to include all appropriate fields for physical and behavioral health services. Form combines the two separate Acute and CRS forms and those forms are replaced with this one form Exhibit 520-1](#)



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**AMPM POLICY 520, ATTACHMENT A,
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EXHIBIT 520-1
ACUTE CARE ENROLLMENT TRANSITION INFORMATION FORM²

1. 1	Member Name	AKA	Telephone
2. 2	AHCCCS ID #	DOB	Male <input type="checkbox"/> Female <input type="checkbox"/>
3. 3	Rate Code	County Name & #	
4. 4	Relinquishing Contractor / <u>RBHA</u>		
5. 5	Receiving Contractor/ <u>RBHA</u>		
6. 6	Medicare Part A <input type="checkbox"/> —Part B <input type="checkbox"/>	Other Insurance	Plan <u>ID</u> #
7. 7	ALTCS Application Pending Yes <input type="checkbox"/> No <input type="checkbox"/>	Date	
8. 8	Diagnosis	Secondary Diagnosis	
9. 9	PCP Name	PCP Telephone	
10.	High Risk Yes <input type="checkbox"/> No <input type="checkbox"/>	Explain Risk	
10-11	Pregnancy EDC	Maternity <u>Care</u> Provider	Telephone
1	High Risk Yes <input type="checkbox"/>	Explain Risk	
11-12	Special Medications	Injectable/Injectable	Yes
12-13	Organ/Tissue	Type	Date
13-14	Catastrophic Reinsurance Yes <input type="checkbox"/> No <input type="checkbox"/>	Diagnosis	Facility
14-15	Specialist Name	Type	Telephone
1	Specialist Name	Type	Telephone
15-16	Out-of-Area-Appointment Yes <input type="checkbox"/>	Provider	Telephone
16-17	Outpatient Services Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
1	Outpatient Services	Provider	Telephone
17-18	Out-Patient t Adult <u>Physical</u>	Number # of <u>V</u> visits <u>r</u> received for <u>C</u> urrent <u>C</u> ontract <u>Y</u> ear	
18-19	Home Health Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
19-20	Home Health Services		
20-21	Case Management Yes <input type="checkbox"/> No <input type="checkbox"/>	Please Explain	
22.	Case Manager Name	Telephone	
21-23	Inpatient/ <u>RTC</u> Yes <input type="checkbox"/>	Facility Name	Telephone
24.	SNF Yes <input type="checkbox"/> No <input type="checkbox"/>	Facility Name	Telephone# of Days
25.	# of SNF Days used/benefit year		
26.	Residential ³ Yes <input type="checkbox"/>	Facility Name	Telephone
22-27	Admitting Diagnosis		
28.	Admission Date ⁴ ALTCS Dental Benefit Used (\$) ⁵		
23-29	Inpatient Treatments Admission Date ALTCS Dental Benefit Used (\$) ² Expected Discharge Date		
2	Number of Inpatient Days/benefit year		
24-30	CRS Diagnosis(s)		
2	CRS Clinic(s)		
25-31	Behavioral Health Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider <u>RBHA</u> <input type="checkbox"/> <u>18-20</u> <input type="checkbox"/>	Telephone
32.	COT Yes <input type="checkbox"/> No <input type="checkbox"/>	Court of Jurisdiction	

² Revised to expand for Administrative Simplification and to clearly indicate fields needed

³ Revised -11-3 APC correction from RTC to residential

⁴ Revised -11-3 APC to place admission date in #28 rather than #29

⁵ Revised -11-3 APC correction to add dollar sign to signify the amount is to be tracked here



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33.	Special Assistance (SMI) Yes <input type="checkbox"/> No <input type="checkbox"/>	Contact Explain Name & Relation and	Telephone: ⁷
26-34	BH Guardian Yes <input type="checkbox"/> No <input type="checkbox"/>	Name	Telephone
35.	Respite Hrs Used ⁹		
27-36	DME Vendor	Telephone	Date
37.	Type of DME Equipment ¹⁰		Telephone
28-38	Type of DME Equipment <u>Medical</u>	Vendor	Own <input type="checkbox"/> Rent <input type="checkbox"/>
39.	Other Care Needs		
	Requiring Supplies Yes	Type	
29-40	Ongoing Non-Emergency Medical Transportation ¹¹ Yes	Mode	
30-41	Date Transportation Needed	Destination	
31-42	Person Completing Form	Telephone	
32-43	Date -of -Notification to Receiving Contractor		
	Behavioral Health or Nursing Facility	Behavioral	Nursing Facility
	Number of Days in Nursing Facility		

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 AHCCCSA.

Revised: 07/01/2016, 10/01/2011, 10/01/2010, 4/2005, 04/1998.

⁶ Revised -11-3 APC correction to add in place of 'explain'

⁷ Revised -11-3 APC correction to add in place of 'explain'

⁸ Revised -11-3 APC correction to remove 'BH' from guardian field

⁹ Post APC change Moved to new line

¹⁰ Revised -11-3 APC correction to switch #36 and 37 for better order

¹¹ Revised -11-3 APC correction to update as NEMT



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1.	Member Name	AKA	Telephone
2.	AHCCCS ID #	DOB	Male <input type="checkbox"/> Female <input type="checkbox"/>
3.	Rate Code	County Name & #	
4.	Relinquishing Contractor /RBHA		
5.	Receiving Contractor/RBHA		
6.	Medicare Part A <input type="checkbox"/> Part B <input type="checkbox"/>	Other Insurance	Plan ID #
7.	ALTCS Application Pending Yes <input type="checkbox"/> No <input type="checkbox"/>	Date	
8.	Diagnosis	Secondary Diagnosis	
9.	PCP Name	Telephone	
10.	High Risk Yes <input type="checkbox"/> No <input type="checkbox"/>	Explain Risk	
11.	Pregnancy EDC	Maternity Provider	Telephone
12.	Special Medications	Injectable Yes <input type="checkbox"/> No <input type="checkbox"/>	
13.	Transplant Yes <input type="checkbox"/> No <input type="checkbox"/>	Type	Date Facility
14.	Catastrophic Reinsurance Yes <input type="checkbox"/> No <input type="checkbox"/>	Diagnosis	
15.	Specialist Name	Type	Telephone
16.	Out-of-Area-Appt Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
17.	Outpatient Services Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
18.	Out-Patient Adult PT Yes <input type="checkbox"/> No <input type="checkbox"/>	# of Visits in Current Contract Year	
19.	Home Health Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
20.	Home Health Services		
21.	Case Management Yes <input type="checkbox"/> No <input type="checkbox"/>	Please Explain	
22.	Case Manager Name	Telephone	
23.	Inpatient Yes <input type="checkbox"/> No <input type="checkbox"/>	Facility Name	Telephone
24.	SNF Yes <input type="checkbox"/> No <input type="checkbox"/>	Facility Name	Telephone
25.	# of SNF Days used/benefit year		
26.	Residential Yes <input type="checkbox"/> No <input type="checkbox"/>	Facility Name	Telephone
27.	Admitting Diagnosis		
28.	Admission Date		
29.	ALTCS Dental Benefit Used (\$)	Expected Discharge Date	
30.	CRS Diagnosis(s)		
31.	Behavioral Health Yes <input type="checkbox"/> No <input type="checkbox"/>	Provider	Telephone
32.	COT Yes <input type="checkbox"/> No <input type="checkbox"/>	Court of Jurisdiction	
33.	Special Assistance (SMI) Yes <input type="checkbox"/> No <input type="checkbox"/>	Contact Name & Relation:	Telephone:
34.	Guardian Yes <input type="checkbox"/> No <input type="checkbox"/>	Name	Telephone
35.	Respite Hrs Used		
36.	DME Vendor	Telephone	Date
37.	Type of DME Equipment		Telephone
38.	Medical Foods Yes <input type="checkbox"/> No <input type="checkbox"/>	Vendor	Own <input type="checkbox"/> Rent <input type="checkbox"/>
39.	Other Care Needs		
40.	Non-Emergency Medical Transportation Yes <input type="checkbox"/> No <input type="checkbox"/>	Mode	
41.	Date Transportation Needed	Destination	
42.	Person Completing Form	Telephone	

¹² Included form without redline changes

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43. Date of Notification to Receiving Contractor

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Revised: 07/01/16, 10/01/11, 10/01/10, 4/05, 04/98

OPEN UNTIL 01-07-2017