AHCCCS NOTIFICATION
TO WAIVE MEDICARE PART D CO-PAYMENTS
FOR MEMBERS IN A MEDICAL INSTITUTION THAT IS FUNDED BY MEDICAID

Use this form to notify AHCCCS when a member is expected to reside in a medical institution that is funded by Medicaid for a full calendar month.

Fax to the AHCCCS Member File Integrity Section (MFIS)
602-253-4807

MEMBER INFORMATION

MEMBER NAME_____ AHCCCS ID_____ DATE OF BIRTH ___/___/___

MEDICAL INSTITUTION INFORMATION

NOTIFICATION OF A MEDICAID FUNDED ADMISSION

TYPE OF MEDICAL INSTITUTION	(x)	DATE OF ADMISSION	PROVIDER ID #	NAME OF MEDICAL INSTITUTION
ACUTE HOSPITAL	_____	_____	_____	_____
PSYCHIATRIC HOSPITAL/ IMD	_____	_____	_____	_____
PSYCHIATRIC HOSPITAL/Non-IMD	_____	_____	_____	_____
RTC/IMD	_____	_____	_____	_____
RTC/Non-IMD	_____	_____	_____	_____
SNF	_____	_____	_____	_____
ICF MR	_____	_____	_____	_____

COMMENTS:

SUBMITTED BY: _____ DATE:_____

TITLE:_____ PHONE #:_____

HEALTH PLAN/RBHA:_____

Last Revision Date: 10/31/2005
Effective Date: 03/15/2006