~~POLICY~~ 401 - ATTACHMENT A - AHCCCS COMPLETE CARE CHANGE OF CONTRACTOR FORM

~~A~~CHANGE REASON:	☐ MEDICAL CONTINUITY OF PRENATAL CARE	☐ MEDICAL CONTINUITY OF CARE

INSTRUCTIONS FOR SUBMISSION:

If the Medical Directors of both the Receiving and Relinquishing Contractors agree to the change of Contractor, Attachment A shall be faxed to AHCCCS Member Contact and Data Unit (MCDU) Attention: Medical Director at 602-252-6536.

If the Medical Directors of both the Receiving and Relinquishing Contractors have discussed the request and have not been able to come to an agreement, the Relinquishing Contractor shall fax Attachment A to AHCCCS Medical Management (MM) Manager at 602-252-2180.

MEMBER INFORMATION

MEMBER NAME: _____ AHCCCS ID: _____ PHONE #: ___ - ___ - ____

ADDRESS: _____ APT/SPACE #: _____ DOB: ___ - ___ - ____ SEX: _____

CITY: _____ STATE: _____ ZIP: _____

MEMBER'S PCP: _____ _____ PHONE #: ___ - ___ - ____

RELINQUISHING CONTRACTOR	RECEIVING CONTRACTOR
CONTRACTOR NAME:	CONTRACTOR NAME:
CONTRACTOR ID #:	CONTRACTOR ID #:
CONTACT NAME:	CONTACT NAME:
CONTACT PHONE:	CONTACT PHONE:
CONTACT FAX:	CONTACT FAX:

PROVIDER REQUESTED FOR CONTINUITY

PROVIDER NAME: _____ AHCCCS ID: _____ PHONE # ___ - ___ - ____

EFFECTIVE DATES: 10/01/17, 10/01/18, 10/01/21, 10/01/22, 11/07/25, 10/01/26
APPROVAL DATES: 05/18/17, 10/22/18, 11/15/18, 03/04/21, 04/27/22, 08/26/25, 05/12/26

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DOCUMENTATION OF MEDICAL CONTINUITY *(INCLUDE ALL INFORMATION SUPPORTING THE NEED FOR THE CHANGE)*
MEMBER REQUESTS CHANGE OF CONTRACTOR TO: _____
MEMBER'S EFFECTIVE DATE IS: ____ - ____ - ____ RATE CODES: _____

☐APPROVED ☐DENIED	☐APPROVED ☐DENIED
MEDICAL DIRECTOR'S SIGNATURE/RELINQUISHING CONTRACTOR	*MEDICAL DIRECTOR'S SIGNATURE/RECEIVING CONTRACTOR*

REASON STATED FOR DENIAL BY RECEIVING CONTRACTOR:

FAMILY MEMBERS INCLUDED IN THE CHANGE PROVIDE: FAMILY MEMBER NAME, AHCCCS ID, DOB

ATTACH ANY RELEVANT DOCUMENTATION DOCUMENTATION ATTACHED

SECTION BELOW TO BE FILLED OUT BY AHCCCS
AFTER REVIEW BY AHCCCS THIS CONTRACTOR CHANGE HAS BEEN: ☐ APPROVED ☐ DENIED
AHCCCS DESIGNEE _____ *DATE* _____
ANY CONTRACTOR CHANGE REQUEST PROCESSED BY THE CONTRACTOR MUST INVOLVE CONTINUITY OF CARE ISSUES. IF A CONTRACTOR CHANGE IS REQUESTED FOR ANY OTHER REASON, THE REQUEST SHOULD BE MANAGED ACCORDING TO ACOM POLICY 401.

EFFECTIVE DATES: 10/01/17, 10/01/18, 10/01/21, 10/01/22, 11/07/25, 10/01/26
APPROVAL DATES: 05/18/17, 10/22/18, 11/15/18, 03/04/21, 04/27/22, 08/26/25, 05/12/26