

~~GCI 1074A FORFF (7-20)~~ ARIZONA DEPARTMENT OF ECONOMIC SECURITY
 ARIZONA EARLY INTERVENTION PROGRAM (AZEIP)
 AZEIP AHCCCS MEMBER SERVICE REQUEST FORM¹

DATE OF REQUEST

Arizona Early Intervention Program (AZEIP) INFORMATION					
AZEIP SERVICE COORDINATOR'S NAME		PHONE NO.	FAX NO.	EMAIL	
AZEIP <u>SERVICE PROVIDING AGENCY</u> ² TBEIS CONTRACTOR		PHONE NO.	FAX NO.	EMAIL	
INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) ³ TYPE:	<input type="checkbox"/> INTERIM Initial IFSP	<input type="checkbox"/> Six Month Review INITIAL	<input type="checkbox"/> PERIODIC REVIEW Annual IFSP	<input type="checkbox"/> Other/Additional ANNUAL	DATE:
Child's Information CHILD INFORMATION					
CHILD'S NAME (LAST, FIRST, MI)		AHCCCS ID NO.	DATE OF BIRTH	EXPECTED MONTH/ YEAR OF TRANSITION FROM AZEIP	
PARENTS'/GUARDIANS' NAME(S)		PREFERRED LANGUAGE AHCCCS HEALTH PLAN		AHCCCS HEALTH PLAN PRIMARY CARE PHYSICIAN	

¹ Updated headers and font case.

² Updated Arizona Early Intervention Program (AZEIP) TBEIS Contractor to Arizona Early Intervention Program (AZEIP) Service Providing Agency.

³ Spelled out Individualized Family Service Plan (IFSP) and updated the types of Individualized Family Service Plan (IFSPs).

MAILING ADDRESS (No., Street, City, State, ZIP)

~~HOME PHONE NO.~~

~~WORK PHONE NO.~~

HOME PHONE

~~CELL/MESSAGE PHONE~~

~~NO.~~

CELL PHONE

Dear Primary Care Physician (PCP):

~~CPSEE ATTACHED: AzEIP Developmental Evaluation Report and results of the most recent evaluations and assessments and IFSP if applicable.~~ The child identified above is determined eligible for the AzEIP based on:

- Significant developmental delay - at least two standard deviations (approximately 50%) below the mean in one or more developmental areas.
- A diagnosed physical or mental condition that has a high probability of resulting in a significant developmental delay⁴

See Attached: AzEIP Developmental Evaluation Report and results of the most recent evaluations and assessments and IFSP if applicable.

The AzEIP IFSP Team is recommending the services identified below. Please review the documentation, indicate whether each requested service is medically necessary by checking "yes" in shaded box next to each service and return to the health plan MCH or EPSDT coordinator or designee who will coordinate prior authorization for the services you deem medically necessary. If you feel the services are not medically necessary, or the child should not receive these services at this time, please explain below:

~~Expected outcomes (refer to Individualized Family Service Plan (IFSP) as applicable):~~

⁴ Added checkboxes to identify the AzEIP eligibility reason.

~~Dear Primary Care Physician (PCP): The child identified above is eligible for AzEIP and the AzEIP Individualized Family Service Plan (IFSP) Team is recommending the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services identified below. Please review the documentation, indicate whether each requested service is medically necessary by checking “yes” in shaded box next to each service and return to the health plan MCH or EPSDT coordinator or designee who will coordinate prior authorization for the services you deem medically necessary. If you feel the services are not medically necessary, or the child should not receive these services at this time, please explain below:⁵~~

<u>PCP NAME</u> ⁶ _____		<u>PHONE</u> _____	<u>EMAIL</u> _____
PRIMARY CARE PHYSICIAN'S SIGNATURE <u>PCP SIGNATURE</u> _____		DATE	

⁵ Deleted section was moved to above and language was updated.

⁶ Moved Primary Care Provider (PCP) contact information into one location.

TO BE COMPLETED BY THE AZEIP SERVICE COORDINATOR PROVIDING AGENCY:							Completed by PCP	Completed by AHCCCS Contractor	
Procedure Code ⁷	Service	AZEIP Requested Provider Name and Phone No.	Start Date	End Date	Frequency	Duration	Medically necessary Necessary Service	AHCCCS Contractor Authorization	NABD ⁸ Sent
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		_____	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____		_____	_____				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	<input type="checkbox"/> Yes <input type="checkbox"/> No

If services are not medically necessary, or if the PCP wants to examine the member to determine medical necessity, the AHCCCS Contractor will deny the services and send a Notice of Adverse Benefit Determination (NABD) letter to the member’s parents/guardians and the AzEIP Service Coordinator.

⁷ Updated column headers

⁸ Revised to update acronym from NOA to NABD.

TO BE COMPLETED BY THE AHCCCS CONTRACTOR:						
<p>The AHCCCS Contractor must document what is approved: provider, service, frequency, duration, and service start and end date. If the requested AzEIP Service Provider is not approved by the Contractor, the AHCCCS Contractor will identify an approved provider below.</p>						
Provider Name	Phone	Service	Start Date	End Date	Frequency	Duration

CONTACTS⁹

<p>Health Plan: _____ Maternal Child Health (MCH) or EPSDT Coordinator or designee: _____ Phone No.: _____ Fax No.: _____ Email: _____</p>
<p>AzEIP Coordinator/Supervisor: _____ Phone No.: _____ Fax No.: _____ Email: _____</p>

⁹ Removed contacts section for being duplicative and not necessary.

<p>Primary Care Physician: _____</p> <p>Phone No.: _____</p> <p>Fax No.: _____</p> <p>Email: _____</p>
<p>Service Provider: _____</p> <p>Phone No.: _____</p> <p>Fax No.: _____</p> <p>Email: _____</p>

ADDITIONAL INFORMATION

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means, if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance, if possible. To request this document in an alternative format or for further information about this policy, contact your local office; TTY/TDD **Services: 7-1-1.** • **Free language assistance for DES services are available upon request.**