AHCCCS MEDICARE RESEARCH REQUEST FORM

To help us research member Medicare data, please complete this form, sign, date and return it.

INSTRUCTIONS FOR COMPLETION: Please print or type. Fill in as much information as possible in the spaces below. Fax completed forms to **AHCCCS/MFIS at (602) 253-4807**.

RECIPIENT MEDICARE INFORMATION

1. AHCCCS ID #: _____
2. NAME: _____
3. DOB: _____
4. SOCIAL SECURITY NUMBER: _____
5. MEDICARE CLAIM NUMBER: _____
6. PART A BEGIN DATE: _____ / PART A END DATE: _____
7. PART B BEGIN DATE: _____ / PART B END DATE: _____

8. SIGNATURE OF PERSON COMPLETING FORM: _____
9. HEALTH PLAN/PROGRAM CONTRACTOR /PROVIDER: _____
10. TELEPHONE #: _____
11. DATE: _____