EXHIBIT 1120-2

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
MONTHLY CERTIFICATION OF EMERGENCY
MEDICAL CONDITION

MONTHLY CERTIFICATION OF EMERGENCY MEDICAL CONDITION

I am the treating physician for _____, _____,
(PRINT MEMBER NAME) (DATE OF BIRTH)

_____ who has been diagnosed with End-Stage Renal Disease (ESRD).
(AHCCCS ID #)

It is my opinion that in the absence of the following dialysis treatments per week, the member's ESRD would reasonably be expected to result in:

- **Placing the member's health in serious jeopardy;**
- **Serious impairment of bodily function; or**
- **Serious dysfunction of a bodily organ or part.**

It is my medical opinion that _____ requires _____ dialysis treatments per week.

_____ _____
SIGNATURE **DATE**

_____
AHCCCS PROVIDER ID #:

_____
DIALYSIS FACILITY

PLEASE FILE THIS DOCUMENT IN THE MEMBER'S MEDICAL RECORD EACH MONTH.

FOR QUESTIONS CALL (602) 417-4400 EXT. 67548

Original Effective Date: 04/01/2007