# CONTRACTOR CHANGE REQUEST FORM

| *Member Name* | *Date of Birth* | *AHCCCS ID #* |
|---|---|---|
| | | |

## CURRENT CONTRACTOR INFORMATION

*PERSON REOUESTING CHANGE* | *PHONE #*

*CONTRACTOR NAME*

*FISCAL COUNTY NAME*

**TRANSFER** ☐ **APPROVED** ☐ **DENIED**

*FISCAL COUNTY #:* | *PROVIDER ID #:* | *DATE:*

**REASON:**

- ☐ **MEMBER/RECIPIENT LEAVING SERVICE AREA**
- ☐ **MEMBER/RECIPIENT RESIDES OUT OF SERVICE AREA**
- ☐ **WITHIN SERVICE AREA FOR MEDICAL CONTINUITY OF CARE**
- ☐ **FAMILY REQUEST**
- ☐ **OTHER – SPECIFY:**

**COMMENTS/CURRENT MEDICAL CONDITION:**
***(ATTACH MEDICAL RELEASE, CURRENT PLAN OF CARE AND OTHER NECESSARY INFORMATION)***

*AUTHORIZED SIGNATURE* | *TITLE* | *DATE*



**Effective Dates: 10/00, 01/16, 10/01/17**
**Revision Dates: 10/11, 01/16, 07/25/17**

*Member Name* | *Date of Birth* | *AHCCCS ID #*

## RECEIVING CONTRACTOR INFORMATION

*CONTRACTOR NAME*

*FISCAL COUNTY NAME* | *FISCAL COUNTY NUMBER* | *PROVIDER ID #*

**TRANSFER:** ☐ **APPROVE** ☐ **DENIED** *EFFECTIVE ENROLLMENT DATE:*

*AUTHORIZED SIGNATURE* | *TITLE* | *DATE*

**IF APPROVED, COMPLETE MEMBER/RECIPIENT INFORMATION BELOW AND SEND THIS FORM TO THE AHCCCS ADMINISTRATION. IF REQUEST DENIED, RETURN FORM TO ORIGINATOR.**

## MEMBER/RECIPIENT INFORMATION

**IS THIS A CHANGE IN CONTRACTORS WITHIN MARICOPA COUNTY?** ☐ **YES** ☐ **NO**

**IS THE CHANGE DUE TO A MOVE TO A NEW COUNTY OF FISCAL RESPONSIBILITY?** ☐ **YES** ☐ **NO**

**HAS THE MEMBER/RECIPIENT PHYSICALLY MOVED TO A NEW COUNTY OF FISCAL RESPONSIBILITY?** ☐ **YES** ☐ **NO**

**IF YES, PROVIDE THE NEW ADDRESS BELOW.**

## EFFECTIVE DATE OF THE MOVE

*RESIDENTIAL ADDRESS:* | *FACILITY NAME (IF APPLICABLE)*

*PHONE #* | *STREET* | *CITY* | *STATE* | *ZIP*

*MAILING ADDRESS (IF DIFFERENT)* | *STREET* | *CITY* | *STATE* | *ZIP*

**TYPE OF PLACEMENT:** ☐ **HOME & COMMUNITY BASED – SPECIFY:**

☐ **NURSING HOME** ☐ **OTHER – SPECIFY:**

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|---|---|---|

**AHCCCS CONTRACTOR CHANGE REQUEST COORDINATOR USE ONLY**

☐ **LOCAL OFFICE CONTACTED:** _____ _____ _____
*NAME* *DATE* *INITIALS*

☐ **LOCAL OFFICE CHANGES MADE:** _____ _____ _____
*NAME* *DATE* *INITIALS*

☐ **MFIS REFERRAL COMPLETED** _____ _____
*DATE* *INITIALS*

☐ **ENROLLMENT EFFECTIVE DATE ADJUSTED IN PMMIS** _____ _____
*DATE:* *INITIALS:*

**COMMENTS:** _____

DE-621 WHITE – Coordinator • CANARY – Current Contractor • PINK – Receiving Contractor



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