AHCCCS
Arizona Health Care Cost Containment System

AMPM CHAPTER 500, CARE COORDINATION REQUIREMENT

AMPM POLICY 520, ATTACHMENT A, ENROLLMENT TRANSITION INFORMATION (ETI) FORM

1.	Member Name	AKA			Telephone
2.	AHCCCS ID #		DOB		Male □ Female □
3.	Rate Code	County Name & #			
4.	Relinquishing Contractor /RBHA				
5.	Receiving Contractor/RBHA				
6.	Medicare Part A □ Part B □	Other Insurance			Plan ID #
7.	ALTCS Application Pending Yes □ No □	Date			
8.	Diagnosis	Secondary Diagnosis			
9.	PCP Name				Telephone
10.	High Risk Yes □ No	Explain Risk			
11.	Pregnancy EDC	Maternity Provider			Telephone
12.	Special Medications				Injectable Yes □ No □
13.	Transplant Yes □ No □	Type	Date	Facility	
14.	Catastrophic Reinsurance Yes □ No □	Diagnosis			
15.	Specialist Name	Type			Telephone
16.	Out-of-Area-Appt Yes □ No □	Provider			Telephone
17.	Outpatient Services Yes □ No □	Provider			Telephone
18.	Outpatient Adult PT Yes □ No □	# of Visits in Current Contract Year			
19.	Home Health Yes □ No	Provider			Telephone
20.	Home Health Services				
21.	Case Management Yes □ No □	Please Explain			
22.	Case Manager Name				Telephone
23.	Inpatient Yes □ No	Facility Name			Telephone
24.	SNF Yes □ No □	Facility Name			Telephone
25.	# of SNF Days used/benefit year				
26.	Residential Yes □ No □	Facility Name			Telephone
27.	Admitting Diagnosis				
28.	Admission Date				
29.	ALTCS Dental Benefit Used ($)	Expected Discharge Date			
30.	CRS Diagnosis(s)				
31.	Behavioral Health Yes □ No □	Provider			Telephone
32.	COT Yes □ No □	Court of Jurisdiction			
33.	Special Assistance (SMI) Yes □ No □	Contact Name & Relation:			Telephone:
34.	Guardian Yes □ No □	Name			Telephone
35.	Respite Hrs Used				
36.	DME Vendor	Telephone			Date
37.	Type of DME Equipment				Telephone
38.	Medical Foods Yes □ No □	Vendor			Own □ Rent □
39.	Other Care Needs				
40.	Non-Emergency Medical Transportation Yes □ No □	Mode			
41.	Date Transportation Needed	Destination			

Effective Date: 10/01/18
Revised: 04/98, 4/05, 10/01/10, 10/01/11, 07/01/16, 11/02/17

42.	**Person Completing Form**	**Telephone**
43.	**Date of Notification to Receiving Contractor**	

This information is considered CONFIDENTIAL and disclosure is governed by applicable Federal, State, and Agency regulations. Information on this form is current as of this notification date. This form must be completed for all members requiring transition services in accordance with AHCCCS policies: No changes or revisions to this form are permitted without written approval from AHCCCS.