EXHIBIT 1120-1

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
INITIAL DIALYSIS CASE CREATION FORM

INITIAL DIALYSIS CASE CREATION FORM

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 START DATE
(only for initial certification)

____ DIALYSIS FACILITY

PLEASE SUBMIT THIS FORM TO AHCCCS FOR ALL NEW DIALYSIS PATIENTS.
FAX: (602) 256-6591

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