Exhibit 26-2

CLAIM STATUS REQUEST FORM

Provider Name :____________________________ Provider # :____________________ Contact : _____________________________

Please complete one request for each different provider ID. ****CRN and Claim Status Spaces for AHCCCS use only**

Recipient’s name:	Recipient’s AHCCCS ID:	Dates of service:	Billed amount:
**CRN:	**Claim Status		
Recipient’s name:	Recipient’s AHCCCS ID:	Dates of service:	Billed amount:
**CRN:	**Claim Status		
Recipient’s name:	Recipient’s AHCCCS ID:	Dates of service:	Billed amount:
**CRN:	**Claim Status		
Recipient’s name:	Recipient’s AHCCCS ID:	Dates of service:	Billed amount:
CRN:	Claim Status		
Recipient’s name:	Recipient’s AHCCCS ID:	Dates of service:	Billed amount:
**CRN:	**Claim Status		
Recipient’s name:	Recipient’s AHCCCS ID:	Dates of service:	Billed amount:
**CRN:	**Claim Status		
Recipient’s name:	Recipient’s AHCCCS ID:	Dates of service:	Billed amount:
**CRN:	**Claim Status		
Recipient’s name:	Recipient’s AHCCCS ID:	Dates of service:	Billed amount:

Completed By:_______________________________ Date completed: _______________________ Page ____ of ____ pages