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 patient’s ESRD would reasonably be expected to result in:

· Placing the patient’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.

Print Certifying MD Name

Certifying MD 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