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| Transplant Stage Invoice Cover Sheet |

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| Mail or deliver to:  AHCCCS /DHCM/Reinsurance Unit 701 East Jefferson Street  Mail Drop 6100  Phoenix, Arizona 85034  Fax 602-417-4725 |

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Date:

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| Contractor Name (Health Plan or Program Contractor) |  | |
| AHCCCS ID # for Contractor and Facility |  |  |
| Submitted By |  | |
| Contact Phone Number |  | |
| E-mail address |  | |
| Recipient Name |  | |
| Recipient AHCCCS ID # |  | |
| AHCCCS Transplant Case Number |  | |
| Stage Description |  | |
| Stage Number & Stage Name |  | |
| Stage Dates of Service |  | |
| Total Billed Charges for Stage |  | |
| Contractor Paid Amount |  | |

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| **Box A1**  Listing of Non-payable charges due to OPFS: CRN(s) listed in numerical order by form type | | **Box A2**  Listing of Denied Services CRN(s) listed in numerical order by form type | | Reinsurance Action Request Form Attached  Yes  or No |
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| **Total $** |  | **Total $** |  |
| **Spread Sheet Attached Yes**   **No** | | | |

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| **Submissions must include the following:**  Facility Invoice, Proof of Payment, Facility Claims (totaled by form type), Letter of Agreement (if place of service is a non-contracted facility) | | | |
| **Box B minus Box A2 must equal Box C** | | | |
| **Box B TBC from Attached Claims** | | **Box C TBC from PMMIS Screen** | |
| Attached Form I Total $ |  | RI115 Form I Total $ |  |
| Attached Form O Total $ |  | RI115 Form O Total $ |  |
| Attached Form A Total $ |  | RI115 Form A Total $ |  |
| Attached Form C Total $ |  | RI115 Form C Total $ |  |