# SUBMIT COMPLETED DOCUMENT TO: [IMDPLACEMENT@AZAHCCCS.GOV](mailto:IMDPlacement@azahcccs.gov)

# ACOM POLICY 109 - ATTACHMENT A - INSTITUTION FOR MENTAL DISEASE (IMD)

# PLACEMENT EXCEEDING 15 DAYS

## REQUESTING CONTRACTOR INFORMATION

|  |  |
| --- | --- |
| Submitting Contractor Name: |  |
| Submitting Contractor Contact Name: |  |
| Submitting Contractor Contact Phone Number: |  |
| Submitting Contractor Contact Email: |  |

Was notification provided to other responsible entity? Yes  No  N/A (Integrated Member)

## MEMBER INFORMATION

|  |  |
| --- | --- |
| Member Name - First/Last |  |
| Member DOB: |  |
| Member AHCCCS ID: |  |
| IMD Name: |  |
| IMD Provider ID: |  |

|  |  |
| --- | --- |
| **First IMD Admit Date**: |  |
| First IMD Admit Date of/Anticipated Date of Discharge: |  |
| Total Days During the Calendar Month of First IMD Stay: |  |

|  |  |
| --- | --- |
| **Second IMD Admit Date**: |  |
| IMD Name: |  |
| IMD Provider ID: |  |
| Second IMD Admit Date of/Anticipated Date of Discharge: |  |
| Total Days During the Calendar Month of Second IMD Stay: |  |

|  |  |
| --- | --- |
| **Third IMD Admit Date**: |  |
| IMD Name: |  |
| IMD Provider ID: |  |
| Third IMD Admit Date of/Anticipated Date of Discharge: |  |
| Total Days During the Calendar Month of Third IMD Stay: |  |

|  |  |
| --- | --- |
| **Fourth IMD Admit Date**: |  |
| IMD Name: |  |
| IMD Provider ID: |  |
| Fourth IMD Admit Date of/Anticipated Date of Discharge: |  |
| Total Days During the Calendar Month of Fourth IMD Stay: |  |

|  |  |
| --- | --- |
| **Fifth IMD Admit Date:** |  |
| IMD Name: |  |
| IMD Provider ID: |  |
| Fifth IMD Admit Date of/Anticipated Date of Discharge: |  |
| Total Days During the Calendar Month of Fifth IMD Stay: |  |

|  |  |
| --- | --- |
| Date of 16th Day of IMD Stay in Month:  or  Date of 16th Cumulative Day of IMD Stay in Month:  (if applicable) |  |