# SUBMIT COMPLETED DOCUMENT TO: 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: |  |

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| --- | --- |
| **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:  |  |

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