

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:	

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)	
16 th Day of IMD Stay in Month:	
Date of 16 th Cumulative Day of IMD Stay in Month:	