

AHCCCS CONTRACTOR OPERATIONS MANUAL

201, ATTACHMENT A - AHCCCS NOTIFICATION TO WAIVE MEDICARE PART D COPAYMENT

Fax to AHCCCS Member Contact and Data Unit (MCDU): mcdumemberescalations@azahcccs.gov AHCCCS ID NUMBER: **MEMBER NAME** DATE OF BIRTH TYPE OF MEDICAL **AHCCCS PROVIDER** NAME OF MEDICAL **DATE OF ADMISSION ID NUMBER INSTITUTION INSTITUTION COMMENTS: CONTRACTOR NAME** DATE SUBMITTED BY **TITLE**

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Effective Dates: 07/18/13, 07/01/16, 09/20/17, 10/30/19

PHONE NUMBER

Approval Dates: 09/07/17, 05/30/19