|  |  |  |
| --- | --- | --- |
| **Change Reason**: | Medical Continuity of Prenatal Care | **Medical Continuity of Care** |

**Instructions for submission:**

If the Medical Directors of both the Receiving and Relinquishing Contractors agree to the change of Contractor, Attachment A shall be faxed to AHCCCS Member Contact and Data Unit (MCDU) Attention: Medical Director at 602-252-6536.

If the Medical Directors of both the Receiving and Relinquishing Contractors have discussed the request and have not been able to come to an agreement, the Relinquishing Contractor shall fax Attachment A to AHCCCS/Medical Management (MM) Manager at 602-252-2180.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Member Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Member Name: | | | | | |  | AHCCCS ID: | | |  | | | | | | | Phone #: | | | |  | | - | | | |  | | | | - | |  | | |
| Address: | |  | | | | | Apt/Space #: | | |  | | | DOB: | |  | | - |  | | | - | | |  | | | | Sex: | | | | | |  | |
| City: | |  | | | | | State: | |  | | | | ZIP: | |  | | | | |  | | | | | |  | | | |  | | | | | |
| Member’s PCP: | | | | |  | |  | | | | |  | | | | | Phone #: | | | |  | | | - | | | |  | | | | - | |  | |
|  | | | |  | | |  | | | | |  | | | | |  | | |  | | | |  | | | |  | | | |  | |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Relinquishing Contractor** | | | **Receiving Contractor** | | |
| Contractor Name: | |  | Contractor Name: | |  |
| Contractor ID #: |  | | Contractor ID #: |  | |
| Contact Name: |  | | Contact Name: |  | |
| Contact Phone: |  | | Contact Phone: |  | |
| Contact Fax: |  | | Contact Fax: |  | |
|  |  | |  |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider Requested for Continuity** | | | | | | | | | | | |
| Provider Name: | |  | AHCCCS ID: |  | Phone # |  | - |  | - |  | |
|  |  | |  |  |  |  |  |  |  |  | |
|  |  | |  |  |  |  |  |  |  |  | |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Documentation of Medical Continuity *(include all information supporting the need for the change)* | | | | | | | | | |
| Member requests change of Contractor to: | | | | | |  | | | |
|  | | | | | | | | | |
| Member’s effective date is: | |  | - |  | - | |  | Rate Codes: |  |
|  |  | |  |  |  | |  |  |  |

|  |  |  |
| --- | --- | --- |
| Approved Denied |  | Approved Denied |
|  |  |  |
|  |
| *Medical Director’s Signature/Relinquishing Contractor* |  | *Medical Director’s Signature/Receiving Contractor* |

|  |  |  |
| --- | --- | --- |
| Reason stated for denial by Receiving Contractor: | |  |
|  |  | |
|  | | |
|  | | |

|  |
| --- |
| Family Members Included in the Change **Provide: Family Member Name, AHCCCS ID, DOB** |
|  |
|  |
|  |

|  |
| --- |
| Attach Any Relevant Documentation **Documentation attached** |

|  |  |  |  |
| --- | --- | --- | --- |
| Section below to be filled out by AHCCCS | | | |
|  |  |  |  |
| After review by AHCCCS this Contractor change has been: | Approved  Denied | | |
|  |  |  | |
| *AHCCCS Designee* |  | *Date* | |
| *Any Contractor change request processed by the Contractor must involve continuity of care issues. If a Contractor change is requested for any other reason, the request should be managed according to*  *ACOM Policy 401.* | | | |