**Complete this form to start the Children’s Rehabilitative Services (CRS) designation completed treatment process. Return this form and all supporting medical records to:**

|  |  |  |
| --- | --- | --- |
| **Mail:**AHCCCS-CRS Unit801 E Jefferson St. MD 3500Phoenix, AZ, 85034 | **Fax:**602-252-5286 | **Email:**dmpscrs@azahcccs.gov |

|  |  |
| --- | --- |
| **MEMBER’S NAME:** |  |
| **DATE OF BIRTH:** |  |
| **AHCCCS ID:** |  |
| **DATE OF REQUEST:** |  |

|  |  |
| --- | --- |
| **THE CRS CONDITION(S) DESCRIPTION:** |  |
| **ENTITY REQUESTING:** | [ ] MSIC [ ] CRS Provider [ ] Contractor |
| **REQUESTER’S PHONE NUMBER:** |  |
| **REQUESTER’S FAX NUMBER:** |  |
| **COMMENTS:** |  |

[ ]  The contractor confirms that the member no longer requires active treatment for the CRS qualifying condition(s).