I am the treating physician for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

 Member Name Member Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ who has been diagnosed with End-Stage Renal Disease (ESRD).

AHCCCS ID #

It is my opinion that in the absence of the following dialysis treatments per week, the member’s ESRD would reasonably be expected to result in:

* Placing the member’s health in serious jeopardy,
* Serious impairment of bodily function, or
* Serious dysfunction of a bodily organ or part.

It is my medical opinion that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ requires \_\_\_\_\_\_ dialysis treatments per week. Member Name

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Provider Name AHCCCS Provider ID #:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dialysis Start Date

(only for initial certification)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dialysis Facility

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| **Submit This Form to AHCCCS/DFSM for All New Dialysis Patients****Fax: (602) 256-6591** |

For Questions Call (602) 417-4400