|  |
| --- |
|  **Current Contractor Information** |
|  |  |  |
| ***Person Requesting Change*** |  | ***Phone #*** |
|  |
| ***Contractor Name*** |
|  |
| ***Fiscal County Name*** |
|  |  |  |  |  |  |  |  |  |  |  |
| **Transfer** |  | **Approved** |  |  | **Denied** |
|  |  |  |  |  |  | ***Fiscal County #:*** |  | ***Provider ID #:*** |  | ***Date:*** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Reason:** |  |  |  |  |  |
|  |  |
|  | **Member/Recipient Leaving Service Area** |  |
|  |  |
|  | **Member/Recipient Resides Out of Service Area** |
|  |  |  |
|  | **Within Service Area for Medical Continuity of Care** |
|  |  |
|  | **Family Request** |  |
|  |  |
|  | **Other – Specify:** |

|  |  |
| --- | --- |
| **Comments/Current Medical Condition:*****(Attach Medical Release, Current Plan of Care and Other Necessary Information)*** |  |
|  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| ***Authorized Signature*** |  | ***Title*** |  | ***Date*** |

|  |
| --- |
| **Receiving Contractor Information** |
|  |
| ***Contractor Name*** |
|  |  |  |  |  |
| ***Fiscal County Name*** |  | ***Fiscal County Number*** |  | ***Provider ID #*** |
|   |  |
| **Transfer:** |  | **Approved** |  |  | **Denied** | ***Effective Enrollment Date:*** |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| ***Authorized Signature*** |  | ***Title*** |  | ***Date*** |

|  |
| --- |
| **If approved, complete member/recipient information below and send this form to the AHCCCS Administration. If request denied, return form to originator.** |
| **Member/Recipient Information** |
|  |
| **Is this a change in Contractors within Maricopa County?** |  | **Yes** |  |  | **No** |
|  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Is the change due to a move to a new county of fiscal responsibility?** |  | **Yes** |  |  | **No** |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Has the member/recipient physically moved to a new county of fiscal responsibility?** |  |  |  |  |  |
|  | **Yes** |  |  | **No** |

|  |  |
| --- | --- |
| **If YES, provide the new address below.**  |  |

|  |
| --- |
| **Effective Date of the Move** |
|  |  |  |
| ***Residential Address:*** |  | ***Facility Name (if applicable)*** |
|  |  |  |  |  |  |  |  |  |
| ***Phone #*** |  | ***Street*** |  | ***City*** |  | ***State*** |  | ***Zip*** |
|  |  |  |  |  |  |  |  |  |
| ***Mailing Address******(if different)*** |  | ***Street*** |  | ***City*** |  | ***State*** |  | ***Zip*** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Placement:** |  | **Home & Community Based – Specify:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Nursing Home** |  | **Other – Specify:** |  |

|  |
| --- |
| **AHCCCS Contractor Change Request Coordinator Use Only** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Local Office Contacted:** |  |  |  |  |  |  |
|  |  |  | ***Name*** |  | ***Date*** |  | ***Initials*** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Local Office Changes Made:** |  |  |  |  |  |  |
|  |  |  | ***Name*** |  | ***Date*** |  | ***Initials*** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **MFIS Referral Completed** |  |  |  |  |  |
|  |  |  | ***Date*** |  | ***Initials*** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Enrollment Effective Date Adjusted in PMMIS** |  |  |  |  |
|  |  | ***Date:*** |  | ***Initials:*** |  |

|  |  |
| --- | --- |
| **Comments:** |  |
|  |
|  |
|  |

DE-621 WHITE – Coordinator • CANARY – Current Contractor • PINK – Receiving Contractor