EXHIBIT 1620-8, PROGRAM CONTRACTOR CHANGE REQUEST FORM (PCCR)

Member Name	*Date of Birth*	*AHCCCS ID #*

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*

Effective Dates: 10/00, 01/16, 10/01/17
Revision Dates: 10/11, 01/16, 07/25/17

EXHIBIT 1620-8, PROGRAM CONTRACTOR CHANGE REQUEST FORM (PCCR)

Member Name | *Date of Birth* | *AHCCCS ID #*

RECEIVING CONTRACTOR INFORMATION

CONTRACTOR NAME

FISCAL COUNTY NAME | *FISCAL COUNTY NUMBER* | *PROVIDER ID #*

TRANSFER: ☐ **APPROVE** ☐ **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:**

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EXHIBIT 1620-8, PROGRAM CONTRACTOR CHANGE REQUEST FORM (PCCR)

Member Name	*Date of Birth*	*AHCCCS ID #*

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

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Revision Dates: 10/11, 01/16, 07/25/17