Questions? Call 602-364-4558 or 800-867-5808

MEMBER INFORMATION

FIRST NAME:	***MIDDLE NAME:***	***LAST NAME:***
DATE OF BIRTH:	***AHCCCS ID:***	***CURRENT HEALTH PLAN***
HEALTH PLAN REQUESTED		***DATE OF LAST BEHAVIORAL HEALTH SERVICE***

REASON FOR THE REQUEST

Please provide the reason you are requesting administrative decertification.

ATTESTATION STATEMENT

Please read each statement carefully. If you agree with the statement please check the box.

☐ I understand that I have been determined eligible for Serious Mental Illness (SMI) services; however, I have not been getting services through the RBHA or TRBHA for at least two years.

☐ I understand that by signing this form I will no longer be eligible to receive services through the SMI program. SMI services might include a case manager, SMI related housing resources and subsidies, and some Non-Title XIX/XXI funded services. I also understand that my decertification may affect my copayment structure and that it could affect my eligibility for AHCCCS if it is based upon the AHCCCS Medical Assistance-Specialty Programs Office (formerly called SSI/MAO Unit).

☐ I understand that if I want to get SMI services in the future that I will have to go through the SMI determination process again.

☐ I understand that I can ask for a new SMI Eligibility Determination at any time by calling my Health Plan. If you need assistance identifying your health plan or information about how to contact your health plan, you may contact AHCCCS Member Services at 1(855)HEA-PLUS (1-855-432-7587). You can also find information about your health plan on the AHCCCS website.

MEMBER SIGNATURE

I understand that I will not be eligible for SMI services after submitting this form.

PRINTED NAME	***SIGNATURE***	***DATE***

Effective Date: 10/01/17, 03/01/19, 10/01/19

Approval Dates: 01/04/17, 12/06/18, 11/21/19

FOR AHCCCS USE ONLY (DO NOT COMPLETE THIS SECTION)		
MEETS DECERTIFICATION CRITERIA (YES/NO)	*AHCCCS ID*	*CIS ID*
Signature of designated representative from the AHCCCS Behavioral Health Services Unit		
NAME & CREDENTIALS	*SIGNATURE*	*DATE*