DATE OF REQUEST

ARIZONA EARLY INTERVENTION PROGRAM (AzEIP) INFORMATION					
AzEIP SERVICE COORDINATOR'S NAME		PHONE	FAX	EMAIL	
AzEIP SERVICE PROVIDING AGENCY		PHONE	FAX	EMAIL	
INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) TYPE:	☐ INTERIM	☐ INITIAL	☐ PERIODIC REVIEW	☐ ANNUAL	DATE:

CHILD'S INFORMATION			
CHILD'S NAME (LAST, FIRST, MI)	AHCCCS ID	DATE OF BIRTH	EXPECTED MONTH/ YEAR OF TRANSITION FROM AzEIP
PARENTS'/GUARDIANS' NAME(S)	PREFERRED LANGUAGE	AHCCCS HEALTH PLAN	
MAILING ADDRESS *(No., Street, City, State, ZIP)*		HOME PHONE	CELL PHONE

Dear Primary Care Physician (PCP):

The child identified above is determined eligible for the AzEIP based on:

☐ Significant developmental delay - at least two standard deviations (approximately 50%) below the mean in one or more developmental areas.

☐ A diagnosed physical or mental condition that has a high probability of resulting in a significant developmental delay.

See Attached: AzEIP Developmental Evaluation Report and results of the most recent evaluations and assessments and IFSP if applicable.

The AzEIP IFSP Team is recommending the services identified below. Please review the documentation, indicate whether each requested service is medically necessary by checking "yes" in shaded box next to each service and return to the health plan MCH or EPSDT coordinator or designee who will coordinate prior authorization for the services you deem medically necessary. If you feel the services are not medically necessary, or the child should not receive these services at this time, please explain below:

PCP NAME	PHONE	FAX	EMAIL
PCP SIGNATURE		DATE	

COMPLETED BY THE AZEIP SERVICE PROVIDING AGENCY							Completed by PCP	Completed by AHCCCS Contractor	
AzEIP Service Providing Agency TIN									
Procedure Code	Service	AzEIP Provider Name	Start Date	End Date	Frequency	Duration	Medically Necessary	Authorization	NABD Sent
							☐ Yes ☐ No	☐ Approved ☐ Denied	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Approved ☐ Denied	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Approved ☐ Denied	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Approved ☐ Denied	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Approved ☐ Denied	☐ Yes ☐ No

If services are not medically necessary, or if the PCP wants to examine the member to determine medical necessity, the AHCCCS Contractor will deny the services and send a Notice of Adverse Benefit Determination (NABD) letter to the member's parents/guardians and the AzEIP Service Coordinator.

COMPLETED BY THE AHCCCS CONTRACTOR						
The AHCCCS Contractor must document what is approved: provider, service, frequency, duration, and service start and end date. If the requested AzEIP Provider is not approved by the Contractor, the AHCCCS Contractor will identify an approved provider below.						
Provider Name	**Phone**	**Service**	**Start Date**	**End Date**	**Frequency**	**Duration**

ADDITIONAL INFORMATION

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make reasonable accommodation to allow a person with a disability to take part in a program, service, or activity. For example, this means, if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance, if possible. To request this document in an alternative format or for further information about this policy, contact your local office; TTY/TDD **Services: 7-1-1. • Free language assistance for DES services are available upon request.**