GCI-1074A FORFF (7-20)	ARIZONA DEPARTMENT OF ECONOMIC SECURITY ARIZONA EARLY INTERVENTION PROGRAM (AZEIP) AZEIP AHCCCS MEMBER SERVICE REQUEST FORM		DATE
AzEIP SERVICE COORDINATOR'S NAME	PHONE NO.	FAX NO.	EMAIL
AzEIP TBEIS CONTRACTOR	PHONE NO.	FAX NO.	EMAIL
TYPE: ☐ Initial IFSP ☐ Six Month Review ☐ Annual IFSP ☐ Other/Addendum DATE:			

Child's Information

CHILD'S NAME	AHCCCS ID NO.	DATE OF BIRTH	EXPECTED MONTH/ YEAR OF TRANSITION FROM AZEIP
PARENTS'/GUARDIANS' NAME(S)	PREFERRED LANGUAGE	AHCCCS HEALTH PLAN	PRIMARY CARE PHYSICIAN
MAILING ADDRESS *(No., Street, City, State, ZIP)*	HOME PHONE NO.	WORK PHONE NO.	CELL/MESSAGE PHONE NO.

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

Expected outcomes (refer to Individualized Family Service Plan (IFSP) as applicable):

Dear Primary Care Physician (PCP): The child identified above is eligible for AzEIP and the AzEIP Individualized Family Service Plan (IFSP) Team is recommending the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 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:

PRIMARY CARE PHYSICIAN'S SIGNATURE	DATE

TO BE COMPLETED BY THE AZEIP SERVICE COORDINATOR:					Completed by PCP	Completed by AHCCCS Contractor	
Requested Services/CPT Code	**Requested Provider and Phone No.**	**Planned Start Date**	**Frequency**	**Duration**	**Medically necessary service**	**AHCCCS Contractor**	**NOA Sent**
					☐ Yes ☐ No	☐ Approve ☐ Deny	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Approve ☐ Deny	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Approve ☐ Deny	☐ 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 letter to the member's parents/guardians and the AzEIP Service Coordinator.							

TO BE COMPLETED BY THE AHCCCS CONTRACTOR:

The AHCCCS Contractor must document what is approved: provider, frequency, duration, and service begin date and service end date.

☐ If the Service Provider is unknown, the AHCCCS Contractor will identify a Service Provider below for:

☐ Physical Therapy (PT) ☐ Occupational Therapy (OT) ☐ Speech-Language Pathologist (SLP)

☐ If the requested Service Provider is not approved by the Contractor, the AHCCCS Contractor will identify an approved provider below.

Approved Provider	Provider Phone No.	Approved Service(s)	Begin Date	End Date	Frequency	Duration

CONTACTS

Health Plan: Maternal Child Health (MCH) or EPSDT Coordinator or designee: Phone No.: Fax No.: Email:
AzEIP Coordinator/Supervisor: Phone No.: Fax No.: Email:
Primary Care Physician: Phone No.: Fax No.: Email:
Service Provider: Phone No.: Fax No.: Email:

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.**