~~Initial Dialysis Case Creation Form~~

I am the treating physician for _____, _____,
(~~Print~~ Member Name) (Member Date of Birth)

_____ who has been diagnosed with End-Stage Renal Disease (ESRD).
(AHCCCS ID #)

It is my opinion that in the absence of the following dialysis treatments per week, the member's ESRD would reasonably be expected to result in:

- Placing the member's health in serious jeopardy,~~;~~
- Serious impairment of bodily function, ~~;~~ or
- Serious dysfunction of a bodily organ or part.

It is my medical opinion that _____ requires _____ dialysis treatments per week. (Member Name)

_____ _____
Signature Date
~~Date~~

_____
_____
_____

Provider Name[1] AHCCCS Provider ID #:

_____
Dialysis Start Date
(only for initial certification)

_____
Dialysis Facility

~~Please~~ Submit This Form to AHCCCS/DFSM for All New Dialysis Patients~~.~~
Fax: (602) 256-6591

For Questions Call (602) 417-4400 ~~EXT. 67548~~

[1] Included field for providers name