~~Monthly Certification Of Emergency Medical Condition~~

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 _____
(Member Name)
dialysis treatments per week.

_____ _____
Signature Date

_____ _____
Provider Name[1] AHCCCS Provider ID #:

_____
Dialysis Facility

~~Please~~ File This Document in the Member's Medical Record Each Month.

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

[1] Included field for Provider's Name