# POLICY 430, ATTACHMENT D – ARIZONA EARLY INTERVENTION PROGRAM (AzEIP) AHCCCS MEMBER SERVICE REQUEST FORM

GCI-1074A FORFF (1-14)

Arizona Department of Economic Security
Arizona Early Intervention Program (AzEIP)

DATE

## AzEIP AHCCCS Member Service Request Form

| 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 IFSP as applicable):

**Dear Primary Care Physician:** The child identified above is eligible for AzEIP and the AzEIP Individualized Family Service Plan (IFSP) Team is recommending the 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 coordinator 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:**

| Requested Services/CPT Code | Requested Provider and Phone No. | Planned Start Date | Frequency | Duration | Completed by PCP: Medically necessary service | Completed by AHCCCS Contractor: AHCCCS Contractor | Completed by 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 Action (NOA) 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: ☐ PT ☐ OT ☐ 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 |
|---|---|---|---|---|---|---|
| | | | | | | |





**Effective Date: XX/XX/XX**
**Approval Date: 10/18/18**

| | | | | | | |
|---|---|---|---|---|---|---|
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## Contacts

Health Plan:

MCH Coordinator:

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