

Request for additional units. Existing Authorization Units

Standard Request - Determination within 14 calendar days of receiving all necessary information

Expedited Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

*INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID/Medicaid ID * Last Name, First Date of Birth *
(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI * Requesting TIN * Requesting Provider Contact Name
Requesting Provider Name Phone Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI * Servicing TIN * Servicing Provider Contact Name
Servicing Provider/Facility Name Phone Fax

AUTHORIZATION REQUEST

Primary Procedure Code * <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	Additional Procedure Code <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	Start Date OR Admission Date * <input type="text"/> (MMDDYYYY)	Diagnosis Code* <input type="text"/> <input type="text"/> <input type="text"/> (ICD-10)
Additional Procedure Code <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	Additional Procedure Code <input type="text"/> <input type="text"/> (CPT/HCPCS) (Modifier)	End Date OR Discharge Date <input type="text"/> (MMDDYYYY)	Total Units/Visits/Days <input type="text"/>

OUTPATIENT SERVICE TYPE *		(Enter the Service type number in the boxes)		<input type="text"/>	
412	Auditory Services	249	Home Health	650	Radiation Therapy
422	Biopharmacy	927	Outpatient Hospice	472	Stereotactic Radiosurgery
DME		290	Hyperbaric Oxygen Therapy	499	Transplants - Office Visit
417	Rental	410	Observation	109	Transplants - Other Visit
120	Purchase <input type="text"/> (Purchase Price)	792	Vendor	724	Transportation
299	Drug Testing	Nutritional Supplements and/or services		997	Office Visit/Consult (non par)
922	Experimental & Investigational Services	407	Enteral Feedings	365	Office Visit/Vaccines & Administration
709	Genetic Testing	441	Parenteral Feedings	370	Office Visit/Dermatology Procedure
799	Genetic Counseling	360	Modified Solid Food Supplements	375	Office Visit/ Dental

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Standard Request - Determination within 14 calendar days of receiving all necessary information.

Expedited Request - I certify this request is urgent and medically necessary to treat an injury, illness or condition (not life threatening) within 72 hours to avoid complications and unnecessary suffering or severe pain.

URGENT REQUESTS MUST BE SIGNED BY THE REQUESTING PHYSICIAN TO RECEIVE PRIORITY.

* INDICATES REQUIRED FIELD

MEMBER INFORMATION

Member ID *

Last Name, First

Date of Birth *
(MMDDYYYY)

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code
(CPT/HCPCS) (Modifier)

Start Date OR Admission Date *
(MMDDYYYY)

Diagnosis Code *
(ICD-10)

Additional Procedure Code
(CPT/HCPCS) (Modifier)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity
(MMDDYYYY)

Additional Diagnosis Code
(ICD-10)

INPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

- 141 Premature/False Labor
- 300 Neonate
- 121 Long Term Acute Care
- 492 Sub Acute
- 402 Skilled Nursing Facility

- 970 Medical
- 411 Surgical
- 209 Transplant Surgery

- Delivery**
- 779 C-Section
 - 720 Vaginal Delivery
- Inpatient Rehab**
- 220 Comprehensive Inpatient Rehab Facility
 - 479 Inpatient Hospital

**ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.**

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered benefit and medically necessary with prior authorization as per Ambetter policy and procedures.

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EXHIBIT 430-2
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
(EPSDT AGED MEMBERS - INITIAL OR ONGOING REQUESTS)

MEMBER INFORMATION Member's AHCCCS ID Number: _____ Contracted Health Plan: _____

Member's Name: _____ Date of Birth: _____
Last First Initial

Members' Address: _____

Assessment performed by: _____ AHCCCS Provider ID: _____

Provider Specialty: _____ Telephone Number: _____ Assessment Date: _____

TYPE OF REQUEST Initial Ongoing **PREFERRED SUPPLEMENT** Type: _____

Substitution Permissible: Yes No

TYPE OF NUTRITION FEEDING Weaning from Tube Feeding
 Oral Feeding –Sole Source Oral Feeding – Supplemental Emergency Supplemental Nutrition

ASSESSMENT FINDINGS: Indicate which of the following criteria have been met to support that oral supplemental nutritional feedings are medically necessary. (Supporting documentation dated no earlier than 3 months prior to the date of this request must be submitted with the Certificate of Medical Necessity to support each of the criteria selected below.)

Member Meets the Criteria in the Left Column <i>OR</i> Meets at Least Two Criteria in the Right Column	
<input type="checkbox"/> Member has been diagnosed with a chronic disease or condition, is below the recommended BMI percentile (or weight-for-length percentile for members less than two years of age) for the diagnosis per evidence-based guidance as issued by the American Academy of Pediatrics, and there are no alternatives for adequate nutrition.	<p style="margin: 0;">Use the space below, to indicate which <i>two</i> or more criteria have been met:</p> <input type="checkbox"/> Member is at or below the 10th percentile for weight-for-length/BMI, on the appropriate growth chart for their age and gender, for 3 months or more. <input type="checkbox"/> Member has reached a plateau in growth and/or nutritional status for more than 6 months, or more than 3 months if member is an infant less than 1 year of age. <input type="checkbox"/> Member has already demonstrated a medically significant decline in weight within the 3 month period prior to the assessment. <input type="checkbox"/> Member is able to consume/eat no more than 25% of nutritional requirements from age-appropriate food sources.
Additionally, Both of the Following Requirements Must be Met	
<ul style="list-style-type: none"> • The member has been evaluated and treated for medical conditions that may cause problems with growth (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems, etc.), AND • The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. ** Refer to AMPM, Policy 430. 	

Initial and Ongoing Certificate of Medical Necessity is valid for a period of 6 months. Subsequent submissions must include a current physical assessment in the form of a clinical note or other supporting documentation that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current height/weight percentiles, and BMI percentile for members two years of age or older. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

 Submitting Provider Signature _____
 Date

 Printed Name _____ _____
 Provider Type _____
 Contact Number

ATTACHMENT C
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
CERTIFICATE OF MEDICAL NECESSITY FOR COMMERCIAL ORAL NUTRITIONAL SUPPLEMENTS
FOR MEMBERS 21 YEARS OF AGE OR GREATER -INITIAL OR ONGOING REQUESTS

MEMBER INFORMATION Member's AHCCCS ID Number: _____ Contracted Health Plan: _____

Member's Name: _____ Date of Birth: _____
Last First Initial

Members' Address: _____

Assessment performed by: _____ AHCCCS Provider ID: _____

Provider Specialty: _____ Telephone Number: _____ Assessment Date: _____

TYPE OF REQUEST

TYPE OF NUTRITION FEEDING

- | | | |
|----------------------------------|--|---|
| <input type="checkbox"/> Initial | <input type="checkbox"/> Weaning from Tube Feeding | <input type="checkbox"/> Oral Feeding –Sole Source |
| <input type="checkbox"/> Ongoing | <input type="checkbox"/> Oral Feeding – Supplemental | <input type="checkbox"/> Emergency Supplemental Nutrition |

PREFERRED SUPPLEMENT Type: _____ Substitution Permissible: Yes No

ASSESSMENT: Supporting documentation dated within 3 months of this request must be submitted with the Certificate of Medical Necessity to support each of the criteria listed below.

All of the Following Requirements Must be Met
The Member is currently underweight with a BMI of less than 18.5, presenting serious health consequences for the member, or has already demonstrated a medically significant decline in weight within the 3 month period prior to the assessment.
The member is able to consume/eat no more than 25% of his/her nutritional requirements from typical food sources.
The member has been evaluated and treated for medical conditions that may cause problems with weight gain (such as feeding problems, behavioral conditions or psychosocial problems, endocrine or gastrointestinal problems, etc.)
The member has had a trial of higher caloric foods, blenderized foods, or commonly available products that may be used as dietary supplements for a period no less than 30 days in duration. ** Refer to AMPM, Policy 310-GG.

Initial and Ongoing Certificate of Medical Necessity is valid for a period of 6 months. Subsequent submissions must include a current physical assessment in the form of a clinical note or other supporting documentation that includes the members overall response to supplemental therapy and justification for continued supplement use. This must include the member's tolerance to formula, recent hospitalizations, current height, weight, and BMI. Documentation demonstrating encouragement and assistance provided to the caregiver in weaning the member from supplemental nutritional feedings should be included, when appropriate.

Submitting Provider Signature

Date

Printed Name

Provider Type

Contact Number



**Health Net Access, Inc.
Healthcare Services Department
CASE MANAGEMENT REFERRAL FORM**

URGENT (member contacted within 1 business day)

This form is for outpatient case management ONLY. Claim issues, primary care physician (PCP) changes, assistance with locating specialists, or transportation requests are processed via Member Services. If a member has a provider access issue, please contact the member's PCP and medical group. All inquiries regarding members who are currently in a skilled nursing facility (SNF), hospital, rehabilitation facility, etc., may be referred to the Concurrent Review Department (CCR). For questions regarding member authorizations, contact the Prior Authorization Department.

***Email the completed form to
CMAccess/GRP/HNCA/HNT or fax to 1-800-956-0721 or 1-855-825-6146.***

Date:	Referral Contact Name:	Contact Telephone Number:
Member Name:		Product/Tier (if applicable):
Subscriber #:	DOB:	Member Telephone Number:
Primary Diagnosis:		
Contact Person/Relationship to Member:		Telephone Number:
Attending MD/Specialist Name:		Telephone Number:

Providers must check one of the boxes below and complete the Notes/Comments section to explain the reason the member is requesting case management.

Case Management Referral Reason:

<input type="checkbox"/> Treatment/Medications needed at this time <input type="checkbox"/> Needs/Issues identified following a hospital discharge or emergency room (ER) visit <input type="checkbox"/> Needs coordination of finances to meet health needs <input type="checkbox"/> Premature/delayed discharge from appropriate level of care <input type="checkbox"/> Current disease/illness process <input type="checkbox"/> Temporary or permanent onset of new disability <input type="checkbox"/> Clinical trials <input type="checkbox"/> High-risk OB (HROB) <input type="checkbox"/> Transgender	<input type="checkbox"/> Inappropriate utilization of services <input type="checkbox"/> Safety concerns <input type="checkbox"/> High cost ongoing injury or illness <input type="checkbox"/> Lack of family/social support <input type="checkbox"/> Exhaustion of benefits <input type="checkbox"/> Transition of Care with completed application <input type="checkbox"/> Transplant (Potential/Actual) <input type="checkbox"/> Other General Case Management request <input type="checkbox"/> Complex Case Management request
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***Notes/Comments: (Referral reason must be clearly indicated below.)**

Referral to Health Net Fax Form – Health Net Access, Inc.

Health Net Access clinicians are available 24 hours a day, 365 days a year to provide education and support to Health Net Access members who have chronic conditions. **To refer a patient to Health Net’s Disease Management program, please complete this form and fax it to 1-800-451-4730. Note: Do not mail this completed form; fax only please.**

Provider Information:

Name:	
Office telephone:	
Email address:	
Date of referral:	
Reason for referral:	

Member Information:

First and Last Name	Subscriber ID #	Gender	DOB	Telephone #	Program Referred For

Referrals are accepted for the following:

Targeted Disease Management Conditions

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- Diabetes
- Heart Failure (HF)

Types of Support

- adherence to treatment plan
- gap closure
- high-risk chronic condition management
- medication persistence

For Healthy Pregnancy and for case management needs, including high-risk OB case management, please refer to the Healthcare Services Department Case Management Referral Form, available in the Forms section of the Provider Library on the Health Net provider website at provider.healthnet.com, and fax to 1-800-956-0721.

Health Net members have access to Decision Power[®] through their current enrollment with Health Net Access, Inc. Decision Power is not part of Health Net’s commercial medical benefit plans. Also, it is not affiliated with Health Net’s provider network and it may be revised or withdrawn without notice. Decision Power is part of Health Net’s Medicare Advantage benefit plans. But it is not affiliated with Health Net’s provider network. Decision Power services, including clinicians, are additional resources that Health Net makes available to enrollees of the above listed Health Net companies. Health Net and Decision Power are registered service marks of Health Net, Inc. All rights reserved.



Request for Primary Care Physician (PCP) or Medical Group Change Form

Physician Name:			
Location:			
Physician ID #:			
IPA/Med Grp #:			
Reason for Request:			
	Member Name(s)	Date of Birth	Subscriber #
1			
2			
3			
Please check Yes or No to answer the following questions:			Yes
Is the member currently hospitalized?			No
Is the member in her third trimester of pregnancy?			
Did the member receive any services with the assigned PCP/medical group?			
Is the member currently receiving treatment?			
Is the member scheduled to receive future treatment (surgery, specialist care, etc.)?			
Has the member delivered a baby within the past 60 days?			
Does the member have an infant less than 60 days old who is currently in the hospital?			
Did the member receive any services in the emergency room?			
<p>Disclaimer: Any prior authorizations submitted to or approved by the existing PCP/medical group will no longer be valid with the new PCP/medical group. If a member becomes hospitalized prior to the effective date of change, the member will be changed back to existing PCP/medical group until the episode of care is complete. If the mother of a newborn requests a PCP/medical group change prior to her first postpartum visit (which usually occurs within 40 days of delivery), the change cannot be processed. (The only exception to this is if the requested PCP is in the same medical group).</p>			
Member signature: _____			
Member address: _____			
Member telephone #: _____			
Name of staff completing transfer: _____			
Staff member's telephone #: _____ Ext. #: _____ Fax #: _____			
Additional information: _____			
Today's Date: ____/____/____		<input type="checkbox"/> Fax <input type="checkbox"/> Email Effective date: ____/____/____ (Please check one.)	
OFFICE USE:			
Date change entered: ____/____/____		Rep's Name: _____	

Please fax to:
 Attention: Health Net Access
 AZ Medicaid Member Services
 (818) 676-5161 or (818) 676-6664
Or email to: HNA_ProviderPCPTranfer@healthnet.com



Forma para Solicitar cambio de Doctor/Grupo Medico

Nombre de el Nuevo Doctor Primario:		
Number de identificacion del Medico:		
Direccion del Doctor Primario:		
Grupo Medico:		
Escriba la razon pare el cambio:		
Nombre Y Apellido	Fecha de Nacimiento	Numero de Suscriptor#
1		
2		
3		
Por favor Marque "Si"o "No" en las siguientes preguntas:		SI
Se encuentra el afiliado actualmente hospitalizado?		<input type="checkbox"/>
Esta la afiliada en su tercer trimestre de embarazo?		<input type="checkbox"/>
El afiliado ha recibido servicios medicos con su doctor primario o con un doctor afiliado a su grupo medico?		<input type="checkbox"/>
Esta el afiliado recibiendo algun tratamiento medico actualmente?		<input type="checkbox"/>
Esta el afiliado programado para recibir algun tratamiento medico futuro como una cirugia o visitas al especialista?		<input type="checkbox"/>
El afiliado tiene un Nuevo bebe de menos de 60 dias de nacido y que esta internado en algun hospital actualmente?		<input type="checkbox"/>
Por favor lea la declaracion detalladamente:		
Cualquier autorizacion previa sometida o aprobada por el doctor primario o grupo medico al que esta asignado actualmente, no sera valida con el nuevo doctor primario o grupo medico.		
Si el miembro se encuentra hospitalizado en el dia efectivo del cambio, el cambio sera anulado y se mantendra con el mismo doctor primario y grupo medico hasta que el tratamiento de cuidado sea completado.		
Si tiene un recién nacido y solicita un cambio de doctor primario y grupo medico y no ha completado su cuidado postnatal, que usualmente se completa entre los 40 dias despues del parto, el cambio no podra ser procesado. La unica excepcion seria si cambia con un doctor primario dentro del mismo grupo medico.		
Firma del afiliado: _____		
Domicilio del afiliado: _____		
Nombre del Representate que completa la forma: _____		
Numero de telefono del Representante: _____ Ext: _____ # de Fax: _____		
Informacion Adicional: _____		
(Marque <input checked="" type="checkbox"/> uno)		
Fecha de hoy: ____/____/____		Como fue enviado? <input type="checkbox"/> Fax <input type="checkbox"/> Correo Electronico
Fecha efectiva: ____/____/____		
Uso Interno:		
Cambio de Fecha entó: ____/____/____		Rep's Name: _____

Por Favor envíe por Fax
Atencion: Health Net Access
AZ Medicaid Member Services
(818) 676-5161 or (818) 676-6664
Correo Electronico a:

HNA_ProviderPCPTTransfer@healthnet.com

CASE MANAGEMENT REFERRAL FORM
Fax referrals to 800-840-3813

- SC/COC HMO PPO/POS RPPO
 TUCSON PHOENIX

MEMBER INFORMATION		REFERRAL INFORMATION	
NAME:		REFERRED BY:	
ID#:		CONTACT # FOR ABOVE:	
DIAGNOSIS: PRIMARY		SECONDARY	
REFERRAL REASON			
PCP INFORMATION		SPECIALIST INFORMATION	
NAME		NAME	
LAST	FIRST	LAST	FIRST
PHONE(S)		PHONE(S)	
FAX		FAX	
NAME		NAME	
LAST	FIRST	LAST	FIRST
PHONE(S)		PHONE(S)	
FAX		FAX	
STAFF ASSIGNED Case Management (internal use only)			
NAME		DATE	
REFERRALS			
RENAL <input type="checkbox"/>	ALERE <input type="checkbox"/>	TRANSPLANT <input type="checkbox"/>	COMPLEX <input type="checkbox"/>
<input type="checkbox"/> INSTITUTIONALIZED MBR <input type="checkbox"/> ALTCS / AHCCS <input type="checkbox"/> OTHER (Specify)			



PROVIDER STATE FAIR HEARING REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Provider Inquiry Request form instead of this form.

Mail the completed form to the following addresses. Please note the specific address for all Health Net Access disputes.

Health Net Access Provider State Fair Hearing
1230 West Washington Street, Suite 401, Tempe, AZ 85281-1245
Health Net Access Provider Services (888) 788-4408

For provider dispute inquiries or filing information, contact us at the phone numbers listed above.

*PROVIDER NAME:		*PROVIDER TAX ID #:
PROVIDER ADDRESS:		Contracting: Y/N (pls. circle)

PROVIDER TYPE: Physician Mental Health Hospital ASC/ Outpatient Services SNF DME
 Rehab Home Health Ambulance Other Professional (please specify type of "other") _____

***CLAIM INFORMATION:** Single Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:* _____

*Patient Name:		Date of Birth:
*Social Security Number :	*AHCCCS ID:	*Original Claim ID Number: (If multiple claims, use attached spreadsheet)
*Service "From/To" Date:	Original Claim Amount Billed:	Original Claim Amount Paid:

Dispute Type: Claim Appeal of Medical Necessity/Utilization Management Decision Contract Dispute
 Seeking Resolution of a Billing Determination Disputing a Request For Reimbursement of Overpayment Other

***DESCRIPTION OF DISPUTE: INDICATE REASON FOR DISPUTE, PROVIDER'S POSITION AND RATIONALE (Additional paper can be attached if necessary)**

***EXPECTED OUTCOME: PLEASE PROVIDE BY CLAIM, IF MULTIPLE**

_____	_____	()
Contact Name (please print)	Title	Telephone # (w/area code)
_____	_____	()
Signature and date	Email address	Fax # (w/area code)

[] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED:**
(Please do not staple information)

For Health Use Only
Case # _____
Provider # _____

PROVIDER STATE FAIR HEARING REQUEST

INSTRUCTIONS: (For use with multiple "like" claims only)

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Provider Inquiry Request Form instead of the Provider Dispute Resolution Form.

Mail the completed form to the following addresses:

Health Net Access Provider State Fair Hearing
 1230 West Washington Street, Suite 401, Tempe, AZ 85281-1245
 Health Net Access Provider Services (888) 788-4408

For provider dispute inquiries or filing information, contact us at the phone numbers listed above.

Number	*Patient Name		Date of Birth	*Member ID No./ AHCCCS Number	*Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	*Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED:

(Please do not staple information)

HN Access/Provider State Fair Hearing Form

4/1/15

Page ____ of ____

<p>For Health Plan Use Only Case # _____ Provider # _____</p>
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PROVIDER CLAIM DISPUTE FORM

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required
 - Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME
 - Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed
 - For routine follow-up, please use the Provider Inquiry Request Form instead of this form
- Mail the completed form to the following address, which is specific to Health Net Access disputes.
 Health Net Access Provider Dispute Unit
 1230 West Washington Street, Suite 401, Tempe, AZ 85281-1245
 Health Net Access Provider Services: (888) 788-4408
 For provider dispute inquiries or filing information, contact us at the telephone number listed above.

*PROVIDER NAME:		*PROVIDER TAX ID #:	
PROVIDER ADDRESS:			Contracting: Y / N (circle)

PROVIDER TYPE: Physician Mental health Hospital ASC/outpatient services SNF DME
 Rehab Home health Ambulance Other: _____

***CLAIM INFORMATION** Single Multiple "LIKE" claims (complete attached spreadsheet) Number of claims: _____

*Member Name:		Date of Birth:	
*Social Security Number:	*AHCCCS ID:	*Original Claim ID Number: (If multiple claims, use attached spreadsheet)	
*Service "From/To" Date:	Original Claim Amount Billed:	Original Claim Amount Paid:	

DISPUTE TYPE: Dispute of Medical Necessity/Utilization Management Decision Contract Dispute
 Seeking Resolution of a Billing Determination Disputing a Request for Reimbursement of Overpayment Other

***DESCRIPTION OF DISPUTE: INDICATE REASON FOR DISPUTE, PROVIDER'S POSITION AND BASIS** (Additional paper can be attached if necessary)

***EXPECTED OUTCOME: PLEASE PROVIDE BY CLAIM, IF MULTIPLE**

_____	_____	()
Contact Name (please print)	Title	Telephone # (w/area code)
_____	_____	()
Signature and date	Email address	Fax # (w/area code)

[] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED:**
 (Please do not staple information)

For Health Use Only
Case # _____
Provider # _____

PROVIDER CLAIM DISPUTE

INSTRUCTIONS: (For use with multiple "like" claims only)

- Please complete the below form. Fields with an asterisk (*) are required
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME
- Provide additional information to support the description of the dispute
- Do not include a copy of a claim that was previously processed
- For routine follow-up, please use the Provider Inquiry Request Form instead of the Provider Dispute Resolution Form

Mail the completed form to the following address:

Health Net Access Provider Dispute Unit
 1230 West Washington Street, Suite 401, Tempe, AZ 85281-1245
 Health Net Access Provider Services: (888) 788-4408

For provider dispute inquiries or filing information, contact us at the telephone number listed above.

Number	*Patient Name		Date of Birth	*Member ID No./ AHCCCS Number	*Original Claim ID Number	*Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	*Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED:

(Please do not staple information)

Page ____ of ____

<p>For Health Plan Use Only Case # _____ Provider # _____</p>
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**Health Net Access Health Education Department
Provider Order Form for Health Education Materials**

**No Cost Health Education Materials for Health Net Access Members
Fax Request to (800) 628-2704 Any Questions Call (800) 804-6074**

Today's Date: _____

PROVIDER INFORMATION-PLEASE PRINT CLEARLY	
Provider/Clinic/Organization Name:	Contact Name:
Address:	Phone Number:

- **50 materials will be sent for each topic ordered. Please allow 4-6 weeks for processing & delivery.**
- **A maximum of 5 topics may be ordered each month.**
- **Clinics needing a larger order must call (800) 804-6074.**

SELECT REQUESTED TOPICS AND LANGUAGES			
Topic	Language	Topic	Language
Asthma: Take Control of Your Asthma	<input type="checkbox"/> English <input type="checkbox"/> Spanish	Kids and Teens Challenge Incentive Program Flyer	<input type="checkbox"/> English & Spanish
Dental: Healthy Teeth for Happy Smiles	<input type="checkbox"/> English & Spanish	Nutrition: Healthy Breakfast	<input type="checkbox"/> English & Spanish
Diabetes: Tips to Control Diabetes	<input type="checkbox"/> English <input type="checkbox"/> Spanish	Nutrition: Healthy Eating for Healthy Living	<input type="checkbox"/> English <input type="checkbox"/> Spanish
Exercise: Basics of Exercise	<input type="checkbox"/> English <input type="checkbox"/> Spanish	Weight Control Tips	<input type="checkbox"/> English & Spanish
High Blood Pressure	<input type="checkbox"/> English <input type="checkbox"/> Spanish		

*Materials are available in alternative formats upon request.

Health Net Access members can get additional health education information and wellness resources by logging on to www.healthnet.com/access.

AHCCCS EPSDT TRACKING FORMS

The Arizona Health Care Cost Containment System (AHCCCS) EPSDT Tracking Forms must be used by all providers offering care to AHCCCS members less than 21 years of age to document age-specific, required information related to EPSDT screenings and visits. Only AHCCCS EPSDT Tracking Forms may be used; paper form substitutes are not acceptable. However, the provider may choose to utilize an electronic EPSDT Tracking Form generated through AHCCCS (once available) or the provider's electronic health record system, so long as the electronic form includes all components present on the AHCCCS EPSDT Tracking Form. These components include, but are not limited to:

- Documentation of comprehensive physical exam (including appropriate weights and vital signs)
- Age-appropriate screenings (vision, hearing, oral health, nutrition, developmental, nutritional, tuberculosis (TB) and lead)
- Developmental surveillance
- Anticipatory guidance (Age Appropriate Education and Guidance)
- Social-emotional health (Behavioral Health) surveillance
- Age-appropriate labs and immunizations, and
- Medically necessary referrals including those to the member's dental home starting at 1 year of age, or sooner as needed, for routine biannual examinations.

Interested persons may refer to Chapter 400 in this Manual for a discussion of EPSDT responsibilities and services.

AHCCCS Contractors are required to print two-part carbonless EPSDT Tracking Forms (a copy for the medical record and a copy for providers to send to the Contractor's EPSDT Coordinator) and distribute these forms to their contracted providers. Providers may also choose to print the EPSDT Tracking Form from the AHCCCS website.

A copy of the completed EPSDT Tracking Form, signed by the clinician, should be placed in the member's medical record. Depending on the member's enrollment status, an additional distributed copy of the EPSDT Tracking Form may be required, as detailed below.

- For members enrolled with an AHCCCS Contractor, a copy of the completed and signed form must be sent to that Contractor.
- For AHCCCS Fee-For-Service members [e.g., enrolled in the American Indian Health Program (AIHP)], the provider should maintain a copy of the EPSDT Tracking Form in the medical record, but does not need to send a copy elsewhere.

AHCCCS Contractors and AHCCCS medical providers may reproduce EPSDT Tracking Forms as needed. All others may reproduce the forms with permission of AHCCCS via an approved written request directed to:

AHCCCS
Division of Health Care Management
CQM/Maternal and Child Health
701 E. Jefferson, Mail Drop 6700
Phoenix, AZ 85034
(602) 417-4410

NOTE: The Centers for Medicare and Medicaid Services require AHCCCS to provide specified services to our EPSDT population. These EPSDT Tracking Forms have been designed to ensure that needed services are performed, and that our members are provided an opportunity to receive preventive care. Please do NOT alter or amend these forms in any way without discussion with our Maternal and Child Health Manager at the address above.

Contact information for AHCCCS Contracted health care plans may be found at www.ahcccs.state.az.us.

Date	Last Name	First Name	AHCCCS ID #	DOB	Age				
Primary Care Provider		PCP ph. #	Health Plan	Accompanied By (Name)					
Relationship									
Admitted to NICU: (Birth)		Current Medications/Vitamins/Herbal Supplements:			Temp:	Pulse:	Resp:		
<input type="checkbox"/> Yes	<input type="checkbox"/> No								
Allergies:		Birth Weight:		Weight:		Length:		Head Circumference:	
		lb	oz	lb	oz	%	cm	%	cm
Hospital Newborn Hearing Screen: <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown									
Second Newborn Hearing Screen (If 2 nd Needed/Completed): <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown									

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

ORAL HEALTH: Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed)

NUTRITIONAL SCREENING: Breastfeeding Frequency/Duration: _____ Supplements: _____ Vit D

Formula Type: _____ Amount/Duration: _____ Adequate Weight Gain Yes No Receiving WIC Services

DEVELOPMENTAL SURVEILLANCE: Rooting Reflex Startle Suck & Swallow Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention

Car/Car Seat Safety (Rear-Facing) Safe Sleep Shaken Baby Prevention Safe Bathing/Water Temperature

Passive Smoke Safety at Home/Child-Proofing Sun Safety Pacifier Use Bottle Propping Infant Bonding

Support Systems/Resources Infant Crying/Appropriate Interventions Other: _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child

Appropriate Bonding/Responsive to Needs Infant Hands to Mouth/Self-Calming Baby Blues/Postpartum Depression Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision/Red Reflex			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: 2nd Arizona Newborn Screening Bloodspot Test (5 – 10 Days of Age or First PCP Visit) Other _____

IMMUNIZATIONS ORDERED: DATE 1ST HEPB ADMINISTERED: _____ HepB (Not Previously Administered) Other _____

Given at Today's Visit Parent Refused Delayed Deferred Reason: _____

Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC

Specialist: Developmental Behavioral Other _____ 2nd Newborn Hearing Screen (If Needed)

Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied By (Name)	Relationship

Admitted to NICU: <i>(Birth)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Temp:	Pulse:	Resp:	
Allergies:	Birth Weight:	Weight:		Length:	Head Circumference:
	lb oz	lb oz	%	cm	%

Risk Indicators of Hearing Loss: Yes No

Hospital Newborn Hearing Screen: ABR OAE: **Rt. Ear** Pass Refer **Lt. Ear** Pass Refer Unknown

Second Newborn Hearing Screen (If 2nd Needed/Completed): ABR OAE: **Rt. Ear** Pass Refer **Lt. Ear** Pass Refer Unknown

FAMILY/SOCIAL HISTORY: *(Current Concerns/ Follow-Up on Previously Identified Concerns)*

PARENTAL CONCERNS: *How are you feeling about baby? Do you feel safe in your home?*

ORAL HEALTH: Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed)

NUTRITIONAL SCREENING: **Breastfeeding** *Frequency/Duration:* _____ **Supplements:** _____ Vit D
 Formula Type: _____ *Amount/Duration:* _____ **Adequate Weight Gain** Yes No **Receiving WIC Services**

DEVELOPMENTAL SURVEILLANCE: Some Head Control Tummy Time/Lifts Head, Neck With Forearm Support Social Smile
 Coos Begins Imitation of Movement and Facial Expressions Makes Eye Contact Fixes/Follows With Eyes to Midline
 Startles At Loud Noises Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car/Car Seat Safety (*Rear-Facing*) Safe Sleep Shaken Baby Prevention Safe Bathing/Water Temperature Passive Smoke
 Safety at Home/Child-Proofing Sun Safety Pacifier Use Bottle Propping Infant Bonding Support Systems/Resources
 Infant Crying/Appropriate Interventions Parent Reads to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Appropriate Bonding/Responsive to Needs Infant Hands to Mouth/Self-Calming Enjoys Interacting With Others
 Postpartum Depression Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)	WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs	
Eyes/Vision/Red Reflex			Abdomen	
Ear			Genitourinary	
Mouth/Throat/Teeth			Extremities	
Nose/Head/Neck			Spine	
Heart			Neurological	

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: 2nd Arizona Newborn Screening Bloodspot Test (*If Needed*) Other _____
 Results of 2nd AZ Newborn Screening Received (*If No, What Follow Up Taken:* _____)

IMMUNIZATIONS ORDERED: HepB DTaP Hib IPV PCV Rotavirus Other _____
 Given at Today's Visit Parent Refused Delayed Deferred *Reason:* _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC
Specialist: *Developmental* *Behavioral* *Other* _____

Date/Time	Clinician Name (Print)	Clinician Signature	NPI #	See Additional Supervisory Note <input type="checkbox"/> Yes <input type="checkbox"/> No
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Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	
Current Medications/Vitamins/Herbal Supplements:			Blood Pressure:	Temp:	Pulse:
Allergies:	Weight:		Height:		BMI:
	lb / kg	%	cm	%	kg/m ² %
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to Perform
Hearing Screening:	Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	Age Appropriate Speech:	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about your child? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing (Twice Daily by Parent) Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet Junk Food Soda/Juice Supplements _____
 Activity/Family Exercise Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Uses Imaginary Characters Matches Colors and Shapes Counts to 5 Knows Gender
 Names Self & Others Begins to Play Interactive Games Stand on One Foot Communication/Language Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing Sun Safety Sports/Helmet Use TV Screen Time
 Supervise Outdoor Play Positive Discipline/Redirect/Reinforce Limits Establish Routine for: Bed/Meals/Toileting Preschool
 Provide Opportunities for Fantasy Play/Problem Solving Allow Child to Play Independently/Be Available if Child Seeks You Out
 Encourage Literacy Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Manage Anger "Monster" Fear Frustration/Hitting/Biting/Impulse Control Separates Easily from Parent
 Objects to Major Change in Routine Shows Interest in Other Children Kind to Animals Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: Blood Lead Testing (Child at Risk/Not Already Done at 12/24Months) TB Skin Test (If at Risk) Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza Had Chicken Pox
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology CRS DDD Dental Head Start OT PT Speech WIC
 Specialist: Developmental Behavioral Other _____

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)		Relationship
Current Medications/Vitamins/Herbal Supplements:			Blood Pressure:	Temp:	Pulse:
Allergies:			Weight:	Height:	BMI:
			lb / kg	%	cm
					kg/m ²
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to Perform
Audiometry:	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal		Age Appropriate Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No		

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How do you feel about your child? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Twice Daily Brushing/Flossing (with Parent Assistance) Sealants Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet/5 Servings Fruits & Veggies Junk Food Soda/Juice Supplements _____
 Activity/Family Exercise (1hr/day) Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Expressive & Understandable Language School Attendance Reading at Grade Level
 Follows Simple Directions Prints Some Letters & Numbers Balances on One Foot Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Booster Seat) Safety at Home Sun Safety Sport/Helmet Use Bullying Street safety
 TV Screen Time Positive Discipline/Redirect Provide Opportunities for Social Interaction Age Appropriate Chores
 Daily Reading Other _____

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Frustration/Impulse Control Communication/Language Has Friends Plays Well with Others/By Self Feels Capable
 Is Liked by Other Children Expresses Full Range of Emotions Anger Control Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: Blood Lead Testing (Child at Risk/Not Already Done at 12/24 Months) TB Skin Test (If at Risk) Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV Influenza Had Chicken Pox
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology CRS DDD Dental OT PT Speech
 Specialist: Developmental Behavioral Other _____

 Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	

Admitted to NICU: (Birth)	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:	Temp:	Pulse:	Resp:
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Allergies:	Birth Weight:	Weight:	Length:		Head Circumference:
	lb oz	lb oz %	cm %	cm %	

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: Parent Cleaning Baby's Gums With Washcloth/Infant Toothbrush Fluoride Supplement Fluoride Varnish by PCP

NUTRITIONAL SCREENING: Breastfeeding Frequency/Duration: _____ Supplements: _____ Vit D
 Formula Type: _____ Amount/Duration: _____ Adequate Weight Gain Yes No Receiving WIC Services
 Cereal Type: _____ Plan to Introduce Solids _____ Soda/Juice

DEVELOPMENTAL SURVEILLANCE: Using A String of Vowels Rolls Over Transfers Small Objects Vocal Imitation
 Sits With Support Explores With Hands and Mouth Peek-a-Boo/Patty Cake Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car/Car Seat Safety (Rear-Facing) Safe Sleep Shaken Baby Prevention Passive Smoke Safety at Home/Child-Proofing
 Sun Safety Refrain From Jump Seat/Walker Sleep/Wake Cycle Introduce Cup Begin Using High Chair
 Wary of Strangers Introduce Board Books Parent Reads to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Baby
 Appropriate Bonding/Responsive to Needs Recognizes Familiar People Distinguishes Emotions by Tone of Voice
 Self-Calming Enjoys Social Play Postpartum Depression Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Blood Lead Testing (Child At Risk) Finger Stick (Result: ____) Venous Other _____

IMMUNIZATIONS ORDERED: HepB DTaP Hib IPV PCV Influenza Rotavirus Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC Specialist: Developmental Behavioral Other _____

Date/Time _____ Clinician Name (Print) _____ Clinician Signature _____ NPI # _____ See Additional Supervisory Note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)		Relationship
Current Medications/Vitamins/Herbal Supplements:			Blood Pressure:	Temp:	Pulse:
Allergies:		Weight:		Height:	
		lb / kg	%	cm	%
				BMI:	
				kg/m²	%
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Unable to Perform
Audiometry:	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal		Age Appropriate Speech:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How do you feel about your child? Do you feel safe in your home?

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing 2x Daily/Flossing Dental Sealants Fluoride Supplement

Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet/5 Servings Fruits & Veggies Low-Fat Milk Junk Food Soda/Juice
 Supplements _____ Activity/Family Exercise (1hr/day) Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: School Attendance Reading at Grade Level School Performance IEP/504 Plan
 Discuss Body Changes Has Friends Does Chores When Asked Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Booster Seat) Safety at Home Sun Safety Sport/Bike Helmet Use Bullying/Fighting
 Street Safety Smoke-Free Environment Positive Discipline Reading Other _____

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Frustration /Impulse Control Communication/Language Comfortable Body Image Encourage Independence
 Praise Strengths Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	<input type="checkbox"/> TB Skin Test (If at Risk) <input type="checkbox"/> Hgb/Hct <input type="checkbox"/> Other _____
IMMUNIZATIONS ORDERED:	<input type="checkbox"/> HepA <input type="checkbox"/> HepB <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Td <input type="checkbox"/> IPV <input type="checkbox"/> Influenza <input type="checkbox"/> Had Chicken Pox <input type="checkbox"/> Other _____ <input type="checkbox"/> Given at Today's Visit <input type="checkbox"/> Parent Refused <input type="checkbox"/> Delayed <input type="checkbox"/> Deferred Reason: _____ <input type="checkbox"/> Shot Record Updated <input type="checkbox"/> Entered in ASIIS <input type="checkbox"/> Importance of Immunizations Discussed <input type="checkbox"/> Parent Refusal Form Completed
REFERRALS:	<input type="checkbox"/> ALTCS <input type="checkbox"/> Audiology <input type="checkbox"/> CRS <input type="checkbox"/> DDD <input type="checkbox"/> Dental <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> Speech Specialist: <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Other _____

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)		Relationship
Admitted to NICU: (Birth) <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Medications/Vitamins/Herbal Supplements:			Temp:
					Pulse:
					Resp:
Allergies:		Birth Weight:	Weight:	Length:	Head Circumference:
		lb oz	lb oz %	cm %	cm %
Hospital Newborn Hearing Screen: <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown					
Second Newborn Hearing Screen (If 2nd Needed/Completed): <input type="checkbox"/> ABR <input type="checkbox"/> OAE: Rt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer Lt. Ear <input type="checkbox"/> Pass <input type="checkbox"/> Refer <input type="checkbox"/> Unknown					

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

ORAL HEALTH: Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed)

NUTRITIONAL SCREENING: **Breastfeeding** Frequency/Duration: _____ **Supplements:** _____ Vit D
 Formula Type: _____ **Amount/Duration:** _____ **Adequate Weight Gain** Yes No **Receiving WIC Services**

DEVELOPMENTAL SURVEILLANCE: Responds to Sounds Responds to Parent’s Voice Follows With Eyes to Midline
 Awake For 1 Hour Stretches Beginning Tummy Time Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car/Car Seat Safety (Rear-Facing) Safe Sleep Shaken Baby Prevention Safe Bathing/Water Temperature
 Passive Smoke Safety at Home/Child-Proofing Sun Safety Bottle Propping Infant Bonding
 Support Systems/Resources Infant crying/Appropriate Interventions Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Infant Hands to Mouth/Self -Calming Appropriate Bonding/Responsive to Needs Postpartum Depression Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision/Red Reflex			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: 2nd Arizona Newborn Screening Bloodspot Test (5 – 10 Days of Age or First PCP Visit) Other _____
 Results of 2nd AZ Newborn Screening Received (If No, What Follow Up Taken: _____)

IMMUNIZATIONS ORDERED: **DATE 1ST HEPB/2ND HEPB ADMINISTERED:** _____/_____/_____ HepB (Not Previously Administered) Other _____
 Given at Today’s Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC
Specialist: Developmental Behavioral Other _____ 2nd Newborn Hearing Screen (If Needed)

Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

9 Months Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)		Relationship

Admitted to NICU: (Birth) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No	Temp:	Pulse:	Resp:
Allergies:	Birth Weight: lb oz	Weight: lb oz %	Length: cm %	Head Circumference: cm %	

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

DEVELOPMENTAL SCREENING TOOL COMPLETED: ASQ PEDS

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Parent Cleaning Baby’s Gums With Infant Toothbrush
 Fluoride Supplement Fluoride Varnish by PCP (Once Every 6mo)

NUTRITIONAL SCREENING: Breastfeeding Formula Amount: _____ Supplements: _____ Vit D Receiving WIC Services
Adequate Weight Gain Yes No Plan to Introduce Table Foods _____ Drinks From Cup Soda/Juice

DEVELOPMENTAL SURVEILLANCE: Sits Independently Pulls to Stand/Cruising Plays Peek-A-Boo Uses Words “Mama/Dada”
 Waves Bye-Bye Wary of Strangers Immature Pincer Repeats Sounds/Gestures for Attention Explores Environment Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention
 Choking Prevention/Soft Texture Finger Foods Car/Car Seat Safety (Rear-Facing) Safe Sleep Shaken Baby Prevention
 Passive Smoke Safety at Home/Child-Proofing Sun Safety Sleep/Wake Cycle TV Screen Time Exploration/Learning
 Redirection/Positive Parenting Language/Read to Child/Introduce Board Books Follow Child’s Lead in Play
 Parent Communicates to Child “What Things Are” (Ball, Cat, Etc.) Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Appropriate Bonding/Responsive to Needs Self-Calming Growing Independence Shows Preference for Certain People/Toys
 Cries When Primary Caregiver Leaves Postpartum Depression Other: _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Blood Lead Testing (Child At Risk) Finger Stick (Result: _____) Venous Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: HepB DTaP Hib IPV PCV Influenza Other _____
 Given at Today’s Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC
Specialist: Developmental Behavioral Other _____

Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

4 Years Old

AHCCCS EPSDT Tracking Form

	Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied By (Name)		Relationship
Current Medications/Vitamins/Herbal Supplements:				Blood Pressure:	Temp:	Pulse:
Allergies:			Weight:		Height:	
			lb / kg	%	cm	%
					BMI:	
					kg/m²	%
Vision Chart Exam:	Right	Left	Both	Corrected	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to Perform
Hearing Screening:	Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform		Age Appropriate Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No	

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about child? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing (Twice Daily by Parent) Fluoride Supplement

Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet Junk Food Soda/Juice Supplements _____
 Activity/Family Exercise Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Sings a Song Draws a Person with 3 Parts Names Self & Others Names 4 Colors/3 Shapes
 Counts 1-7 Objects Out Loud (Not Always in Order) Shows Interest in Other Children Dresses Self Brushes Own Teeth
 Asks/Answers - Who, What, Where, Why Follows 2 Unrelated Directions Balances/Hops on One Foot Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing Sun Safety Sports/Helmet Use Good and Bad Touches
 Positive Discipline/Redirect Reading/Preschool School Readiness
 Allow Child to Play Independently/be Available if Child Seeks You Out Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Self-Calming Separates Easily from Parent Kind to Animals Objects to Major Change in Routine Has Words for Feelings
 Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: Blood Lead Testing (Child at Risk/Not Already Done at 12/24Months) TB Skin Test (If at Risk) Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza Had Chicken Pox
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology CRS DDD Dental Head Start OT PT Speech WIC
 Specialist: Developmental Behavioral Other _____

 Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB

Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship
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Admitted to NICU: <i>(Birth)</i>	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:		Temp:	Pulse:	Resp:
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Allergies:		Birth Weight:	Weight:	Length:	Head Circumference:	
		lb oz	lb oz %	cm %	cm	%

FAMILY/SOCIAL HISTORY: *(Current Concerns/ Follow-Up on Previously Identified Concerns)*

PARENTAL CONCERNS: *How are you feeling about baby? Do you feel safe in your home?*

ORAL HEALTH: Daily Gum Cleaning with Washcloth or Infant Toothbrush (Parent Education Completed)

NUTRITIONAL SCREENING: **Breastfeeding** *Frequency/Duration:* _____ **Supplements:** _____ Vit D
 Formula Type: _____ *Amount/Duration:* _____ **Adequate Weight Gain** Yes No **Receiving WIC Services**
 Cereal Type: _____ **Plan to Introduce Solids** _____ Soda/Juice

DEVELOPMENTAL SURVEILLANCE: Babbles and Coos Laughs Begins to Roll Front to Back Pushes Up With Arms
 Controls Head Well Reaches For Objects Interest in Mirror Images Pushes Down With Legs When Feet on Surface
 Appropriate Eye Contact Tummy Time Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car/Car Seat Safety (*Rear-Facing*) Safe Sleep Shaken Baby Prevention Safe Bathing/Water Temperature
 Passive Smoke Safety at Home/Child-Proofing Sun Safety Bottle Propping Support Systems/Resources
 Infant Crying/Appropriate Interventions Discuss Child Temperament Establish Daily Routines/Infant Regulation
 Establish Nighttime Sleep Routine/Sleep Through Night (Greater 5 hours) Parent Reads to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Baby
 Infant Hands to Mouth/Self-Calming Smiles When Hears Parents' Voices Appropriate Bonding/Responsive to Needs
 Easily Distracted/Excited by Discovery of Outside World Postpartum Depression Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Other _____

IMMUNIZATIONS ORDERED: HepB DTaP Hib IPV PCV Rotavirus Other _____
 Given at Today's Visit Parent Refused Delayed Deferred *Reason:* _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC
 Specialist: *Developmental* *Behavioral* *Other* _____

 Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	
Current Medications/Vitamins/Herbal Supplements:			Blood Pressure:	Temp:	Pulse: Resp:
Allergies:			Weight:		Height:
			lb / kg	%	cm
			BMI:		
			kg/m ²	%	
Vision Chart Exam:	Right	Left	Both	Corrected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Perform
Hearing Screening:	Right <input type="checkbox"/> Pass <input type="checkbox"/> Refer	Left <input type="checkbox"/> Pass <input type="checkbox"/> Refer	<input type="checkbox"/> Unable to Perform	Age Appropriate Speech:	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How do you feel about your child? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Twice Daily Brushing/Flossing (With Parent Assistance) Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet/5 Servings Fruits & Veggies Junk Food Soda/Juice Supplements _____
 Activity/Family Exercise (1hr/day) Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Uses Imaginary Characters Matches Colors and Shapes/Prints Some Numbers and Letters
 Counts to 10 Follows Simple Directions Listens and Attends Can Button & Zip Clothing Independently
 Goes to Bathroom Independently Holds Pencil/Cuts with Scissors Cooperates More in Group Setting
 Good Articulation/Language Skills Hops/Skips Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Booster Seat) Safety at Home Sun Safety Sports/Helmet Use Bullying Good and Bad Touches
 TV Screen Time Begins to Agree with Rules Dictates Story to Adults Listens to Authority Figure & Follows Instructions
 School Readiness Communication with Teachers Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Self-Calming Wants to Please & Be with Friends Shows Empathy for Others Positive about Self & Abilities
 Tells Stories of Convenience (Lying) Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: Blood Lead Testing (Child at Risk/Not Already Done at 12/24Months) TB Skin Test (If at Risk) Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV Influenza Had Chicken Pox
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology CRS DDD Dental Head Start OT PT Speech WIC
 Specialist: Developmental Behavioral Other _____

 Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	
Current Medications/Vitamins/Herbal Supplements:			Blood Pressure:	Temp:	Pulse:
Allergies:	Weight:		Height:		BMI:
	lb / kg	%	cm	%	kg/m ² %
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unable to Perform
Audiometry:	<input type="checkbox"/> Within Normal Limits <input type="checkbox"/> Abnormal <input type="checkbox"/> Unable to perform			Menses:	Menarche:
FAMILY/SOCIAL HISTORY: <i>(Current Concerns/ Follow-Up on Previously Identified Concerns)</i>				<input type="checkbox"/> Yes <input type="checkbox"/> No	

PARENTAL CONCERNS: *How do you feel about your child? Do you feel safe in your home?*

HEALTH RISK ASSESSMENT: Early Adolescent GAPS (*Beginning at 10 Years*) Other _____

ORAL HEALTH: *White Spots on Teeth:* Yes No Daily Brushing 2x Daily/Flossing Dental Sealants **Fluoride Supplement**
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet 5 Servings of Fruits & Veggies Junk Food Soda/ Energy Drinks
 Supplements _____ Activity/Family Exercise (1hr/day) **Overweight** **Underweight** *Observation* *Referral*

DEVELOPMENTAL SURVEILLANCE: School Attendance Reading at Grade Level Discuss Body Changes Dating
 Sexuality/Orientation Performing Well in School Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car/Seat Belt Safety Safety at Home Sports/Injury Prevention Bullying /Violence Prevention Sun Safety
 Safety Rules with Adults Sex Education/STI Monitor TV/Computer Time Peer Refusal Skills Self-Control
 Depression/Anxiety Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants Risks of Tattoos/ Piercing
 After-School Activities/Supervision Educational Goals/Activities Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Comfortable Body Image Feels Good About Self
 Is Child Happy? Social Interaction Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary Tanner Stage _____		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: TB Skin Test (*If at Risk*) Hgb/Hct Other _____

IMMUNIZATIONS ORDERED: Tdap (11 – 12 Years Only) Meningococcal (11 – 12 Years Only) HPV (11 – 12 Years) HepA HepB
 MMR Varicella Td IPV Influenza Had Chicken Pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology CRS DDD Dental OB/GYN OT PT Speech
 Specialist: *Developmental* *Behavioral* *Other* _____

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
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Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship
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Admitted to NICU: (Birth) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No	Temp:	Pulse:	Resp:
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Allergies:	Weight:		Length:		Head Circumference:		BMI:	
	lb	oz	%	cm	%	cm	%	kg/m ²

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

DEVELOPMENTAL SCREENING TOOL COMPLETED: ASQ MCHAT PEDS

VERBAL LEAD RISK ASSESSMENT: (Blood Lead Test Required) Child At Risk Yes No Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing (Twice Daily by Parent) Fluoride Supplement
First Dental Appointment Completed Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Feeds Self Nutritionally Balanced Diet Junk Food Soda/Juice
 Activity Supplements _____ Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Kicks a Ball Stacks 5-6 Blocks 50 Word Vocabulary Walks Upstairs/Runs Well
 Put Two Words Together Jumps Up Follows Two Step Commands Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing Sun Safety Trike/Bike Safety (Helmet Use)
 Establish Daily Routine Discipline/Redirection/Praise Provide Opportunities for Success/Choice Praise for Effort/Success
 Encourage/Support Wide Range of Emotions Read to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Appropriate Bonding/Responsive to Needs Self-Calming Frustration/Hitting/Biting/Impulse Control Communication/Language
 Sense of Humor Demonstrates Increasing Independence Plays Alongside Peers Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision/Red Reflex			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Blood Lead Testing (Required) TB Skin Test (If at Risk) Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza
 Had Chicken Pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC
Specialist: Developmental Behavioral Other _____

	Date	Last Name	First Name	AHCCCS ID #	DOB	Age
	Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	
Current Medications/Vitamins/Herbal Supplements:				Blood Pressure:	Temp:	Pulse:
Allergies:			Weight:		Height:	
			lb / kg	%	cm	%
					BMI	
					kg/m ²	%
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Unable to Perform
Audiometry:	<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unable to perform	Menses:	Menarche:	LMP:
FAMILY/SOCIAL HISTORY/CONCERNS: (Current Concerns/ Follow-Up on Previously Identified Concerns)				<input type="checkbox"/> Yes	<input type="checkbox"/> No	

HEALTH RISK ASSESSMENT: HEADDSS GAPS Other _____

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing 2x Daily/Flossing Fluoride Supplement
 Last Dental Appointment: _____ Future Dental Appointment Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Nutritionally Balanced Diet 5 Servings of Fruits & Veggies Junk Food Soda/ Energy Drinks
 Supplements _____ Activity/Exercise (1hr/day) Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Abstract Thinking School Attendance Sexuality/Orientation
 Physical Growth and Development Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Violence Prevention/Gun Safety Drowning/Sun Safety
 Car/Seat Belt/Driving Safety Safety at Home Sports/Injury Prevention Peer Refusal Skills Age Appropriate Limits
 Self-Control Sex Education/STI/Resources Availability of Family Planning Services Social Interaction/Dating
 Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants Risks of Tattoos/ Piercing Education Goals/Activities Job/Career Planning
 Parenting Advice (As Appropriate) Other _____

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): Philosophical/Idealistic Comfortable Body Image
 Self-Confident Building Intimate/ Complex Relationships Depression/Anxiety/Sleep Issues Mood Changes Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary Tanner Stage _____		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: TB Skin Test (If at Risk) Hgb/Hct Lipid Profile Other _____

IMMUNIZATIONS ORDERED: HepA MMR Varicella HepB Tdap Influenza Meningococcal HPV IPV Td
 Had Chicken Pox Other _____
 Given at Today's Visit Refused Delayed Deferred Reason: _____
 Shot Record Updated/Entered in ASIIS Importance of Immunizations Discussed Refusal Form Completed

REFERRALS: ALTCS Audiology CRS DDD Dental PT OB/GYN OT Speech Specialist: Developmental Behavioral Other _____

 Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship	
Admitted to NICU: (Birth) <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Medications/Vitamins/Herbal Supplements:		Risk Indicators of Hearing Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No		Temp: <input type="text"/>
				Pulse: <input type="text"/>	Resp: <input type="text"/>
Allergies:			Weight:	Length:	Head Circumference:
			lb oz %	cm %	cm %

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

DEVELOPMENTAL SCREENING TOOL COMPLETED: ASQ MCHAT PEDS

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing (Twice Daily by Parent) Fluoride Supplement
 Fluoride Varnish by PCP (Once Every 6 Months) First Dental Appointment Completed Scheduled Dental Home Provider: _____

NUTRITIONAL SCREENING: Feeds Self Breastfeeding Whole Milk Nutritionally Balanced Diet Junk Food Soda/Juice
 Solids Activity Supplements _____ Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Uses a cup Walks Says 10-20 Words Says "No" Name One Picture/2 Colors
 Follows Simple Rules/Bring Me the Book Knows Animal Sounds Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning prevention Choking Prevention
 Car/Car Seat Safety (Rear-Facing) Safety at Home/Child-Proofing Sun Safety Helmet Use Never Leave Toddler Alone
 Sibling Interaction Discipline/Limits Growing Independence Encourage Expression of Wide Range of Emotions
 Read to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Appropriate Bonding/Responsive to Needs Self-Calming Frustration/Hitting/Biting/Impulse Control Communication/Language
 Demonstrates Increasing Independence Defiant Behavior/Offer Child Choices Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision/Red Reflex			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Blood Lead Testing (Child At Risk/Not already Done at 12 Months) Finger Stick (Result: ____) Venous
 TB Skin Test (If at Risk) Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza
 Had chicken pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC
Specialist: Developmental Behavioral Other _____

Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship
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Admitted to NICU: (Birth)	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:	Temp:	Pulse:	Resp:
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			

Allergies:	Weight:		Length:		Head Circumference:	
	lb	oz	%	cm	%	cm

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about child? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing (Twice Daily by Parent) Fluoride Supplement
 Fluoride Varnish by PCP (Once Every 6 Months) First Dental Appointment Completed Scheduled Dental Home Provider: _____

NUTRITIONAL SCREENING: Feeds Self Breastfeeding Whole Milk Nutritionally Balanced Diet Junk Food Soda/Juice
 Solids Activity Supplements _____ Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Says 3-6 words Says No Wide Range of Emotions Repeats Words from Conversation
 Uses Utensils Understands Simple Commands Climbs Stairs Walking Puts Objects In/Out of Container Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency /911 Gun Safety Drowning Prevention Choking Prevention
 Car/Car Seat Safety (Rear-Facing) Safety at Home/Child-Proofing Sun Safety Helmet Use Growing Independence
 Defiant Behavior/Offer Child Choices Gentle Limit Setting/Redirection/Safety Reading/Parent Asks Child "What's that?"
 Follow Child's Lead in Play Offer Opportunity to Scribble/Explore Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Appropriate Bonding/Responsive to Needs Self-Calming Frustration/Hitting/Biting/Impulse Control Communication/Language
 Social Interaction/Eye Contact/Comforts Others Begins to Have Definite Preferences Other: _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision/Red Reflex			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Blood Lead Testing (Child At Risk/Not already Done at 12 Months) Finger Stick (Result: ____) Venous
 TB Skin Test (If at Risk) Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza
 Had chicken pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AZEIP CRS DDD Dental Early Head Start OT PT Speech WIC
Specialist: Developmental Behavioral Other _____

13-17 Years Old

AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied By (Name)	
Relationship					
Current Medications/Vitamins/Herbal Supplements:			Blood Pressure:	Temp:	Pulse:
Allergies:		Weight:		Height:	
		lb / kg	%	cm	%
				BMI	
				kg/m²	%
Vision Chart Exam:	Right	Left	Both	Corrected <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to Perform <input type="checkbox"/>	
Audiometry:	<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Abnormal	<input type="checkbox"/> Unable to perform	Menses:	Menarche:
FAMILY/SOCIAL HISTORY: <i>(Current Concerns/ Follow-Up on Previously Identified Concerns)</i>				<input type="checkbox"/> Yes	<input type="checkbox"/> No

PARENTAL CONCERNS: *How are you feeling about your teenager? Do you feel safe in your home?*

HEALTH RISK ASSESSMENT: HEADDSS GAPS Other _____

ORAL HEALTH: *White Spots on Teeth:* **Yes** **No** **Daily Brushing 2x Daily/Flossing** **Fluoride Supplement**

Last Dental Appointment: _____ Future Dental Appointment Scheduled _____ Dental Home: Provider Name _____

NUTRITIONAL SCREENING: **Nutritionally Balanced Diet** **5 Servings of Fruits & Veggies** **Junk Food** **Soda/ Energy Drinks**

Supplements _____ **Activity/Exercise (1hr/day)** **Overweight** **Underweight** **Observation** **Referral**

DEVELOPMENTAL SURVEILLANCE: **School Attendance** **Reading at Grade Level** **Dating** **Sexuality/Orientation**

Risk-Taking **Other** _____

ANTICIPATORY GUIDANCE PROVIDED: **Emergency/911** **Violence Prevention/Gun Safety/Bullying** **Drowning/Sun Safety**

Car/Seat Belt/Driving Safety **Safety at Home** **Sports/Injury prevention** **Peer Refusal Skills** **Age Appropriate Limits**

Sexual Orientation/Dating **Sex Education/STI/Resources** **Availability of Family Planning Services** **Social Interaction**

Tobacco/Alcohol/Drugs/Rx Drugs/Inhalants **Risks of Tattoos/ Piercing** **Educational Goals/Activities** **Job/Career Planning**

Community Involvement **After-School Activities/Supervision** **Other** _____

SOCIAL-EMOTIONAL HEALTH(OBSERVED BY CLINICIAN/PARENT REPORT): **Comfortable Body Image** **Mental Health Concerns**

Dealing with Stress **Depression/Anxiety** **Decision-Making** **Other** _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary Tanner Stage _____		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: **TB Skin Test (If at Risk)** **Hgb/Hct** **Lipid Profile** **Other** _____

IMMUNIZATIONS ORDERED: **HepA** **MMR** **Varicella** **HepB** **Tdap** **Influenza** **Meningococcal** **HPV** **IPV** **Td**

Had Chicken Pox **Other** _____

Given at Today's Visit **Parent Refused** **Delayed** **Deferred** *Reason:* _____

Shot Record Updated **Entered in ASIIS** **Importance of Immunizations Discussed** **Parent Refusal Form Completed**

REFERRALS: **ALTCS** **Audiology** **CRS** **DDD** **Dental** **PT** **OB/GYN** **OT** **Speech**

Specialist: *Developmental* *Behavioral* *Other* _____

Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note **Yes** **No**

Revised 04/01/2014

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied By (Name)	
Relationship					
Admitted to NICU: (Birth)		Current Medications/Vitamins/Herbal Supplements:		Risk Indicators of Hearing Loss:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Temp:		Pulse:		Resp:	
Allergies:		Birth Weight:	Weight:	Length:	Head Circumference:
		lb oz	lb oz %	cm %	cm %

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

VERBAL LEAD RISK ASSESSMENT: (Blood Lead Test Required) Child At Risk Yes No Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing (Twice by Parent) Fluoride Supplement Fluoride Varnish by PCP
 First Dental Appointment Completed Scheduled Dental Home: Provider Name _____ (Once Every 6mo)

NUTRITIONAL SCREENING: Breastfeeding Whole Milk Amount _____ Milk Intake/Weaning
 Adequate Weight Gain Solids: _____ Soda Juice Supplements

DEVELOPMENTAL SURVEILLANCE: First Steps "Mama/Dada" Specific Uses Single Words Scribbles Precise Pincer Grasp
 Follows Simple One Step Requests Looks for Hidden Objects Extends Arm/Leg for Dressing Points to Objects
 Plays: Hides Object/Pushes Ball Back and Forth Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car/Car Seat Safety(Rear-Facing) Passive Smoke Safety at Home/Child-Proofing Sun Safety Discipline/Praise
 Following Child's Lead in Play Ignore Tantrums/Give Attention to Positive Behaviors Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Self-Calming Prefers Primary Caregiver Over All Others Shy/Anxious With Strangers Tantrums Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Blood Lead Testing (Required) Hgb/Hct (Required, If not Done at 9 Months) TB Skin Test (If at Risk) Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza
 Had Chicken Pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC
 Specialist: Developmental Behavioral Other _____

 Date/Time Clinician Name (Print) Clinician Signature NPI # See Additional Supervisory Note Yes No



Health Net

**Health Net Member Direct Payment Notification Template:
Provider or Facility**

Instructions for the provider or facility: Use the following text and choose Facility or Provider from this template to create a form. Health Net members must read and acknowledge the following guidelines before making any agreement to pay you, a participating Health Net provider, or a facility directly for covered services.

The Arizona state constitution permits you to pay a health care <facility/provider> directly for health care services. Before you make any agreement to do so, please read the following important information.

If you are a Health Net member and your health care <facility/provider> is contracting with Health Net, the following guidelines apply:

1. You may not be required to pay the health care <facility/provider> directly for the services covered by your plan, except for cost-share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.
2. Your provider's agreement with Health Net may prevent the health care <facility/provider> from billing you for the difference between the <facility's/provider's> billed charges and the amount allowed by your health plan for covered services.
3. If you pay directly for a health care service, your health care <facility/provider> is not responsible for submitting claim documentation to Health Net. Before paying your claim, your health plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.
4. If you do not pay directly for a health care service, your health care <facility/provider> may be responsible for submitting claim documentation to your health plan for the health care service.

Your signature below acknowledges that you received this notice before paying a <facility/provider> directly for a health care service.

Signature: _____ Date: _____

Print Name: _____

13-424a

Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

Instructions

Purpose

The Potential Quality Issue (PQI) Referral Form is to be used to report any potential or suspected deviation from the standard of care that cannot be determined to be justified without additional review. It should also be used for hospital-acquired conditions (HACs), health care-acquired conditions (HCACs), other provider preventable conditions (OPPCs), and serious reportable adverse events (SRAEs).

Important

The PQI Referral Form is a confidential document used by the Health Net Quality Management Program to aid in the evaluation and improvement of the overall quality of care delivered to Health Net enrollees. PQI referral forms are reviewed and evaluated confidentially in a separate and secure manner, outside of Health Net's member appeal and grievance case processing procedures.

Refer issues identified as *member appeals* or *member grievances* to Health Net's Member Appeals and Grievances Department for appropriate case handling and resolution.

Note

To protect the confidentiality and privilege of this PQI referral, follow the guidelines outlined below:

1. Never discuss the details of this referral reporting with anyone (including the enrollee) other than those to whom you have been specifically directed to communicate with by your supervisor or a representative of the PQI review entity.
2. Although you must never refer to the referral reporting itself (for example, Unity) within the member's medical records, you should objectively record pertinent facts of the incident (for example, injury or medication reaction) within the record whenever appropriate.
3. Never make or retain photocopies of this PQI referral reporting under any circumstances.
4. Never use or refer to this report in associate disciplinary action of any kind or any time.

Referral Content

1. Write or print legibly. Include your complete contact information, including fax number.
2. Use the check-boxes provided in the report categories.
3. Summarize a brief description of the events as follows:
 - a. Describe event(s) chronologically, including admission and re-admission dates.
 - b. Quote relevant statements made by the provider or others.
 - c. Specify any equipment or medication involved.
 - d. Provide a complete explanation describing the potential deviation in the standard of care.
4. Complete and submit this report directly via secure fax at (877) 808-7024 within one business day of the event/occurrence. The case will be forwarded for clinical evaluation and/or review.
5. Incomplete referral forms are returned to the Health Net associate, such as the registered nurse (RN), who initiated the referral and/or his or her supervisor.



Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

Do not photocopy this form. The information contained is confidential and peer-review protected.

Complete and forward immediately to Health Net via secure fax: (877) 808-7024

REFERRAL SOURCE

Referral date: _____
Referred by (Name): _____
Telephone number: _____

Fax number: _____
Identified by: _____

MEMBER DEMOGRAPHICS

Member name (Last, First, MI): _____
ID#: _____ Gender: M F
Treating practioner: _____
Primary care physician (PCP): _____
Associated participating physician group (PPG): _____

TYPE OF EVENT(S)

Date(s) of event: _____ Name of facility: _____
Admission date: _____ Prior admission dates (if applicable): _____

HAC/HCAC, OPPC, SRAE, & AND OTHER PQI INDICATORS

BOLDED TEXT INDICATES HAC/HCAC, OPPC OR SRAE

Surgical events:

- Surgery on wrong body part**
- Surgery on wrong patient**
- Wrong surgical procedures on a patient**
- Foreign object retained after surgery**
- Anesthesia adverse event
- Surgery with post-operative/intra-operative death in a normal healthy patient**
- Acute MI or CVA within 48 hours after elective surgery
- Cardiac or respiratory arrest in the operating room (OR)
- Unplanned return to OR, unplanned removal, injury or repair of an organ

Surgical site/post-operative infections:

- Mediastinitis after coronary artery bypass graft (CABG)**
- Bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)**
- Orthopedic procedures on spine, neck, shoulder, elbow, knee or hip**
- Other (explain)

Hospital-acquired (nosocomial) infections:

- Catheter-associated urinary tract infection (UTI)**
- Vascular catheter-associated Infection**
- Other (Please explain)

Deep vein thrombosis or pulmonary embolism following orthopedic procedures:

- Total knee replacement**
- Total hip replacement**
- Other (explain)

Patient death/disability:

- Maternal death or serious disability associated with labor or delivery in a low-risk
- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics
- Patient death or serious disability associated with use or function of a device in patient care in which the device is used or functions other than as intended
- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
- Unexpected death (Please explain)

Admission/readmission/discharge:

- Unexpected / unanticipated readmission within 30 days to acute level of care with same or similar diagnosis or as a complication of the previous admission
- Unplanned admission following diagnostic test or outpatient procedure
- Neurological deficit present at discharge not present on admit
- Delay in transfer/treatment or discharge – which results in a poor outcome to the member or additional costs to the plan
- Delayed diagnosis or missed diagnosis – resulting in adverse member outcome or extended hospital stay
- Infant discharged to the wrong person**

Patient issue:

- Member leaves against medical advise (AMA) when there is a potential for serious adverse event(s)
- Patient suicide attempt or serious injury to self while in treatment



Potential Quality Issue (PQI) Referral Form

(Includes HACs/HCACs, OPPCs and SRAEs)

Falls (with trauma):

- Fractures
- Dislocations
- Intracranial injuries
- Other (explain)

Injury:

- Crushing injuries
- Burns
- Electric shock
- Other (explain)

Manifestations of poor glycemic control:

- Diabetic ketoacidosis
- Nonketotic hyperosmolar coma
- Hypoglycemic coma
- Secondary diabetes with ketoacidosis
- Secondary diabetes with hyperosmolarity

Obstetrics:

- Nonmedically indicated (elective) delivery less than 39 weeks gestational age
- Newborn Apgar <4 at 1 minute or < 6 at 5 minutes

Outpatient/ambulatory care:

- Breach of member confidentiality or ethics concern/violation
- Abnormal diagnostic study not followed up appropriately where the potential for adverse outcome exists
- Inattention to or lack of appropriate follow-up of consultant's major recommendations without appropriate rationale
- Practitioner's failure to follow-up on any member's significant complaint or physical finding within a reasonable period of time
- Members with a disease process requiring follow-up with no evidence of follow-up and no documentation in the medical records of member contact for follow-up
- Hospitalization resulting from inappropriate drug therapy

Other:

- Pressure ulcer stages III & IV occurring after hospital admission
- Air embolism
- Blood transfusion incompatibility
- Any substandard care with the potential for harm to the member (please explain fully)
- Other (select only when no other selection is applicable and explain fully)

Based on my clinical expertise and judgment, I believe there was a deviation in the standard of care resulting in a potential quality of care issue for the following reasons (please provide complete and detailed summary):



Health Net®

REFERRAL FORM

The use of this form is voluntary and is intended to promote the coordination of care

NOTE: Please confirm that the specialist the member is being referred to is contracting for the applicable line of business (commercial, Medicare Advantage, AHCCCS) and participates in the member's network or delegated medical group.

TO BE COMPLETED BY REFERRING PHYSICIAN'S OFFICE:

Patient Name: _____ Date of Birth: _____ Date: _____

Patient ID#: _____ Patient's Telephone Number: _____

Referring Physician: _____ Telephone Number: _____

NPI #: _____ Fax Number: _____

Address: _____

(Street Address)

(City & ZIP Code)

Diagnosis: _____

Reason for Referral: _____

REFERRAL TO: (Note: Referral for select services or to a non-participating physician requires prior authorization.)

Consulting Physician: _____ Telephone Number: _____

Fax Number: _____

Address: _____

(Street Address)

(City & ZIP Code)

**(PLEASE INCLUDE ALL RELEVANT LAB, X-RAY, TEST RESULTS,
MEDICAL RECORD COPIES, MEDICATION LIST, ETC.)**

TO BE COMPLETED BY CONSULTING PHYSICIAN'S OFFICE:

Summary of Diagnostic Impressions: _____

Summary of Recommendations: _____

(Physician's Signature)

**FAX BACK TO REFERRING
PHYSICIAN**

EXHIBIT 820-1

**ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
(AHCCCS)
HYSTERECTOMY CONSENT FORM**

A hysterectomy is the removal of the whole uterus (womb). A hysterectomy cannot be reversed and it will permanently prevent you from having children. A hysterectomy should only be performed when there is a disease of the woman's uterus or some other problem that can only be treated by removing the uterus. It is a serious operation and there are discomforts and a chance of serious health problems.

AHCCCS does not cover hysterectomy procedures when performed only for the purpose of rendering an individual sterile.

By signing below, I hereby consent of my own free will to undergo a hysterectomy, which will render me permanently incapable of reproducing. My signature also acknowledges that I have read and understood the above information.

MEMBER SIGNATURE

DATE

MEMBER AHCCCS IDENTIFICATION
NUMBER

MEMBER SOCIAL SECURITY NUMBER

In accordance with Federal Regulation 42 C.F.R. §441.255, the signature and date below are required in order for reimbursement to be made.

PERSON WHO OBTAINED THE MEMBER'S
CONSENT TO THE HYSTERECTOMY

DATE

EXHIBIT 420-1
CONSENT FOR STERILIZATION

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

■ CONSENT TO STERILIZATION ■

I have asked for and received information about sterilization from _____
_____ *Doctor or Clinic*. When I first asked

for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible. **I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.** I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____

Specify Type of Operation

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: _____

I, _____ *Date*, hereby consent of my

Own free will to be sterilized by _____
_____ *Doctor or Clinic*

by a method called _____
_____ *Specify Type of Operation*

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____ *Signature* _____ *Date*

You are requested to supply the following information, but it is not required:

(Ethnicity and Race Designation) (please check)

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino

Race (mark one or more):

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

■ INTERPRETER'S STATEMENT ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ *Interpreter's Signature* _____ *Date*

■ STATEMENT OF PERSON OBTAINING CONSENT ■

Before _____ signed the

Name of Individual

consent form, I explained to him/her the nature of sterilization operation _____, the fact that it is

Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ *Signature of Person Obtaining Consent*

_____ *Date*

_____ *Facility*

_____ *Address*

■ PHYSICIAN'S STATEMENT ■

Shortly before I performed a sterilization operation upon _____ on _____

Name of Individual

Date of Sterilization

I explained to him/her the nature of the sterilization operation _____, the fact that it is

Specify Type of Operation

intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(INSTRUCTIONS FOR USE OF ALTERNATIVE FINAL PARAGRAPH: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

- 1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.
- 2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery

Individual's expected date of delivery: _____

Emergency abdominal surgery (describe circumstances): _____

_____ *Physician's Signature*

_____ *Date*



Health Net of Arizona
 1230 W. Washington St Suite 401
 Tempe, AZ 85281-1245

Payee Name
Payee Address

MARCUS WELBY, M.D.
 PO BOX 99999
 MESA, AZ 85277-0490

Process Date 05/31/2013
Payee ID 999999999 A
SVC Provider DOC HOLIDAY, M.D.
SVC Provider No 999999999 F

Statement of Outstanding Refunds

Patient Name	Subscriber ID	Acct #	Claim #	Date of Adjustment	Svc Date From	Svc Date To	Billed Amount (\$)	Amount Due (\$)	Anticipated Clipping Date
SAMPLE, JOHN	R09999999	099999999999	2013140NZ3016	05/20/2013	01/12/2013	01/16/2013	\$950.00	-\$412.77	07/04/2013

TOTAL OUTSTANDING REFUND	-\$412.77
---------------------------------	-----------

Refund due to Health Net. Send check to: Health Net of AZ Refunds, P.O. Box 749801, Los Angeles, CA 90074-9801

For questions, please contact the Provider Call Unit at P.O. Box 276090 Sacramento, CA 95827-6090 or call (800)289-2818

EXHIBIT 300-3C
APPLICATION OF PHYSICAL THERAPY 15 VISIT OUTPATIENT LIMIT
ACUTE & ALTCS MEMBERS 21 YEARS OF AGE AND OLDER

CONDITION	CONTRACTOR IMPLEMENTATION (FISCAL IMPLICATIONS)
MEMBER IS MEDICAID ONLY AND IS NOT MEDICARE ELIGIBLE. (ALSO KNOWN AS NON DUAL)	Contractor is responsible for the visit up to 15 PT visits per contract year.
MEMBER IS DUAL ELIGIBLE (ALSO KNOWN AS MEDICARE PRIMARY, NON QMB DUAL)	<p>Contractor is responsible for Medicare cost sharing (copay, coinsurance, and deductible) up to 15 PT visits.</p> <ul style="list-style-type: none"> • In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will pay the Medicare cost sharing up to the 15 visit limit per contract year. As part of their Medicare benefit, members may opt to receive service up to Medicare maximum dollar amount; however the Medicare cost sharing for any visits beyond the 15 visit limit allowed by AHCCCS are the members' responsibility. • In the event that the member exhausts the Medicare dollar maximum amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the Contractor.
MEMBER IS QMB DUAL	<p>Contractor is responsible for Medicare cost sharing up to Medicare maximum dollar amount.</p> <ul style="list-style-type: none"> • In the event that the 15 PT visit limit is reached prior to the Medicare maximum dollar amount, the Contractor will continue to pay the Medicare cost sharing for PT visits until the Medicare maximum dollar amount for therapy is reached. • In the event that member exhausts the Medicare maximum dollar amount prior to utilizing the 15 PT visit limit allowed by AHCCCS, the additional visits up to maximum of 15 are the responsibility of the Contractor.

DEFINITIONS:

Visit - a visit equals PT services received in one day. The 15 visit limit applies regardless that the member has the same contractor or changes contractors during the contract year.

Setting - Any outpatient place of service (nursing homes, nursing facilities and custodial care setting are considered inpatient settings).

Dual Eligible (Non-QMB Dual) - An individual who is Medicare and Medicaid eligible with Income above 100% FPL. The individual does not qualify for QMB.

QMB Dual - An individual who is Medicare and Medicaid eligible with income not exceeding 100% FPL.



Referral Fax Form

Fax to: (800) 451-4730 [or (678) 355-4018 for pregnancy notification only]

Decision Power® clinicians are available 24 hours a day, 365 days a year to provide education and support to your patients who have chronic conditions or need health education on any health topic.

Referring physician information:

Physician/PPG office name: _____ Health Net provider #: _____

Office address: _____

City: _____ State: _____ ZIP code: _____

Date of referral: _____ Name of person completing form: _____

Please complete one form for each member referral.

Member information:

Table with 7 columns: Name, Identification (ID) number, Gender, Date of birth (DOB), Telephone number, Diagnosis/medical condition, Reason for referral

Referrals are accepted for the following:

Chronic conditions:

- Asthma
Chronic obstructive pulmonary disease (COPD)
Coronary artery disease (CAD)
Diabetes
Lifestyle Programs
Tobacco Cessation
Heart failure (HF)

Lifestyle programs:

- Tobacco Cessation

Types of support:

- Adherence to treatment plan
High-risk chronic condition management
Gap closure
Medication persistence
Nutrition/lifestyle changes
Understanding symptom action plans
Healthy Pregnancy Program (for questions about pregnancy referrals, contact Alere™ at (855) 870-2229)

To refer a patient to Decision Power, please complete this form and return it to Decision Power via secure fax line at (800) 451-4730 [or (678)-355-4018 for pregnancy notification only.] NOTE: Do not mail this completed form –SECURE FAX ONLY.

Health Net members have access to Decision Power® through their current enrollment with any of the following Health Net companies: Health Net of Arizona, Inc., Health Net of California, Inc., Health Net Health Plan of Oregon, Inc., and Health Net Life Insurance Company.

Decision Power is not part of Health Net's commercial medical benefit plans. Also, it is not affiliated with Health Net's provider network and it may be revised or withdrawn without notice. Decision Power is part of Health Net's Medicare Advantage benefit plans. But it is not affiliated with Health Net's provider network. Decision Power services, including clinicians, are additional resources that Health Net makes available to enrollees of the above listed Health Net companies. Health Net and Decision Power are registered service marks of Health Net, Inc. All rights reserved.

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352

0348-0046

(See reverse for public burden disclosure.)

1. Type of Federal Action: <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	2. Status of Federal Action: <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	3. Report Type: <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change For Material Change Only: year _____ quarter _____ date of last report _____
4. Name and Address of Reporting Entity: <input type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, <i>if known</i> : Congressional District, if known:	5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime: Congressional District, if known:	
6. Federal Department/Agency:	7. Federal Program Name/Description: CFDA Number, <i>if applicable</i> : _____	
8. Federal Action Number, if known:	9. Award Amount, if known: \$ _____	
10. a. Name and Address of Lobbying Registrant <i>(if individual, last name, first name, MI):</i>	b. Individuals Performing Services <i>(including address if different from No. 10a)</i> <i>(last name, first name, MI):</i>	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.	Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Authorized Representative

Date

Type or Print Name

Name of Provider

Title

Address



REQUEST FOR APPEAL

Only use this form to appeal claims reimbursement. Do not use this form when submitting a corrected claim or requested missing information. Include new information that was not originally submitted documenting the reason for the appeal request, the Explanation of Payment (EOP), prior authorization letter or form, supporting medical records, and claim number for each claim in dispute. If possible, include a copy of the Remittance Advice and procedure codes or copies of the UB-92, UB-04, or CMS-1500. Submit all appeal requests to the following address:

**Health Net of Arizona
Attention: Provider Appeals
P.O. Box 279378
Sacramento, CA 95827-9378**

Date _____ Submitted By (Name): _____

Provider name/group: _____

Provider address: _____

Provider tax ID: _____ Provider telephone number: _____

Member name: _____ Member ID: _____

Number of claims appealed: _____ Amount in dispute: _____

Reason for appeal:

- | | |
|--|---|
| <input type="checkbox"/> Paid at incorrect contract rate | <input type="checkbox"/> Overpayment |
| <input type="checkbox"/> Incorrect copayment | <input type="checkbox"/> Denied in error due to no authorization – attached |
| <input type="checkbox"/> Inappropriate denial | <input type="checkbox"/> Denied in error due to eligibility – correct ID attached |
| <input type="checkbox"/> Incorrect tax ID | <input type="checkbox"/> Denied in error due to timely filing – proof attached |
| <input type="checkbox"/> Capitated in error | <input type="checkbox"/> Wrong amount of units paid |
| <input type="checkbox"/> Denied as duplicate in error | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Partial payment | |

Additional Comments: _____

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card. Employer group members please call 800-289-2818.

English

Servicios de Idiomas Sin Costo. Usted puede solicitar un intérprete. Puede solicitar que se le lean los documentos y que algunos de ellos se le envíen en su idioma.

Para obtener ayuda, llámenos al número que aparece en su tarjeta de identificación. Los afiliados a grupos de empleadores deben llamar al 800-289-2818.

Spanish

免費語言服務。您可以取得口譯員服務。我們可以把文件朗讀給您聽，部分文件可以翻譯成您的語言並寄送給您。如需協助，請撥您會員卡所列的電話號碼與我們聯絡。雇主團體會員請撥 800-289-2818。

Chinese

Mga Walang Bayad na Serbisyo sa Wika. Makakakuha ka ng interpreter. Maipapagawa mong basahin sa iyo ang mga dokumento at ipadala ang ilan sa iyo sa iyong wika. Para sa tulong, tawagan kami sa numerong nakalista sa iyong ID card. Sa mga miyembro ng grupo ng employer pakitawagan ang 800-289-2818.

Tagalog

Doo ɓaah hiliní da hazaad bee haká'adoowołgo. Ata' halne'é ła' aká'adoowołgíí jóki'. Naaltsoos binahji' éé dahózinígíí hach'í' yiidooltah áádóó ła' hach'í' adoolyijíł t'áá hó hazaad k'ehjí. Aká'adoowoł biniiyé, nihich'í' hódílnih béesh bee hane'é binumber bee néé hó'dolzin biniiyé nanitinígíí bikáá'.

Bá nida'anishígíí atah jiljigo t'áá shòḍi koji' hodílnih 800-289-2818.

Navajo



Prior Authorization/Formulary Exception Request Fax Form
 FAX TO: (800) 977-4170

Form must be fully completed to avoid a processing delay.

For status of a request, call: (800) 410-6565

Patient's Name (Last, First, MI)						Date of Birth ----- MM / DD / YYYY -----					
Member ID # ----- Please print clearly and enter one digit per box -----						Patient's Phone ----- Please print clearly and enter one digit per box -----					
Patient's Address, City, State, Zip						Gender <input type="checkbox"/> M <input type="checkbox"/> F		Allergies			
Provider's Name (Last, First, MI)						Provider Specialty			Contact Name		
Provider's Address, City, State, Zip						NPI #					
----- Provider's Phone ----- Please print clearly and enter one digit per box -----						----- Provider's Fax ----- Please print clearly and enter one digit per box -----					
Medication Name and Strength						Quantity		Direction for Use and Duration			
Administered: <input type="checkbox"/> Doctor's Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Home Health <input type="checkbox"/> By Patient <input type="checkbox"/> Other (specify):											
Diagnosis				ICD-9 Code				New Start with This Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Date of First Dose			
Medications Previously Tried with Dates of Use											
Medical Justification and Supporting Information (attach labs and/or chart notes as appropriate)											

For Commercial members for injectable drugs only:

Are you the patient's primary care physician? Yes <input type="checkbox"/> No <input type="checkbox"/>	Has the patient provided an authorized referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
Utilization Management Authorization # (attach copy):	The patient will obtain the medication from: The Provider <input type="checkbox"/> A Pharmacy <input type="checkbox"/>

For Medicare members only: Please review carefully and complete each applicable subsection.

For all requests: Is the patient currently receiving dialysis? Yes <input type="checkbox"/> No <input type="checkbox"/>	
For immunosuppressive medication requests: Is it being used for a transplant? Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Date of transplant:
For antiemetic medication requests: Will the patient be on any other concurrent antiemetic therapy? Yes <input type="checkbox"/> No <input type="checkbox"/> Specify drug(s) & route: _____	Will this drug be used as full therapeutic replacement for intravenous antiemetic drugs within 2 hours and continued for a period not to exceed 48 hours of chemotherapy? Yes <input type="checkbox"/> No <input type="checkbox"/>
For nutritional supplement (enteral or parenteral) medication requests: Does the patient have a G-tube? Yes <input type="checkbox"/> No <input type="checkbox"/> Does the patient have a permanent dysfunction of the digestive track? Yes <input type="checkbox"/> No <input type="checkbox"/>	
For nebulized medication requests: Does the patient reside in a long term care facility or a skilled nursing facility? Yes <input type="checkbox"/> No <input type="checkbox"/>	

I certify that the above information is correct to the best of my knowledge.

Physician's Signature	Date
Name of provider/vendor submitting this form if other than the prescriber above	Phone #

The documents accompanying this facsimile transmission may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the information contained in this transmission is strictly prohibited. If you have received this transmission in error, please notify the sender immediately by telephone or by return FAX and destroy this transmission, along with any attachments.

Mailing Address: Health Net of Arizona Pharmacy Department 5225 E. Williams Circle, Suite 4000 Tucson, AZ. 85711

For copies of prior authorization forms and guidelines, please call (800) 410-6565 or visit the provider portal at www.healthnet.com.



Health Net of Arizona Demographic Update Form

Please complete the applicable information and fax to:
(602) 794-1803 in Phoenix

Tax ID Change Address Change Name Change Provider Term Request

Current Information:	Group/Provider Name: _____
	NPI #: _____ Tax ID #: _____ - _____ Does update apply to all providers under Tax ID? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list applicable provider IDs: _____
Tax ID Change: (If applicable, attach new W9)	<input type="checkbox"/> Add New Tax ID #: _____ - _____ Effective Date: ____/____/____
	<input type="checkbox"/> Terminate Tax ID #: _____ - _____ Term Date: ____/____/____ Termination Reason: _____
Name Change: (If applicable)	New Provider Name: _____
	New Group Name (attach new W9): _____

New Delete Effective Date: ____/____/____

Primary Address:	Street: _____ Suite #: _____
	City: _____ State: _____ ZIP Code: _____
	Email Address: _____
	Telephone: () _____ Fax: () _____ Office Hours: _____

New Effective Date: ____/____/____

Billing Address: (Attach new W9)	Street: _____ Suite #: _____
	City: _____ State: _____ ZIP Code: _____
	Telephone: () _____ Fax: () _____

New Delete Effective Date: ____/____/____

Additional Location: (If applicable, attach page for additional locations)	Street: _____ Suite #: _____
	City: _____ State: _____ ZIP Code: _____
	Telephone: () _____ Fax: () _____
	Office Hours: _____

Provider Term Request:	Provider Name & ID: _____
	Effective Date of Term: ____/____/____
	Reason for Term: _____
	Reassign Members (PCPs only)? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, provider to reassign to: _____ Forwarding Information: _____

Signature: _____	Print Name/Title: _____
Date: ____/____/____	

Statement of Pended Retractions Detail

Call-Out Numbers	Field Name and Description
1	Health Net's address
2	Payee Name and Address – physician or facility where Health Net is sending the Statement of Pended Retractions (SPR)
3	Vendor # – a unique number that identifies provider or corporation
4	Suffix – the legal entity from which the dollars are paid
5	Payee Tax ID – provider tax identification number (TIN)
6	Process Date – date the SPR is generated
7	Bank Code – internal indicator of the bank or company that paid the claim
8	Payer Tax ID – Health Net's TIN
9	Patient Name
10	HN ID # – Health Net member identification (ID) number that appears on the membership card
11	Subscriber – individual holding the policy
12	Claim Type – code identifying the type of claim
13	Provider Name
14	Provider # – a number assigned by Health Net that identifies attending provider
15	Claim # – a unique number assigned by Health Net to identify the specific claim
16	Patient Act # – represents the provider's specific identification number for the member
17	Creation Date – identifies the date on which the retraction (claim reversal) was made
18	Activate Date – represents the date the claim reversal is eligible for offset by Health Net's automated overpayment recovery system. The Activate Date does not reflect the date the claim is eligible for manual offset by Health Net. Claims reversed by Health Net prior to April 14, 2008 (the date Health Net reinstated the automated overpayment recovery system), are not eligible for offset by the automated system. The Activate Date for such claims should be disregarded and providers should reimburse Health Net directly for the overpayment or contact their collection representative to arrange for a manual offset against their next remittance.
19	Check # – represents the provider's check number for the related claims overpayment refund
20	Rendering NPI – represents the National Provider Identifier (NPI) for the rendering provider
21	Status – reflects the status of the retraction as follows: P=Pending, which represents claims that are not activated for automatic offsets; U=Used, which represents claims that have been partially used for automatic offsets or partially paid in cash by the provider; H=Hold, which represents claims that have been put on hold and therefore are not available for automatic offsets
22	Service Date – date(s) on which the service(s) were rendered
23	Proc Code – list of CPT, HCPCS or Revenue codes
24	QTY – number of times a particular service was delivered
25	Description – brief description of service performed, cash receipts and write-offs
26	Billed \$ – amount charged by the provider for each procedure
27	Adjust \$ – the ineligible amount, as well as reductions to allowed amount
28	Adj RSNS – reason for determination of ineligible amount as well as reductions to allowed amount. Codes are explained at the bottom of the statement
29	Deduct \$ – the amount of allowable expenses that are the member's responsibility
30	COINS & Copay \$ – member's copayment or coinsurance amount based on benefit plan
31	Withheld – the amount retained by Health Net based on the provider's contract. Returned to provider at year end under certain conditions
32	Net Paid \$ – amount Health Net is paying the provider on the procedure code billed, based on the price category of the provider, with reductions to the allowed amount based on the benefit plan of the member. If negative, it represents the amount due to Health Net from the provider on the procedure code reversed with reductions to the allowed based on the benefit plan of the member
33	Retraction Subtotal – subtotal of the reversal of the claim
34	Claim Total – totals of all the claim transactions
35	Reason Code – explanations for adjustments shown in the statement
36	Negative Remit Address – a reminder that provider must send payment to Health Net for the amounts shown on this statement
37	Includes payment mailing address and telephone number to call with questions

EXHIBIT A Sample Statement of Pended Retractions

HEALTH NET
of ARIZONA, INC.
1230 W. Washington St., Suite 401
Tempe, AZ 85281-2145

② **Payee Name** Main Street Medical Group
Payee Address 123 Main Street
Any City, AZ 12345-6789

③ **Vendor #** 0000012456 **Process Date** 09/21/2007 ⑥
④ **Suffix** 1234 **Bank Code** AB ⑦
⑤ **Payee Tax ID** 123456789 **Payor Tax ID** 123456789 ⑧

⑨			⑩			⑪			⑫	
Patient Name SAMPLE, JOHN			HN ID # HN123456789			Subscriber SAMPLE, JOHN			Claim Type E	
⑬ Provider Name Joe Doctor, MD			⑭ Provider # 1A2345		⑮ Claim # 123456789123456789		⑯ Patient Act# 1A2345			
⑰ Creation Date 11/17/2006			⑱ Activate Date 08/12/2009		⑲ Check #		⑳ Rendering NPI		㉑ Status P	
Service Date	Proc Code	QTY	Description	Billed \$	Adjust \$	Adj RSNS	Deduct \$	COINS & Copay \$	Withheld	Net Paid \$
05/23/2006	99213	1	CARE IN DOCTOR'S OFF	-115.00	-68.93	J,IB,A	0.00	-30.00	0.00	-38.93
⑳	㉑	㉒	㉓	㉔	㉕	㉖	㉗	㉘	㉙	㉚
RETRACTION SUBTOTAL				-115.00	-68.93		0.00	-30.00	0.00	-38.93

Patient Name SAMPLE, JANE			HN ID # HN123456789			Subscriber SAMPLE, JOHN			Claim Type E	
Provider Name Jane Doctor, MD			Provider # 1A2345		Claim # 123456789123456789		Patient Act# 1A2345			
Creation Date 06/22/2007			Activate Date 08/22/07		Check #		Rendering NPI		Status P	
Service Date	Proc Code	QTY	Description	Billed \$	Adjust \$	Adj RSNS	Deduct \$	COINS & Copay \$	Withheld	Net Paid \$
08/07/2006	99213	1	CARE IN DOCTOR'S OFF	-115.00	-32.08	TD	0.00	0.00	0.00	-32.08
RETRACTION SUBTOTAL				-115.00	-32.08		0.00	0.00	0.00	-32.08

Patient Name SAMPLE, JANE			HN ID # HN123456789			Subscriber SAMPLE, JOHN			Claim Type E	
Provider Name Tom Doctor, MD			Provider # 1A2345		Claim # 123456789123456789		Patient Act# 1A2345			

Sample Statement of Pended Retractions

HEALTH NET
of ARIZONA, INC.
1230 W. Washington St., Suite 401
Tempe, AZ 85281-2145

Payee Name	Joe Doctor
Vendor #	0000012456
Process Date	09/21/2007

Creation Date 06/22/2007			Activate Date 03/17/2010		Check #		Rendering NPI		Status P	
Service Date	Proc Code	QTY	Description	Billed \$	Adjust \$	Adj RSNS	Deduct \$	COINS & Copay \$	Withheld	Net Paid \$
10/20/2006	99213	1	CARE IN DOCTOR'S OFF	-115.00	-32.08	TD	0.00	0.00	0.00	-32.08
RETRACTION SUBTOTAL				-115.00	-32.08		0.00	0.00	0.00	-32.08

Patient Name SAMPLE, JANE	HN ID # HN123456789	Subscriber SAMPLE, JOHN	Claim Type E							
Provider Name Joe Doctor, MD	Provider # 1A2345	Claim # 123456789123456789	Patient Act# 1A2345							
Creation Date 06/22/2007			Activate Date 03/17/2010		Check #		Rendering NPI		Status P	
Service Date	Proc Code	QTY	Description	Billed \$	Adjust \$	Adj RSNS	Deduct \$	COINS & Copay \$	Withheld	Net Paid \$
12/26/2006	99213	1	CARE IN DOCTOR'S OFF	-125.00	-32.08	TD	0.00	0.00	0.00	-32.08
RETRACTION SUBTOTAL				-125.00	-32.08		0.00	0.00	0.00	-32.08
CLAIM TOTAL				-470.00	-165.17		0.00	-30.00	0.00	-135.17

33

34

35

Reason Code:

- J: REVERSAL OF PRIOR PAYMENT
- IB: CHARGE DENIED. MEMBER IS INELIGIBLE FOR THIS DATE OF SERVICE. EXPENSES INCURRED PRIOR TO COVERAGE. MEMBER RESPONSIBLE.
- A: BILLED AMOUNT EXCEEDS HEALTH PLAN ALLOWED AMOUNT. DO NOT BILL MEMBER FOR THE DIFFERENCE.
- TD: PAYMENT WITHDRAWN, ANOTHER CARRIER IS PRIMARY - RESUBMIT THE CLAIM WITH THE EXPLANATION OF BENEFITS FROM THE PRIMARY CARRIER.

36

A negative remit balance is due to Health Net. Send check to: Recovery Dept., One Far Mill Crossing, P.O. Box 904, Shelton, CT 06484-0944

37



Discharge Summary Form

Today's Date: _____

Member Name: _____ Member DOB: _____

Admission Date: _____ Discharge Date: _____

Facility Name: _____

Presenting Problem: _____

Discharge Diagnoses:

Discharge Medications:

Follow-Up Instructions:

Hospitalist's Name: _____

(Please print.)

Contact Telephone Number: _____



Arizona Association of Health Plans
Credentialing Alliance

PRACTITIONER DATA FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST. New providers receive written confirmation of their effective date with the health plan. Members may not be seen until the provider receives written confirmation that a request or change is approved and completed (this includes approval by the Credentialing Committee if applicable). **Please Type or Print Clearly.**

To:		Return To:	
Fax #:	Phone #:	Fax #:	Phone #:

DIRECTIONS:

- Please type or print this form clearly and return the completed form with attachments
- CAQH Registration is required
- Certification in your requested specialty or documentation of your examination date is required in order to successfully complete the contracting process

Attach the following:

IRS 941 coupon or accurate W9 General Anesthesia Permit, Conscious Sedation Permit and/or Oral Conscious Sedation Permit (*Dental providers only*)

Documentation of board certification or scheduled exam date

CAQH Registered?

Yes CAQH # _____ *Please ensure your application is up to date and that each health plan you are requesting participation in is authorized to access your data.*

No

Practitioner's Name & Degree: (Last) (First) (M.I.) (Degree)		<input type="checkbox"/> Female <input type="checkbox"/> Male	Practitioner's Effective Date w/Practice:
		DOB:	
1099 Registered Name (Required):		Tax ID #:	
Group Practice Name (DBA): (If applicable)			
Are you associated with any of the following: <input type="checkbox"/> IPA <input type="checkbox"/> PHO <input type="checkbox"/> N/A		Group Type (<i>check all that apply</i>):	
If IPA or PHO marked please provide Name:		<input type="checkbox"/> PCP <input type="checkbox"/> OBGYN <input type="checkbox"/> Dentist <input type="checkbox"/> Specialist	
Lines of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	Individual NPI#:	Organizational NPI#:	Malpractice Policy #
SSN:	DEA #:	State:	Exp. Date:
		License #:	State:
			Exp. Date:
Is provider a Medicare participating provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		AHCCCS I.D.#:	
Primary Specialty:	Board Certification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Exam:	
Secondary Specialty:	Board Certification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Exam:	
Want Contract as PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Age Range:	
Do you provide services to individuals with special needs/chronic conditions (<i>check all that apply</i>)? <input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Emotional <input type="checkbox"/> None		Physician Assistant Supervising Physician Name:	
Do you provide services to individuals who have difficulty communicating or cooperating (i.e. those with autism or intellectual disabilities)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you provide services to individuals with mobility limitations (i.e. wheelchair bound)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you treat any of the following diagnoses (<i>check all that apply</i>)? <input type="checkbox"/> Anxiety <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> HIV <input type="checkbox"/> None			
PCPs & OBs ONLY: Do you provide any of the following services (<i>check all that apply</i>)? <input type="checkbox"/> EPSDT <input type="checkbox"/> OB <input type="checkbox"/> None			
Do you participate in VFC (Vaccines for Children)? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>PCPs seeing AHCCCS members 18 & < must participate</i>)			VFC PIN Code:
Are You a Baby Arizona Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Practice/Clinic an FQHC or RHC? <input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> N/A	
Hospitals & Ambulatory Surgery Center(s) where practitioner has privileges:			
Names of Practitioners in Call Group (<i>Must be contracted with plan</i>):			



Arizona Association of Health Plans
Credentialing Alliance

PRACTITIONER DATA FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST. New providers receive written confirmation of their effective date with the health plan. Members may not be seen until the provider receives written confirmation that a request or change is approved and completed (this includes approval by the Credentialing Committee if applicable). **Please Type or Print Clearly.**

To:		Return To:	
Fax #:	Phone #:	Fax #:	Phone #:

DIRECTIONS:

- Please type or print this form clearly and return the completed form with attachments
- CAQH Registration is required
- Certification in your requested specialty or documentation of your examination date is required in order to successfully complete the contracting process

Attach the following:

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Documentation of board certification or scheduled exam date

CAQH Registered?

Yes CAQH # _____ Please ensure your application is up to date and that each health plan you are requesting participation in is authorized to access your data.

No

Practitioner's Name & Degree: (Last) (First) (M.I.) (Degree)		<input type="checkbox"/> Female <input type="checkbox"/> Male	Practitioner's Effective Date w/Practice:
		DOB:	
1099 Registered Name (Required):		Tax ID #:	
Group Practice Name (DBA): (If applicable)			
Are you associated with any of the following: <input type="checkbox"/> IPA <input type="checkbox"/> PHO <input type="checkbox"/> N/A		Group Type (check all that apply):	
If IPA or PHO marked please provide Name:		<input type="checkbox"/> PCP <input type="checkbox"/> OBGYN <input type="checkbox"/> Dentist <input type="checkbox"/> Specialist	
Lines of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Commercial	Individual NPI#:	Organizational NPI#:	Malpractice Policy #
SSN:	DEA #:	State:	Exp. Date:
		License #:	State:
			Exp. Date:
Is provider a Medicare participating provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		AHCCCS I.D.#:	
Primary Specialty:	Board Certification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Exam:	
Secondary Specialty:	Board Certification: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Exam:	
Want Contract as PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Age Range:	
Do you provide services to individuals with special needs/chronic conditions (check all that apply)? <input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Behavioral <input type="checkbox"/> Emotional <input type="checkbox"/> None		Physician Assistant Supervising Physician Name:	
Do you provide services to individuals who have difficulty communicating or cooperating (i.e. those with autism or intellectual disabilities)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you provide services to individuals with mobility limitations (i.e. wheelchair bound)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you treat any of the following diagnoses (check all that apply)? <input type="checkbox"/> Anxiety <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> HIV <input type="checkbox"/> None			
PCPs & OBs ONLY: Do you provide any of the following services (check all that apply)? <input type="checkbox"/> EPSDT <input type="checkbox"/> OB <input type="checkbox"/> None			
Do you participate in VFC (Vaccines for Children)? <input type="checkbox"/> Yes <input type="checkbox"/> No (PCPs seeing AHCCCS members 18 & < must participate)			VFC PIN Code:
Are You a Baby Arizona Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Practice/Clinic an FQHC or RHC? <input type="checkbox"/> FQHC <input type="checkbox"/> RHC <input type="checkbox"/> N/A	
Hospitals & Ambulatory Surgery Center(s) where practitioner has privileges:			
Names of Practitioners in Call Group (Must be contracted with plan):			

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY INCLUDING ATTACHMENTS SO THAT WE MAY PROCESS YOUR REQUEST. New providers will receive written confirmation of their effective date with the health plan. Members may not be seen until the provider receives written confirmation that a request or change is approved and completed (this includes approval by the Credentialing Committee if applicable). **Please Type or Print Clearly.**

BILLING SERVICE (If applicable)	Name:			
	Address:		Phone:	
	City:	State:	Zip Code:	Fax:

PAY TO ADDRESS (All payments sent to this address)	Address:		City:	State:
	Billing Phone #:		Billing Fax #:	
				Zip Code:

PRIMARY ADDRESS (Physical location where services are performed)	Address:		City:	Zip Code:
	Phone #:		Fax #:	County:
	Office Hours:		Office Contact (All Other):	

ADDITIONAL OFFICE: (Indicate other additional offices on a separate sheet)	Address:		City:	Zip Code:
	Phone #:		Fax #:	County:
	Office Hours:			

MAILING ADDRESS: (All correspondence will be sent to this address)	Address:		City:	Zip Code:
	E-mail Address:			County:

CREDENTIALING CONTACT:	Name:		E-mail Address:		
	Address:			Phone:	
	City:	State:	Zip Code:	Fax:	

Languages other than English spoken by PRACTITIONER:	<input type="checkbox"/> N/A
Languages other than English spoken by OFFICE STAFF:	<input type="checkbox"/> N/A
Any other Name(s) Possible in Records?	<input type="checkbox"/> N/A

Describe Your Medical Record Keeping System(s) (i.e. EMR, Paper, etc.):		
Describe Your Cost Record Keeping System(s) (i.e. Billing or A/R system):		
Electronic Claims Submission? <input type="checkbox"/> Yes <input type="checkbox"/> No	Internet Access? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a minority or female owned business? <input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic Funds Transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No		