ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

AzEIP AHCCCS MEMBER SERVICE REQUEST

Date: _____ AzEIP Service Coordinator's Name: _____

Phone Number: _____ Email: _____

AzEIP TBEIS Contractor: _____

Phone Number: _____ Email: _____

Type: ☐ Initial IFSP ☐ Six Month Review ☐ Annual IFSP ☐ Other/Addendum: _____

Date: _____

Child's Information

Child's Name *(Last, First, M.I.)*: _____ Date of Birth: _____

AHCCCS ID Number: _____ Expected Month/Year of Transition from AzEIP: _____

Parents'/Guardians' Name(s): _____

Preferred Language: _____ AHCCCS Health Plan: _____

Primary Care Physician: _____

Mailing Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____ Home Phone Number: _____

Work Phone Number: _____ Cell / Message Phone Number: _____

SEE ATTACHED: AzEIP Developmental Evaluation Report and Results of the most recent evaluations and assessments.

Expected outcomes:

Dear Primary Care Physician: The child identified above is eligible for AzEIP and the AzEIP Individualized Family Service Plan (IFSP) Team is recommending the EPSDT services identified below. Please review the documentation, indicate whether each requested service is medically necessary by checking "yes" in shaded box next to each service and return to the health plan MCH coordinator who will coordinate prior authorization for the services you deem medically necessary. If you feel the services are not medically necessary, or the child should not receive these services at this time, please explain below:

Primary Care Physician's Signature: _____ Date: _____

See page 2 for EOE/ADA disclosures

To be completed by the AzEIP Service Coordinator:					Completed by PCP	Completed by AHCCCS Contractor	
Requested Services/CPT Code	**Requested Provider and Phone No.**	**Planned Start Date**	**Frequency**	**Duration**	**Medically necessary service**	**AHCCCS Contractor**	**NOA Sent**
					☐ Yes ☐ No	☐ Approve ☐ Deny	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Approve ☐ Deny	☐ Yes ☐ No
					☐ Yes ☐ No	☐ Approve ☐ Deny	☐ Yes ☐ No

If services are not medically necessary, or if the PCP wants to examine the member to determine medical necessity, the AHCCCS Contractor will deny the services and send a Notice of Action (NOA) letter to the member's parents/guardians and the AzEIP Service Coordinator.

To be completed by the AHCCCS Contractor:

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

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

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

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

Contacts

Health Plan: _____ MCH Coordinator: _____

Phone Number: _____ Fax Number: _____

AzEIP Coordinator: _____

Phone Number: _____ Fax Number: _____

Primary Care Physician: _____

Phone Number: _____ Fax Number: _____

Service Provider: _____

Phone Number: _____ Fax Number: _____

Additional Information