DDD-1426A FORFF (8-23)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Health Care Services

REQUEST FOR INCONTINENCE BRIEFS FOR MEMBERS AGES 3 AND ABOVE

(AMERICAN INDIAN HEALTH PLAN)

MEMBER INFORMATION

Member's Name: _____ Date of Birth: _____

AHCCCS ID No.: _____ Date: _____

Home Address *(No., Street, City, State, ZIP)*: _____

Phone No. *(Include area code)*: _____ Diagnosis: _____

Height: _____ Weight: _____ Waist: _____

Responsible Person's Name: _____ Phone No. *(Include area code)*: _____

Shipping Address *(Cannot ship to a PO Box)*: _____

Attached to the Request:

☐ Primary Care Provider (PCP) script ☐ Disability diagnosis code resulting in incontinence

Support Coordinator's Name: _____

Phone No. *(Include area code)*: _____ FAX No. *(Include area code)*: _____

Support Coordinator's Signature: _____ Date: _____

HEALTH CARE SERVICES PRIOR AUTHORIZATION UNIT USE ONLY

Provider: _____ Authorization No.: _____ Expiration Date: _____

Send completed form to:

Fax: Health Care Service Prior Authorization Unit
602-253-9083

Interoffice: Division of Developmental Disabilities
Health Care Services
Site Code 795M

Mail: Division of Developmental Disabilities
Health Care Services, Site Code 795M
3443 N. Central Ave., Suite 600
Phoenix, AZ 85012

Phone: 602-771-8080