

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

**AzEIP AHCCCS Member Service Request**

DATE  
5/1/2015

AzEIP SERVICE COORDINATOR'S NAME Sally Green		PHONE NO. (480) 555-1212	EMAIL sally@sc.com
AzEIP TBEIS CONTRACTOR AzEIP contractor region #		PHONE NO. (480) 555-1200	EMAIL AzEIP_contractor.com
TYPE: <input type="checkbox"/> Initial IFSP <input type="checkbox"/> Six Month Review <input type="checkbox"/> Annual IFSP <input type="checkbox"/> Other/Addendum:			DATE

**Child's Information**

CHILD'S NAME Patrick MacManus	AHCCCS ID NO. 12345	DATE OF BIRTH 1/1/2013	EXPECTED MONTH/YEAR OF TRANSITION FROM AzEIP
PARENTS' / GUARDIANS' NAME(S) Lillian and Ross MacManus	PREFERRED LANGUAGE	AHCCCS HEALTH PLAN	PRIMARY CARE PHYSICIAN
MAILING ADDRESS (No., Street, City, State, ZIP)	HOME PHONE NO.	WORK PHONE NO.	CELL / MESSAGE PHONE NO.

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

Expected outcomes:

NOT ELIGIBLE. He was evaluated and determined NOT ELIGIBLE for AzEIP. However, the child has a MODERATE DEVELOPMENTAL DELAY in the COMMUNICATION DOMAIN. Please see attached evaluation report to support identification of appropriate services through the health plan.

~~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:  
This child is NOT ELIGIBLE for AzEIP.~~

PRIMARY CARE PHYSICIAN'S SIGNATURE	DATE
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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
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Approve <input type="checkbox"/> Deny	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Approve <input type="checkbox"/> Deny	<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Approve <input type="checkbox"/> Deny	<input type="checkbox"/> Yes <input type="checkbox"/> 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

**AzEIP AHCCCS Member Service Request**

DATE
5/1/2015
EMAIL
sally@sc.com
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AzEIP_contractor.com

AzEIP SERVICE COORDINATOR'S NAME	PHONE NO.
Sally Green	(480) 555-1212
AzEIP TBEIS CONTRACTOR	PHONE NO.
AzEIP contractor region #	(480) 555-1200

TYPE:  Initial IFSP     Six Month Review     Annual IFSP     Other/Addendum: \_\_\_\_\_ DATE \_\_\_\_\_

**Child's Information**

CHILD'S NAME	AHCCCS ID NO.	DATE OF BIRTH	EXPECTED MONTH/YEAR OF TRANSITION FROM AzEIP
Patrick MacManus	12345	1/1/2013	
PARENTS' / GUARDIANS' NAME(S)	PREFERRED LANGUAGE	AHCCCS HEALTH PLAN	PRIMARY CARE PHYSICIAN
Lillian and Ross MacManus			
MAILING ADDRESS (No., Street, City, State, ZIP)	HOME PHONE NO.	WORK PHONE NO.	CELL / MESSAGE PHONE NO.

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PRIMARY CARE PHYSICIAN'S SIGNATURE	DATE

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