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

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1