AHCCCS NOTIFICATION
TO WAIVE MEDICARE PART D CO-PAYMENTS
FOR MEMBERS IN A MEDICAID FUNDED MEDICAL INSTITUTION

Use this form to notify AHCCCS when a member is expected to reside in a medical institution that is funded by Medicaid for a full calendar month.

Fax to the AHCCCS Member Database Management Administration (MDMA)
602-253-4807

MEMBER INFORMATION

MEMBER NAME__________________________________ AHCCCS ID____________________ DATE OF BIRTH ___/___/___

MEDICAL INSTITUTION INFORMATION

NOTIFICATION OF A MEDICAID FUNDED ADMISSION

TYPE OF MEDICAL INSTITUTION	(x)	DATE OF ADMISSION	PROVIDER ID #	NAME OF MEDICAL INSTITUTION
ACUTE HOSPITAL	______	____________________	___________________	____________________
PSYCHIATRIC HOSPITAL/ IMD	______	____________________	___________________	____________________
PSYCHIATRIC HOSPITAL/Non-IMD	______	____________________	___________________	____________________
RTC/IMD	______	____________________	___________________	____________________
RTC/Non-IMD	______	____________________	___________________	____________________
SNF	______	____________________	___________________	____________________
ICF MR	______	____________________	___________________	____________________

COMMENTS:

SUBMITTED BY: ____ DATE:________________________

TITLE:____ PHONE #:______________________

HEALTH
PLAN/T/RBHA:____

Last Revision Date: 10/22/2010
Effective Date: 12/01/2010