



Maricopa Intake Form
Form 7.5.2

Fax completed form to 866-891-3485

*⁽²⁾Intake By: _____ *⁽³⁾Intake Date: ____/____/____ (mm/dd/yyyy)

*⁽⁴⁾Intake Provider ID (MIS#): _____ *⁽⁵⁾Provider Phone Number _____

Maintenance Reason:

Add: (02) Birth (28) Initial Enrollment (41) Re-enrollment

Change: (22) Plan Change (25) Change in Identifying Element

(29) Benefit Selection (43) Change of Location

Closure of Intake: (03) Death (07) Termination of Benefits

(14) Voluntary Withdrawal (AH) Patient Moved

Maintenance Date: _____

Member Information

⁽⁶⁾CIS ID: _____

⁽⁷⁾ AHCCCS ID (ID is not required, but if available should be entered as a mechanism to help prevent duplicate enrollment): _____

*⁽⁸⁾Marital Status: Married Registered Domestic Partner Separated
 Divorced Widowed Single
 Legally Separated Unreported

*⁽⁹⁾Gender: Male Female

*⁽¹⁰⁾Last Name: _____ *⁽¹¹⁾First Name: _____ MI: _____

*⁽¹¹⁾Address Line 1: _____ Address Line 2: _____

*⁽¹²⁾City: _____ *⁽¹³⁾State: _____ *⁽¹⁴⁾Zip Code: _____

*⁽¹²⁾County Code: Apache Cochise Coconino Gila Graham
 Greenlee La Paz Maricopa Mohave Navajo
 Pima Pinal Santa Cruz Yavapai Yuma
 Other Arizona County _____

*⁽¹³⁾Primary Language:

<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> German	<input type="checkbox"/> Sign Language
<input type="checkbox"/> Navajo	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Serbian	<input type="checkbox"/> Croatian
<input type="checkbox"/> Arabic	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Filipino	<input type="checkbox"/> Central Khmer
<input type="checkbox"/> Albanian	<input type="checkbox"/> Hmong	<input type="checkbox"/> Hungarian	<input type="checkbox"/> Serbo Coatian
<input type="checkbox"/> Amharic	<input type="checkbox"/> Lao	<input type="checkbox"/> Persian	<input type="checkbox"/> Mon-Khmer
<input type="checkbox"/> Armenian	<input type="checkbox"/> Russian	<input type="checkbox"/> French	<input type="checkbox"/> Creoles and pidgins
<input type="checkbox"/> Philippine	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Italian	<input type="checkbox"/> Uncoded Languages
<input type="checkbox"/> Polish	<input type="checkbox"/> Umbundu	<input type="checkbox"/> Hindi	<input type="checkbox"/> Central American Indian
<input type="checkbox"/> Somali	<input type="checkbox"/> Korean	<input type="checkbox"/> Yiddish	<input type="checkbox"/> North American Indian
<input type="checkbox"/> Japanese	<input type="checkbox"/> Greek	<input type="checkbox"/> Chinese	<input type="checkbox"/> South American Indian
<input type="checkbox"/> Other (code) _____			



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If the recipient's Primary Language is not listed in the above section, please check the "Other" box and indicate the 3 letter language code from the attached appendix (ISO 639-2 Complete Language List).

*(14) **Date of Birth:** ____/____/____

Race/Ethnicity:

- Not Provided Not Applicable Asian or Pacific Islander Black Caucasian
- Sub Continent Asian American Other Race or Ethnicity Asian Pacific American
- Native American Hispanic American Indian or Alaskan Native Native Hawaiian
- Black (Non-Hispanic) White (Non-Hispanic) Pacific Islander Mutually Defined

Employment Status: Active Full Time Terminated

Insurance Information

*(16) **Medical Insurance 1 (Primary):**

- 1 - Medicare 2 - AHCCCS 3 - Private – Coverage provided entirely by the member
- 4 - CHAMPUS/VA 5 - Other – Coverage from an employee contribution plan provided
- 6 – Blue Cross 7 - HMO 9 - None

Medical Insurance 2:

- 1 - Medicare 2 - AHCCCS 3 - Private – Coverage provided entirely by the member
- 4 - CHAMPUS/VA 5 - Other – Coverage from an employee contribution plan provided
- 6 – Blue Cross 7 - HMO 9 - None

Medical Insurance 3:

- 1 - Medicare 2 - AHCCCS 3 - Private – Coverage provided entirely by the member
- 4 - CHAMPUS/VA 5 - Other – Coverage from an employee contribution plan provided
- 6 – Blue Cross 7 - HMO 9 - None

*(17) **Is member intake for crisis service only?** Yes No