

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

*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 File Integrity Section (MFIS)  
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/RBHA: \_\_\_\_\_