

NARBHA PM Form 3.22.3

Out-of-State Placement --Coordination of Care with AHCCCS Health Plans

Please provide the following information to the member's AHCCCS Health Plan for each person being considered for Out-of-State Placement:

Each AHCCCS Health Plan Behavioral Health Coordinator serves as a contact person and resource for behavioral health providers when problems arise concerning a person's medical care or any other health plan related issue. See [PM Attachment 4.3.1](#) for contact information for other AHCCCS Health Plans.

ARIZONA PHYSICIANS IPA, INC. Jaye Marcus-Ledford (602) 664-5384 Fax: (602) 664-2876 E-mail: jacqueline_a_marcusledford@uhc.com Please be aware that there are two underscore marks **Member Services: (800) 348-4058**

MERCY CARE PLAN Danny Guckenbug (602) 798-2690 (602) 230-9921 BH Fax: (602) 351-2316 E-mail: danny.guckenbug@schalleranderson.com **Member Services: (602) 263-3000**

DES/CMDP Site Code - 942C Annette Sims (602) 351-2245 x7009 Fax: (602) 351-8529 E-mail: Asims@azdes.gov **Member Services: (602) 351-2245**

Other:

Member Name	Date of Birth	AHCCCS I.D.	Primary Care Physician
NARBHA	NARBHA Contact:	NARBHA Contact Phone: 1-877-923-1400	NARBHA FAX: 928-774-5665
Briefly outline the primary behavioral health needs for which an out-of-state placement is being sought:			
What is the proposed placement? (Include name of program, location and phone number):			
Is medical and psychiatric care at the placement all-inclusive (usually yes for Level I Hospital or Level I RTC)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If not all-inclusive, who at proposed placement can Health Plan contact to recommend primary health care needs be met? (Name and phone number)			
Briefly outline anticipated primary care health needs during the out-of-state placement:			
<input type="checkbox"/> routine well-child <input type="checkbox"/> ongoing medical condition care (specify below) <input type="checkbox"/> pharmacy <input type="checkbox"/> laboratory tests <input type="checkbox"/> other:			
Known medical conditions:			
Anticipated length of stay in out-of-state placement:			

Date Faxed to Health Plan: _____

Effective Date: 07/01/07