

**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: _____