520, ATTACHMENT A - ENROLLMENT TRANSITION INFORMATION FORM

INSTRUCTIONS: ALL SECTIONS MUST BE COMPLETED OR MARKED N/A.					
1.	Member Name	AKA			Telephone
2.	AHCCCS ID #		DOB		Male □ Female □
3.	Rate Code	County Name & #			
4.	Relinquishing Contractor /RBHA				
5.	Receiving Contractor/RBHA				
6.	Medicare Part A □ Part B □	Other Insurance			Plan ID #
7.	ALTCS Application Pending Yes □ No □		Date		
8.	Diagnosis		Secondary Diagnosis		
9.	PCP Name				Telephone
10.	High Risk Pregnancy Yes □ No □	Explain Risk			
	Pregnancy EDC	Maternity Provider			Telephone
11.	Medications				Injectable Yes □ No □
12.	Transplant Yes □ No □	Type	Date	Facility	
13.	Catastrophic Reinsurance Yes □ No □	Diagnosis/High Cost Specialty Drug			
14.	Specialist Name	Type			Telephone
15.	Out-of-Area-Appt Yes □ No □	Provider			Telephone
16.	Outpatient Services Yes □ No □	Provider			Telephone
17.	Outpatient Adult PT/OT Yes □ No □	# of Visits in Current Contract Year			
18.	Home Health Yes □ No □	Provider			Telephone
	Home Health Services				
19.	Case Management Yes □ No □	Please Explain			
20.	Case Manager Name/DCS Case worker				Telephone
21.	Contractor Care Manager Name				Telephone
22.	Inpatient Yes □ No □	Facility Name			Telephone
23.	SNF Yes □ No □	Facility Name			Telephone
	# of SNF Days used/benefit year				
24.	Residential Yes □ No □	Facility Name			Telephone
25.	Admitting Diagnosis				
26.	Admission Date		Expected Discharge Date		
27.	Dental Benefit Used ($) ALTCS _____ Adult Dental Emergency Benefit _____				
28.	High Needs / High Cost Yes □ No □				
29.	CRS Diagnosis(s)		MSIC provider		
30.	Behavioral Health Yes □ No □	Provider			Telephone
31.	COT Yes □ No □ Expiration Date _____	Court of Jurisdiction			
32.	Monitored by PSRB Yes □ No □	Care Manager			Telephone

Effective Date: 04/01/98, 4/01/05, 10/01/10, 10/01/11, 07/01/16, 10/01/17, 10/01/18, 10/01/21
Approval Dates: 04/01/98, 4/01/05, 10/01/10, 10/01/11, 07/01/16, 06/01/17, 06/07/18, 04/06/21

33.	Special Assistance (SMI) Yes □ No □	Contact Name & Relation		Telephone
34.	(SMI) Designation Yes □ No □	(SMI) Opt Out Yes □ No □		
35.	Member enrolled in CHP in the last 12 months Yes □ No □			If yes, termination date
36.	Health Care Decision Maker/Guardian Yes □ No □		Name	Telephone
37.	Respite Hours Used			
38.	Medical Equipment Vendor		Telephone	Date
39.	Type of Medical Equipment			Own □ Rent □
40.	Medical Foods Yes □ No □	Vendor		Telephone
41.	End of Life Care Services Yes □ No □			
42.	Exclusive Pharmacy Yes □ No □	Pharmacy	Telephone	Begin Date
	Exclusive Prescriber Yes □ No □	Prescriber	Telephone	Begin Date
	Medication Assisted Treatment (MAT) Yes □ No □	Prescriber	Telephone:	
43.	Other Care Needs			
44.	Non-Emergency Medical Transportation Yes □ No □		Mode	
45.	Date Transportation Needed	Destination		
46.	Person Completing Form			Telephone
47.	Date of Notification to Receiving Contractor			

Comments or additional information:

This information is considered CONFIDENTIAL and disclosure is governed by applicable Federal, State, and Agency regulations. Information on this Form is current as of this notification date. This Form must be completed for all members requiring transition services in accordance with AHCCCS policies: No changes or revisions to this Form are permitted without written approval from AHCCCS