AHCCCS
Arizona Health Care Cost Containment System

SECTION A. TO BE COMPLETED BY REQUESTOR. ATTACH MANDATORY FAX COVER SHEET.

DURABLE MEDICAL EQUIPMENT CONTINUED AUTHORIZATION REQUEST

(FORM TO BE USED ONLY FOR INCONTINENCE SUPPLIES & RENTAL EXTENSIONS)

Submit completed form to:
AHCCCS/DFSM/Tribal ALTCS via TIBCO:
https://tiwebprd.statemedicaid.us

Case Manager must verify the information below before submitting to AHCCCS:

Initial PA Request has been submitted & approved:

☐ Yes - If yes, provide PA Number: _____

☐ No

**If No, please submit a full DME PA Request Packet with all necessary documentation.*

☐ By submitting this PA Continued Authorization Request the assigned Case Manager attests the member has not had any clinical changes, as documented on the PCSP. The Case Manager attests the documentation (Rx, Face to Face Dates & Provider Quote) previously provided within the Fiscal Year (01/01/20XX-12/31/20XX) are the most current available.

☐ Rx: Provide the following:
Most Current Rx Date:
_____
Prescribing Provider Name:
_____
Provider Phone #:
_____
Provider Fax #:
_____
Diagnosis & Code (Related to the Need):
_____

☐ Face to Face: Provide the following:
Most Current Face to Face Date:
_____

Provider Quote has no changes:

☐ Yes

☐ No

**If Yes, please resubmit full DME PA Packet with updated information.*

TRIBAL ALTCS PROGRAM	BLANK [SELECT ANOTHER)
CASE MANAGER NAME	
TRIBAL ALTCS PROGRAM ADDRESS	
CM PHONE NUMBER **CM FAX NUMBER**	
MEMBER'S NAME	
MEMBER'S DOB	
MEMBER'S AHCCCS ID	

SIGNATURES Acknowledge that the Tribal ALTCS Case Manager has reviewed & attests the necessary documentation previously provided to AHCCCS is the most current. There have been no changes to the member's status with the DME extension request.
Note: All areas of this form must be completed, if any sections are left blank the DME PA Continued Request will be returned and need to be resubmitted.

CASE MANAGER SIGNATURE	
DATED	

Comments:

_____
_____
_____
_____
_____