Service Provider Communication Form:

Please complete this form in its entirety and return to the PA Tribal ALTCS team via email at tribalaltcs.generalmailbox.azahcccs.gov

Date:	
Health Plan ID:	Select Health Plan
Case Manager/CM Supervisor Name	

Provider Info:

Provider:	
Name for point of direct contact:	
Phone number for direct contact:	
Email address for direct contact:	

Member Info:

Member Name:	
Member AHCCCS ID:	
Service Review Request:	System Technical Assistance
If "System Technical Assistance", please select System Type:	PMMIS
Type of service:	ALF

Please check each statement as they apply:

I reviewed the following information but was unable to resolve the issue:

Yes NA

- ☐ Did you review with your Supervisor?
- ☐ ☐ Did you review AMPM Policies?
- ☐ ☐ Did you review PMMIS Manual or PMMIS Screens?
- ☐ ☐ Was a service ticket submitted? (For PMMIS and Claims Issue)

  Service Ticket #: CRN #:
- ☐ ☐ Did you review the FAQs?

Comprehensive notes: (Include actions performed prior to escalating the issue to AHCCCS DFSM, such as: Steps taken to try and resolve the issue at the Health Plan level.)

Case Manager/CM Supervisor Signature: Date: