Katie Hobbs, Governor
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AHCCCS
Arizona Health Care Cost Containment System

SPECIALITY RATE REQUEST CHECK SHEET

MEMBER'S NAME:		**AHCCCS ID:**	
CASE MANAGER NAME:		**TRIBAL ALTCS PROGRAM:**	BLANK-SELECT HEALTH PROG
PHONE NUMBER:		**FAX NUMBER:**	

The initial request must be made by the Tribal Case Manager. If a Provider makes a request, it will be pended and a notification will be sent to the case manager requesting.

Special Rate Request:	**Documents Attached:**
☐ In-Patient Dialysis ☐ Ventilator ☐ High Respiratory/Trach ☐ Bariatric ☐ Memory Care ☐ Wandering/Wandering Dementia ☐ Behavioral Health ☐ Behavioral Health High Acuity ☐ Sitter ☐ Other (insert below): _____ ***Duration of Prior Authorization approval is based on clinical review.**	☐ PA Request Form ☐ Face Sheet ☐ Admission Orders ☐ Clinical documentation to support Special Rate being requested ☐ And any other supporting clinicals, scripts, etc. ***All supporting documentation must be within the last 90 days.**

NOTES:

Signatures acknowledge that both Tribal ALTCS Case Manager and Supervisor have reviewed and submitted the necessary documentation to proceed with SNF request.

Case Manager Signature:	
Supervisor Signature:	