INITIAL DIALYSIS CASE CREATION FORM

I am the treating physician for ____________________________________, __________,
(PRINT Member Name) (DATE OF BIRTH)

___________________ who has been diagnosed with end-stage renal disease (ESRD).
(AHCCCS ID #)

It is my opinion that in the absence of the following dialysis treatments per week, the patient's ESRD would reasonably be expected to result in:

- **Placing the patient's health in serious jeopardy;**
- **Serious impairment of bodily function; or**
- **Serious dysfunction of a bodily organ or part.**

It is my medical opinion that ________________________________ requires ______ dialysis treatments per week.

____
Print Certifying MD Name

____________________________ __________ _______________________
Certifying MD Signature **Date** **AHCCCS PROVIDER ID #:**

____
DIALYSIS START DATE
(Only for initial certification)

____
DIALYSIS FACILITY

Please submit this form to AHCCCS for all new dialysis patients.
Fax: (602) 256-6591

FOR QUESTIONS CALL (602) 417-4400