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**Reinsurance Case Creation Request**

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| --- | --- | --- | --- |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_ | Requestor's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone #: \_\_\_\_\_\_\_\_\_\_\_\_ | Fax #: \_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Contractor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Contract Year: \_\_\_\_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ | | | Requested Case Type: \_\_\_\_\_\_\_\_ | | | Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  | | | |  | | |  | | |
| Recipient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | AHCCCS ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Linked ID: \_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  | | | |  | | |  | | |
| Enrollment Contract type: \_\_\_\_ | Rate Code: \_\_\_\_\_\_ Does Recipient Have Existing Case for Contract Year? Yes  No | | | | | | | |
|  | |  | | |  | | | Case Type \_\_\_\_\_\_\_\_ |

**For Case Types KID, RAC -- Recipient Enrollment Contract Type should be A or Y during CRN dates of service:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| \*\* Total Calculated RI Approved Amount by Form Type: | | | | | | |
| Form Type I: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | RI Covered Service (RI325): Yes  No | | | | |
| Form Type L: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | RI Covered Service (RI325): Yes  No | | | | |
| TOTAL $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
|  |  | |
| **For Case Types LMO, LMW, LRO, LRW -- Recipient Enrollment Contract Type should be J, L, or 2 during CRN dates of service:** | | | | | | | |
| **\*\* Total Calculated RI Approved Amount by Form Type:** | | | | | | | |
| Form Type I: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | RI Covered Service (RI325): Yes  No | | | |
| Form Type O: $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | RI Covered Service (RI325): Yes  No | | | |
| Form Type A\* $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | RI Covered Service (RI325): Yes  No | | | |
| Form Type C $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | RI Covered Service (RI325): Yes  No | | | |
| Form Type D $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | RI Covered Service (RI325): Yes  No | | | |
| TOTAL $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| Documentation Attached: | | | Number of Pages: \_\_\_\_\_\_\_\_\_\_ | | | | |
|  | | |  | | | | |
| **\*\* Note: The RI Approved Amount is calculated based on Subcap code, HP Paid Amt, HP Allowed/Approved Amt, AHCCCS Allowed Amt,** | | | | | |
| **Billed Charge, Medicare Approved and Paid and Other Insurance Payments** | | | |  |  |
| AHCCCS Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |  |
| Findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |  |  |
| \*FORM A no longer Reinsured as of 10/1/17 | | | | |  |  |  |
| Revised 9/2017 |  |  | |  |  |  |  |