|  |  |  |
| --- | --- | --- |
| I am the treating physician for |  |  |
|  | Member Name | Member 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 at least three times per week, the member’s ESRD would reasonably be expected to result in:

1. Placing the member’s health in serious jeopardy,
2. Serious impairment of bodily function, or
3. Serious dysfunction of a bodily organ or part.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| It is my medical opinion that |  | requires |  | Dialysis treatments per week. |
|  | Member Name |  |  |  |

|  |  |
| --- | --- |
|  |  |
| Signature | Date |
|  |  |
| Provider Name | AHCCCS Provider ID # |
|  |  |
| Dialysis Start Date |  |
|  |  |
| Dialysis Facility |  |

|  |
| --- |
| **SUBMIT THIS FORM TO AHCCCS/DFSM FOR ALL NEW DIALYSIS PATIENTS**  **FAX: (602) 256-6591** |

The FFS PA request form shall be used as the fax coversheet.

For questions call the AHCCCS Customer Service at: (602) 417-4400