FACILITY NAME:_______________________________ **CONTRACTOR NAME:**___________________

MEMBER NAME:_______________________________ **AHCCCS ID:**_________________________

THE FOLLOWING BILLING/MEMBER LEVEL OF CARE CHANGE(S) HAVE OCCURRED

		Rate:	**Effective:**
I. Facility Reimbursement:	LOC _____	$____________	____________________
II. Level of Care (LOC) Changed to:	_____	$____________	____________________
III. Member Room & Board Responsibility		$____________	____________________

I HAVE READ AND AGREE WITH THE ABOVE CHANGES.

FACILITY REPRESENTATIVE:

Printed ____ Title: __________________________

Signature ____ Date: __________________________

MEMBER / REPRESENTATIVE: (ONLY REQUIRED FOR CHANGES IN ROOM & BOARD)

Printed ____ Relationship: __________________

Signature ____ Date: _________________________

CASE MANAGER:

Printed ____

Signature ____ Date: ________________________

A SIGNED COPY MUST BE PROVIDED TO THE CONTRACTOR'S CASE MANAGER FOR THE MEMBER'S FILE

Effective Dates: 10/01/17, 07/01/20
Revision Dates: 07/25/17, 06/29/20