AHCCCS Fax Cover Sheet

Date:

Contractor Name (Health Plan or Program Contractor)	
AHCCCS ID # for Contractor and Facilty	
Submitted By	
Contact Phone Number	
E-mail address	
Receipient Name	
Receipient AHCCCS ID #	
AHCCCS Transplant Case Number	
Stage Description	
Stage Number & Stage Name	
Stage Dates of Service	
Total Bill Charges for Stage	
Contractor Paid Amount	

Box A1 Listing of Non-Payble Charges due to OPFS: CRN(s) listed in numerical order by form type	Box A2 Listing of Non-Payble Charges due to OPFS: CRN(s) listed in numerical order by form type	Reinsuarance Action Request Form Attached Yes ☐ No ☐
Total $	Total $	
Spread Sheet Attached Yes ☐	No ☐	

Submissions must include the Following :

Facility Invoice, Proof of Payment, Facility Claims (noted by forms type), Letter of Agreement. (if place of dervice is a non-contracted facility.

Box B minus Box A2 must equal Box C			
Box B TBC from Attached Claims		Box C TBC from PMMIS Screen	
Attached Form 1 Total $		RII 15 Frorm 1 Total $	
Attached Form 0 Total $		RII 15 Frorm O Total $	
Attached Form A Total $		RII 15 Frorm A Total $	
Attached Form C Total $		RII 15 Frorm C Total $	