AHCCCS
Arizona Health Care Cost Containment System

FEDERAL EMERGENCY SERVICES (FES) PROGRAM
INITIAL DIALYSIS CASE CREATION FORM

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:

a. Placing the member's health in serious jeopardy,
b. Serious impairment of bodily function, or
c. 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 AHCCCS Provider Services at: 602-417-7670