American Indian Health Program
AHCCCS Member ID Request Form

Facility Name Submitting Request:	**Facility Phone Number:**
Facility Address:	**NPI or Provider ID:**

Return this form to:
To: AHCCCS Administration\DMPS\OCARE\Enrollment
Fax: (602) 252-6536 or
Email: mcdumemberescalation@azahcccs.gov

The household member(s) listed below are requesting an AHCCCS Member ID card.

First Name	Last Name	AHCCCS ID	DOB

☐ I request that AHCCCS take actions as requested above.

Member, Guardian, or Parent Printed Name	
Signature	Date

☐ I request that AHCCCS take actions as requested above.

IHS Benefit Coordinator, or Urban Indian Org Family Health Advocate Printed Name	
Signature	Date

(rev 05/2022)