American Indian Health Program Change Request Form

Instructions:

- **Only AHCCCS registered Indian Health Service (IHS), Tribally owned/and or operated 638 facilities and Urban Indian Health Organizations (receiving Title V funding from IHS) may use this form** to assist the customer in changing their AHCCCS Complete Care (ACC) Health Plan to American Indian Health Program (AIHP).
- **If your facility is not registered, you cannot use this form**. To register as an AHCCCS provider visit the Provider Enrollment website for the Provider Application at https://azahcccs.gov/APEP or contact AHCCCS Provider Services to speak with a representative to help with general questions. Phone: (602) 417-7670 or (800) 433-0425
- Members may contact AHCCCS Enrollment to get help finding an AHCCCS registered facility that can use this form to process a health plan change. Phone: (602) 417-7100 or (800) 334-5283

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

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

The household member(s) listed below are enrolled in an AHCCCS Complete Care Health Plan and request to change their enrollment to American Indian Health Program 999998:

First Name	Last Name	AHCCCS ID	Date of Birth

I affirm under penalty of perjury that the statements and documents provided about the persons named above, that relate to AHCCCS enrollment, are true and correct to the best of my knowledge.

PRINTED NAME OF CUSTOMER OR AUTHORIZED REPRESENTATIVE	SIGNATURE OF CUSTOMER OR AUTHORIZED REPRESENTATIVE	DATE
PRINTED NAME OF IHS BENEFIT COORDINATOR OR PATIENT ENROLLMENT SPECIALIST	SIGNATURE OF IHS BENEFIT COORDINATOR OR PATIENT ENROLLMENT SPECIALIST	DATE