**FAX TO AHCCCS/DIVISION OF MEMBER AND PROVIDER SERVICES (DMPS), MEMBER CONTACT AND DATA UNIT (MCDU)**: mcdumemberescalation@azahcccs.gov

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| MEMBER NAME |  | AHCCCS ID NUMBER |
| DATE OF BIRTH |  |  |
| **TYPE OF MEDICAL INSTITUTION** | **DATE OF ADMISSION** | **AHCCCS PROVIDER****ID NUMBER** | **NAME OF MEDICAL INSTITUTION** |
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| COMMENTS |

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| CONTRACTOR NAME |  | DATE |

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| SUBMITTED BY |
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| TITLE |
|  |
|  PHONE NUMBER |