OPEN LINE REQUEST FORM

Click on the drop down arrow to select your Tribal ALTCS Health Plan/Office

TRIBAL ALTCS HEALTH PLAN:	BLANK, SELECT ANOTHER	**TRIBAL ALTCS CASE MANAGER NAME:**	
AHCCCS ID:		**MEMBER NAME:**	

PLEASE INCLUDE A PRINTOUT OF THE CA165 SCREEN OF HOW THE SERVICE LINE CURRENTLY APPEARS (roll mouse cursor to view sample below).

PLEASE DEDUCT UNITS IF INFORMAL SUPPORT (IFS) OR HOSPITALIZATIONS (A23) OCCURRED DURING THE SERVICE LINE DATES OF SERVICE. ENSURE ALL DATE RANGES/UNITS ARE REFLECTED BELOW SO GAPS IN SERVICES DO NOT OCCUR:

PLEASE MAKE THE FOLLOWING CORRECTIONS:

SER	MOD	EFF DATE	END DATE	UNITS	UNIT CST	PROV

PROVIDE AN EXPLANATION AS TO WHY THE LINE(S) NEED TO BE OPENED:

SIGNATURES ARE REQUIRED AND ACKNOWLEDGE THAT THE CASE MANAGER HAS NOTIFIED THE PROVIDER THAT AHCCCS WILL BE RECOUPING FUNDS PAID AND THE PROVIDER WILL NEED TO RESUBMIT THE CLAIM(S). ALSO, BOTH THE TRIBAL ALTCS CASE MANAGER AND SUPERVISOR ACKNOWLEDGE THEY HAVE BOTH REVIEWED AND SUBMITTTED THE NECESSARY DOCUMENTATION TO PROCEED WITH AN OPEN LINE REQUEST AND CORRECTIONS.

NOTE: IF ALL NECESSARY INFORMATION IS NOT INCLUDED IN THE REQUEST PACKET, IT CANNOT BE PROCESSED AND INSTRUCTIONS WILL BE PLACED ON THE CA165 COMMENTS SCREEN

TRIBAL ALTCS PERSONNEL	SIGNATURES	DATED:
CASE MANAGER: Sign & Date		
SUPERVISOR: Sign & Date		

NOTICE: CASE MANAGER TO PERIODICALLY REVIEW THE CA165 COMMENT SCREEN FOR STATUS UPDATES FROM AHCCCS TRIBAL ALTCS REGARDING THIS OPEN LINE REQUESTS.