Insurance/AHCCCS Verification Form

Office of Newborn Screening-Arizona Department of Health Services

*****Complete this form and include it with the bloodspot specimen card*****

PROVIDER NAME	**PROVIDER NPI#**

BABY'S INFORMATION		
PATIENT NAME:	DATE OF BLOODSPOT SCREEN:	
DATE OF BIRTH:	1ST SCREEN / 2ND SCREEN (*circle one*)	
ADDRESS:		SEX:
CITY:	STATE:	ZIP:
BABY'S **AHCCCS**#		

MOTHER'S INFORMATION
LAST NAME (*maiden name if different*):
(*If applicable*) MOM'S **AHCCCS** #
EMAIL ADDRESS:

INSURANCE INFORMATION	**IF NO INSURANCE** (*check here*) ___________	
POLICYHOLDER NAME:		SEX:
ADDRESS:	DATE OF BIRTH:	
CITY:	STATE:	ZIP:
EMPLOYER:	ID#	
POLICY #	GROUP#	
INSURANCE NAME:	PHONE:	
INSURANCE CLAIMS ADDRESS:		
CITY:	STATE:	ZIP:

This form is to be used for insurance verification of all 2nd newborn bloodspot screens.

Please also include a copy of the insurance card.

CONTACT INFORMATION

GENERAL BILLING: Dept. of Health Services (602) 542-2520

INVOICES: American Exchange (877) 225-0958 *toll free*

NEWBORN SCREENING: Education Dept. (602) 364-0128

PLEASE SUBMIT THIS FORM WITH EACH BLOODSPOT COLLECTION KIT WITHIN 24 HOURS OF COLLECTION TO: AZ STATE LAB, 250 N 17TH. AVE., PHX., AZ 85007

www.aznewborn.com