



EPSDT TRACKING FORM ORDER SHEET

Please fax your request to: 480-784-2933

Provider/Practice Name: _____

Physical Address: _____

City State Zip Code

Shipping Address (if different from physical address)

City State Zip Code

Contact Person: Phone Number: _____

Total # of Health Choice Arizona (HCA) EPSDT eligible (0-21 yrs) members assigned at this location: _____

Please circle the number of packets (1 or 2) needed for each age group (25 forms per packet). *If you have multiple sites under your practice, please submit ONE request per site.*

2 – 4 Days	<u>1</u>	<u>2</u>	24 Months	<u>1</u>	<u>2</u>
1 Month	<u>1</u>	<u>2</u>	3 Years	<u>1</u>	<u>2</u>
2 Months	<u>1</u>	<u>2</u>	4 Years	<u>1</u>	<u>2</u>
4 Months	<u>1</u>	<u>2</u>	5 Years	<u>1</u>	<u>2</u>
6 Months	<u>1</u>	<u>2</u>	6 Years	<u>1</u>	<u>2</u>
9 Months	<u>1</u>	<u>2</u>	7 – 8 Years	<u>1</u>	<u>2</u>
12 Months	<u>1</u>	<u>2</u>	9 – 12 Years	<u>1</u>	<u>2</u>
15 Months	<u>1</u>	<u>2</u>	13 – 17 Years	<u>1</u>	<u>2</u>
18 Months	<u>1</u>	<u>2</u>	18 – 21 Years	<u>1</u>	<u>2</u>

These EPSDT Tracking Forms are being dispensed for utilization during Well Care Visits for Health Choice Arizona (HCA) enrolled members. Please contact other AHCCCS health plans to obtain copies for other AHCCCS health plan enrolled members.