RBHA Change Form (RCF)

(For SMI, DDD, CMDP only)

To: **HCICCustomerService@healthchoiceaz.com**

From: _____ **Phone number:** _____

Date: _____

The following member had their intake on _____ at Select Health Home .

Please have Select RBHA change their RBHA date to End as of _____.

Member Name: _____ **DOB:** _____

T19/T21? Yes ◉ No ○ **AHCCCS ID:** A_____

Program: Population *(If CMDP, please complete CMDP Children Only section below)*

Current Home Address: _____

_____

Current Contact Phone: _____

Is Member in Out of Area Placement (OOA)? Yes ○ No ◉

If OOA and an anchor to HCA is needed,

Estimated Date of Discharge (Up to 2yrs from today's date):

_____

If the Child is on the Comprehensive Medical and Dental Program for Children in Foster Care (CMDP)

Please answer the following:

What County is the Court of Jurisdiction in? _____

Guardian: _____ **County Guardian Resides in:** _____

Guardian Contact Phone: _____

DCS Case Manager: _____ **DCS Contact Phone:** _____

Health Home's COMMENTS:

_____

_____

_____

_____

PRINT