EXHIBIT 410-5, AHCCCS VERIFICATION OF DIAGNOSIS BY CONTRACTOR FOR A PREGNANCY TERMINATION REQUEST

MEMBER NAME: _____ AHCCCS ID#: _____

DATE OF BIRTH: _____ HEALTH PLAN: _____

This page must be submitted by the Contractor with the AHCCCS Certificate of Necessity for Pregnancy Termination along with the clinical information as specified below for each member included in the AHCCCS Monthly Pregnancy Termination Report.

The Contractor must make every reasonable effort to contact the provider to confirm the qualifying diagnosis/condition within 24 hours of receiving the prior authorization request for a pregnancy termination. Except for circumstances beyond the control of the Contractor, a failure to confirm the diagnosis/condition within 24 hours may result in corrective actions and/or sanctions.

Requesting Provider is the provider confirming the qualifying diagnosis/condition:

- ☐ Laboratory Results
- ☐ Diagnostic Testing Results
- ☐ Written Provider Consultation Report

When Requesting Provider is NOT the provider confirming the qualifying diagnosis/condition, Contractor must contact and request documentation from the provider that determined the member had the qualifying diagnosis condition. Contractor requested and received the following:

- ☐ Laboratory Results
- ☐ Diagnostic Testing Results
- ☐ Written Provider Consultation Report

PROVIDER INFORMATION:

NAME OF PROVIDER CONTACTED: _____

FACILITY/PRACTICE NAME: _____ **TELEPHONE NUMBER:** _____

ADDRESS: _____

An authorization decision must be made after contact is made with the provider that determined that the member had the qualifying diagnosis/condition and the supporting documentation has been received.

NAME OF PLAN REPRESENTATIVE COMPLETING VERIFICATION: _____

SIGNATURE: _____ DATE: _____