PM FORM 10.14.2
SINGLE CASE AGREEMENT
White Mountain Apache Tribal Regional Behavioral Health Authority

Requestor's Name and Contact Information: ____

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Request Date: _________________________________

TYPE OF REQUEST:

_______ Single Case Agreement (Client ID: ____)

______ Add New Fee-For Service Contract

______ Add New Services to Existing Fee For Service Contract

______ Extend/Add Services for Existing Single Case Agreement

POTENTIAL PROVIDER INFORMATION:

Name: ____

Main Address: ____
Street City, State, Zip

Site Address (if different): ____
Street City, State, Zip

Administrative Contact Name: _________________________________ **Phone:** ____________________

Out of State: ______ YES ______ NO

Reason for Contract: (Indicate why current provider network can not meet the need)_________________

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Desired Contract Effective Dates: __________________ to _____________________

Initial Intent to Pay: (attach additional copies as necessary)

ACT	Service Code	Service Description	AHCCCS ID #	NPI #	Begin Date	End Date	Units

Clinical Supervisor's Authorized Signature: ____________________________**Date:** ____________

Send signed and completed form to ABHS Provider Network Manager,

Billing Specialist, and file copy in client chart.

Effective 10/01/07
Revised 10/15/07