mercy care
Phone: 602- 263-3000 or 800-624-3879
Fax: 800-217-9345

Clinical Request Form

FDA Phase I or Phase II clinical trial

AHCCCS will cover services related to the qualifying clinical trial including but not limited to: routine care, screenings, laboratory tests, imaging services, inpatient services, physician services, treatment of complications arising from clinical trial participation, or other medical services and costs, consistent with AHCCCS Policy and Arizona Administrative Code. Costs for services that are solely for the purpose of clinical data will not covered.

QUALIFYING CLINICAL TRIAL: Any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of clauses (i)-(iii) of section 1905(gg)(2)(A) of the Act. A study or investigation must be approved, conducted, peer-reviewed, or supported (including by funding through in-kind contributions) by national organizations.

Request Completed by: Phone#:
Date of Request:
Total Number of Pages:

Important Note: This form must be completed in full and include the required Attachment A, Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial. Authorization decision will be made within 72hrs of receipt of completed form and Attachment A.

Member Information

Member Name: Member ID #: DOB:
Other Insurance: Yes ☐ No ☐ If yes, please specify: Phone #:

Ordering Physician Information

Physician Name: TIN/NPI #:
Address:
Phone #: Fax Number:
Contact Person:

Servicing Provider/Facility Information

Servicing Provider/Facility Name: TIN/NPI #:
Address: Phone #: Fax #:

Diagnosis Code(s):
CPT Code(s):
Clinical Rationale for service request:

Provide specification of the clinical trial and any associated service that is not provided to prevent, diagnose, monitor, or treat complications resulting from participation in the clinical trial, and verification that full financial liability for the clinical trial istaken by the researcher or the sponsor, and these services will not be charged to, or paid by, AHCCCS.

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Attachment A Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial

MEDICAID ATTESTATION FORM ON THE APPROPRIATENESS OF THE QUALIFIED CLINICAL TRIAL

Participant

Participant Name: _____

Medicaid I.D.: _____

Qualified Clinical Trial

National Clinical Trial Number (from clinicaltrials.gov): _____

Principal Investigator Attestation

Principal Investigator Name: _____

☐ I hereby attest to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

☐ The Principal Investigator is also the Health Care Provider and hereby attests to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

Signature: _____ Date: _____
(*signature of principal investigator*) (*month, day, year*)

Health Care Provider Attestation

Health Care Provider Name: _____

☐ I hereby attest to the appropriateness of the qualified clinical trial in which the individual identified above is participating.

Signature: _____ Date: _____
(*signature of health care provider*) (*month, day, year*)

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may notconduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-0193. Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Important: To prevent delays in processing time, please provide completed documentation specific to this request. Failure to do so may impact the final determination for this authorization.

Authorization does not guarantee payment. All authorizations are subject to member eligibility on the date of service. If member is determined ineligible, the member may be responsible for these services. To ensure proper payment for services rendered, referral provider/facility must verify eligibility on the date of service. **You may verify eligibility through our Mercy Care Secure Web Portal located in the top central portion of our Mercy Care website at https://www.mercycareaz.org/.**

Revised 11/17/2022