EPSDT TRACKING FORM ORDER SHEET

Please fax your request to: 480-784-2933

Exhibit 3.7

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.

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

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.

Requests will be process within 5 business day. If you have any questions, please contact the EPSDT / Health Promotion Unit at 480-760-4662