Exhibit 3.5.2 Dental Missed Appointment Form

Please Print

Fax to 480-350-2217 on a *DAILY basis*

Date	Practice Name	City

Provider Name	NPI

Member Name	DOB	AHCCCS ID	Missed Appointment Date	Appointment Type*

* New Patient, Recall, restorative, emergency

NOTICE: This message may contain PRIVILEGED and CONFIDENTIAL information and is intended only for the use of the specific individual(s) to which it is addressed. It may contain Protected Health Information that is privileged and confidential. Protected Health Information may be used or disclosed in accordance with law and you may be subject to penalties under law for improper use or further disclosure of the Protected Health Information in this email. If you are not an intended recipient of this email, you are hereby notified that any unauthorized use, dissemination or copying of this email or the information contained in it or attached to it is strictly prohibited. If you have received this message in error, please destroy it and immediately notify the person named above. Thank you.