



## Maricopa County Diabetes Management Program Copayment Reimbursement Form

You are eligible for reimbursement of up to four (4) provider copayments that are diabetic related office visits during your authorization plan year. **Paid receipts and itemized bills must be included to obtain reimbursement. Please submit this form with the paid receipts and itemized bills within 90 days of obtaining your updated diabetic authorization.**

Direct questions regarding completion of this form or the Diabetes Management Program to:

**Employee Benefits**

602-506-1010 (*press option 2 and option 2 again*)

[BenefitsService@mail.maricopa.gov](mailto:BenefitsService@mail.maricopa.gov)

Deliver the completed form to:

**Employee Benefits**

301 W. Jefferson St., Suite 3200

Phoenix, AZ 85003

Or fax the form to (602) 506-2354.

*Do not fax forms one at a time. Please fax all forms together at one time.*

Provider Name \_\_\_\_\_ Date of service \_\_\_\_\_ Copay amount \$ \_\_\_\_\_

Provider Name \_\_\_\_\_ Date of service \_\_\_\_\_ Copay amount \$ \_\_\_\_\_

Provider Name \_\_\_\_\_ Date of service \_\_\_\_\_ Copay amount \$ \_\_\_\_\_

Provider Name \_\_\_\_\_ Date of service \_\_\_\_\_ Copay amount \$ \_\_\_\_\_

I certify to the best of my knowledge that the information I have provided is accurate.

\_\_\_\_\_  
Employee ID

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date



## Maricopa County Diabetes Management Program Dental Exam and Cleaning

**Employee Instructions:** Take this form with you to your next dental appointment. Ask the dentist to complete the date(s) of the exam and sign this form. A dated receipt, also called a Superbill, is acceptable verification if it contains information showing the specific exam was completed.

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Requirement	Annually	Date Completed		Dentist's Name
Oral Exam	Semi-Annually			
Cleaning	Semi-Annually			

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Employee ID

\_\_\_\_\_  
Dentist's Signature

\_\_\_\_\_  
Date



## Maricopa County Diabetes Management Program Consultation with Dietician or Nutritionist

**Employee Instructions:** Take this form with you to your next nutrition appointment. Ask the nutritionist or dietician to complete the date of the visit and sign this form. A dated receipt, also called a Superbill, is acceptable verification if it contains information showing the specific visit was completed.

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Requirement	Frequency	Date Completed	Name
Consultation with nutritionist or dietician	Annually		

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Employee ID

\_\_\_\_\_  
Consultant's Signature

\_\_\_\_\_  
Date



## Maricopa County Diabetes Management Program Dilated Retinal Eye Exam

**Employee Instructions:** Take this form with you to your next eye appointment. Ask the ophthalmologist or optometrist to complete the date of the exam and sign this form. A dated receipt, also called a Superbill, is acceptable verification if it contains information showing the specific exam was completed.

Direct questions regarding completion of this form or the Diabetes Management Program to:

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Deliver the completed form to:

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Phoenix, AZ 85003

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Requirement	Annually	Date Completed	Name
Dilated Retinal Eye Exam			

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Employee ID

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date



## Maricopa County Diabetes Management Program

**Doctor Exam:** Hemoglobin, Foot Exam, Fasting Lipid Panel, Kidney Function

**Employee Instructions:** Take this form with you to your next doctor appointment. Ask the doctor to complete the date(s) of the test and sign this form. **Please do not have test results included.** A dated receipt, also called a Superbill, is acceptable verification if it contains information showing the specific test was completed.

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**Employee Benefits**

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[BenefitsService@mail.maricopa.gov](mailto:BenefitsService@mail.maricopa.gov)

Deliver the completed form to:

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Phoenix, AZ 85003

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Test	Test Type/Description	Frequency	Date Completed		Doctor's Name
Hemoglobin A1c	Blood test measures the blood sugar control over the past 90 days	Semi-annually			
Comprehensive Foot Exam	Tests for amount of feeling in feet: includes monofilament, tuning fork, palpation and visual exam	Annually			
Fasting Lipid Panel	Total cholesterol, LDL, HDL, and triglycerides	Annually			
Kidney Function	Microalbuminuria Screening	Annually			

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Employee ID

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date



## Maricopa County Diabetes Management Program Medication Review

**Employee Instructions:** Take this form with you to your next medication review appointment. Ask the physician/pharmacist to complete the date of the visit and sign this form.

Direct questions regarding completion of this form or the Diabetes Management Program to:

**Employee Benefits**

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**Employee Benefits**

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Requirement	Annually	Date Completed	Name
Medication Review with physician or pharmacist			

\_\_\_\_\_  
Participant Name

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Employee ID

\_\_\_\_\_  
Physician or Pharmacist's Signature

\_\_\_\_\_  
Date