Acknowledgement
of AHCCCS Insurance coverage

Patient Name:_____ Date of Birth _____

I acknowledge at this time I do not have AHCCCS insurance for my child as a primary or secondary insurance. _____ Initials

I acknowledge that I am not enrolling in AHCCCS at this time for my child as a primary or secondary insurance. _____ Initials

I acknowledge that if I do become eligible for AHCCCS I will notify Agave Pediatrics the day that I become eligible._____ Initials

Signature:_____Date:_____