Alabama Medicaid Referral Form

PHI-CONFIDENTIAL

Today's Date _____

Date Referral Begins _____
(if different from above)

Important NPI Information
See Instructions

Medicaid Recipient Information

Recipient Name	Medicaid #	Date of Birth
Address	Telephone # with Area Code (___) _____ Name of Parent/Guardian _____	

Screening Provider

Name Katherine Dougherty-Basila, MD	NPI # 1225229255	Medicaid Provider ID # 240278
Address 460 Alabama Hwy 75 N Albertville, AL 35951	Email Telephone # with Area Code (256) 891-0300 Fax # with Area Code (256) 891-7461	
Signature Katherine Dougherty-Basila, MD	✔ Electronic Signature	

Type of Referral

☐ Case Management / Care Coordination	☐ Lock-In
☐ EPSDT Screening Date _____ *Select one of the following types of EPSDT Screenings:* ☐ Periodic ☐ Interperiodic	☐ Other (Please Describe) _____

Length of Referral

Referral valid for _____ month(s) or _____ visit(s) from date referral begins.

Referral Valid For

☐ Evaluation Only	☐ Treatment Only
☐ Evaluation and Treatment	☐ Hospital Care (Outpatient)
☐ Referral by consultant to other provider for identified condition (cascading referral)	☐ Performance of Interperiodic Screening (if necessary)
☐ Referral by consultant to another provider for additional conditions diagnosed by consultant (cascading referral for EPSDT only)	☐ For Billing Purposes Only ☐ Other (please describe) _____

Reason for referral:	Other conditions/diagnoses identified:

Consultant Information (Consultant can be an individual provider or a provider group to whom a recipient is referred)

Consultant Name	
Address	Telephone # with Area Code (___) _____

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to the screening provider.

Findings should be submitted by

☐ Mail ☐ E -mail ☐ Fax (256) 891-7461 ☐ In addition, please telephone