

Alabama Medicaid Referral Form
PHI-CONFIDENTIAL

Today's Date _____

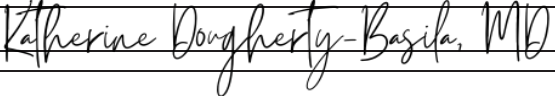
Date Referral Begins _____
(if different from above)

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 	☐ Electronic Signature	

Type of Referral

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

Length of Referral

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