

# Alabama Medicaid Referral Form

## PHI-CONFIDENTIAL

Today's Date \_\_\_\_\_

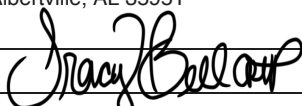
Date Referral Begins \_\_\_\_\_  
(if different from above)

### 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 <b>Tracy Bell, CRNP</b>	NPI # <b>1093897621</b>	Medicaid Provider ID # <b>196685</b>
Address 460 Alabama Hwy 75 N Albertville, AL 35951	Email _____	
Signature 	Telephone # with Area Code ( 256 ) 891-0300 _____	
	Fax # with Area Code ( 256 ) 891-7461 _____	
<input type="checkbox"/> Electronic Signature		

**Type of Referral**

<input type="checkbox"/> Case Management / Care Coordination  <input type="checkbox"/> EPSDT Screening Date _____  <i>Select one of the following types of EPSDT Screenings:</i> <input type="checkbox"/> Periodic <input type="checkbox"/> Interperiodic	<input type="checkbox"/> Lock-In  <input type="checkbox"/> Other (Please Describe) _____
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**Length of Referral**

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

**Referral Valid For**

<input type="checkbox"/> Evaluation Only <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> Referral by consultant to other provider for identified condition (cascading referral) <input type="checkbox"/> Referral by consultant to another provider for additional conditions diagnosed by consultant (cascading referral for EPSDT only)	<input type="checkbox"/> Treatment Only <input type="checkbox"/> Hospital Care (Outpatient) <input type="checkbox"/> Performance of Interperiodic Screening (if necessary) <input type="checkbox"/> For Billing Purposes Only <input type="checkbox"/> Other (please describe)
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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 ( ) _____
<b>Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to the screening provider.</b>	

**Findings should be submitted by**

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