

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	NPI #	Medicaid Provider ID #
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 _____ <input type="checkbox"/> Electronic Signature		

Type of Referral

<input type="checkbox"/> Case Management / Care Coordination	<input type="checkbox"/> Lock-In
<input type="checkbox"/> EPSDT Screening Date _____ Select one of the following types of EPSDT Screenings: <input type="checkbox"/> Periodic <input type="checkbox"/> Interperiodic	<input type="checkbox"/> 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

<input type="checkbox"/> Evaluation Only	<input type="checkbox"/> Treatment Only
<input type="checkbox"/> Evaluation and Treatment	<input type="checkbox"/> Hospital Care (Outpatient)
<input type="checkbox"/> Referral by consultant to other provider for identified condition (cascading referral)	<input type="checkbox"/> Performance of Interperiodic Screening (if necessary)
<input type="checkbox"/> Referral by consultant to another provider for additional conditions diagnosed by consultant (cascading referral for EPSDT only)	<input type="checkbox"/> For Billing Purposes Only
	<input type="checkbox"/> 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

<input type="checkbox"/> Mail	<input type="checkbox"/> E -mail	<input type="checkbox"/> Fax (256) 891-7461	<input type="checkbox"/> In addition, please telephone
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