

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	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____	
	Name of Parent/Guardian _____	

Primary Care Provider /Alabama Coordinated Health Care Network Information

Screening Provider (if different from PCP)

Name	Name
Address	Address
Telephone # with Area Code _____	Telephone # with Area Code _____
Fax # with Area Code _____	Fax # with Area Code _____
Email _____	Email _____
NPI # _____	NPI # _____
Medicaid Provider # _____	Medicaid Provider # _____
Signature <u>Indu Prasadh, MD</u>	Signature _____

Type of Referral

<input type="checkbox"/> PCP/ACHN <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"/> Case Management / Care Coordination	<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 by PCP/ACHN	Other conditions/diagnoses identified by PCP
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Consultant Information (Consultant can be an individual provider or a provider group)

Consultant Name	
Address	Consultant Telephone # with Area Code
Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to PCP	

Findings should be submitted to Primary Care Physician (PCP) by

Mail
 E-mail
 Fax
 In addition, please telephone