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

Name	Address	Telephone # with Area Code	Fax # with Area Code	Email	NPI #	Medicaid Provider #	Signature
	460 AL Hwy 75 N, Albertville, AL 35951	(256) 891-0300	(256) 891-7461	N/A			

Screening Provider (if different from PCP)

Name	Address	Telephone # with Area Code	Fax # with Area Code	Email	NPI #	Medicaid Provider #	Signature

Type of Referral

- ☐ PCP/ACHN
- ☐ EPSDT Screening Date _____
  Select one of the following types of EPSDT Screenings:
  - ☐ Periodic
  - ☐ Interperiodic
- ☐ Case Management / Care Coordination
- ☐ Lock-in
- ☐ Other (please describe) _____

Length of Referral

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

Referral Valid For

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

Reason for referral by PCP/ACHN	Other conditions/diagnoses identified by PCP

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 (256) 891-7461 ☐ In addition, please telephone