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)**

Primary Care Provider	Screening Provider
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 Katherine Dougherty-Basila, MD	Signature Rebecca Epps, PNP

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 ☐ In addition, please telephone