

# 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 <i>Katherine Dougherty Basila, MD</i>	Signature <i>Holly Willoughby, PNP</i>

**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
<b>Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to PCP</b>	

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

Mail
  E-mail
  Fax
  In addition, please telephone