Alabama Medicaid Agency

Request for Medicaid Payment Information /
Copy of Paid Claims Paid by Medicaid
All fields must be completed to expedite requests.

Records Requested By ☐ Attorney ☐ Recipient ☐ Insurance Company

Name/Firm _____

Address _____

Phone _____ FAX _____ Claim # (if applicable) _____

Medicaid Recipient Information

Name _____

Date of birth _____ SSN or Medicaid Number _____

Reason for Request of Medical Records _____

Date of injury / Onset of medical problem _____ Initial complaint _____

Type of accident / injury _____

☐ I am requesting Medicaid payment information / copies of claims paid by Medicaid and have included an authorization from the Medicaid recipient releasing this information to me.

Direct requests for Medicaid payment information / copy of paid claims paid by Medicaid:

Alabama Medicaid Agency
Attention: Benefit Recovery Section
PO Box 5624
Montgomery, AL 36103-5624
Email Address: BenefitRecovery@Medicaid.Alabama.Gov

For Completion by Third Party Division

Medicaid acknowledges receipt of the request for Medicaid payment information / copy of paid claims paid by Medicaid related to the above-stated Medicaid recipient. This request has been completed, and payment information is attached.

_____ _____

Completed By Date Completed