Alabama Medicaid Agency

TARGETED CASE MANAGEMENT SERVICES

REQUEST FOR INTERAGENCY PRIOR AUTHORIZATION TRANSFER

PARENT/GUARDIAN CONSENT FORM

______________________________	____________________	____________________
Name of Client	Medicaid Number	P.A. Number

I,______________________________ , legal representative of the above-named client who currently
(Parent/Guardian)

receives case management services from ____
(Name & Address of Agency)

____
(Provider Number)

requests a transfer to____
(Name & Address of Agency)

__________________________________ for continuation of case management services.
(Provider Number)

My signature below indicates my request for transfer and authorizes the release of all case management records to the receiving agency.

______________________________	______________
Signature of Parent/Guardian	Date

Form 385
Rev 12/21