Patient 1st Recipient Dismissal Form

Recipient Information

Recipient Name _____ **DOB** _____

Medicaid Number _____ **Gender** Male ❑ Female ❑

Address _____ **Telephone #** _____

City _____ **State** _____ **Zip** _____

PMP

Name _____ **NPI #** _____

Reason for Dismissal

❑ Recipient Behavior ❑ Non Compliance w/treatment ❑ Other _____

To assist you and the recipient in the dismissal process, please list the name and telephone number of any referral for this recipient within the last 30 days or send copy of the referral.

Referred To	Diagnosis	Date	Length of Referral

After care management, would you accept this recipient back in your practice? Yes ❑ No ❑

For Medicaid Office Use Only

Refer to Care Coordinator ❑ Refer to Lock-in Program ❑

A Primary Medical Provider may request removal of a recipient from his panel due to good cause. All requests for patients to be removed from a PMP's panel should be submitted on this form and provide the enrollee 30 days written notice. The request should contain documentation as to why the PMP does not wish to serve as the recipient's PMP.*

***IAW: ALABAMA MEDICAID BILLING MANUAL CHAPTER 39**

Please send form to Patient 1st Fax at (334) 353-3856.