PATIENT 1ST Override Request Form

Please fill out this form **completely** to request a Patient 1st override when you have received a denial for referral services **or** the Primary Medical Provider (PMP) has not authorized treatment for **past** date(s) of service. The request must be submitted to Medicaid's Patient 1st Program within 90 days of the date of service. Overrides will not be considered unless the PMP has been **contacted**. Attach a **"clean claim"** with any supporting documentation to this form and mail to Patient 1st at the address below. Patient 1st will process your request within 60 days of receipt. If your request is approved, the corrected claim will be sent to HP and will be processed. If your request is denied, Patient 1st will notify you by mail of the denial. This form is available in Appendix E of the Alabama Medicaid Provider Manual and at www.medicaid.alabama.gov.

Mail To:
Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103

Recipient's name: _____ Medicaid number: _____

Recipient's telephone number: (_____)_____ Date(s) of service: _____

Name of PMP: _____ PMP's telephone number: (_____)_____

Name of person contacted at PMP's office: _____Date contacted: _____

Reason PMP stated he would not authorize treatment: _____

_____

I am requesting an override due to: **(Please check applicable)**

☐ Recipient assigned incorrectly to PMP **Please explain**: _____

_____

☐ This recipient has moved _____

☐ Unable to contact PMP **Please explain**: _____

_____

☐ Other: **Please explain**: _____

_____

Provider name: _____

NPI #_____

Form completed by: _____

Telephone _____ Fax _____