2-23-12

ALABAMA MEDICAID REFERRAL FORM
PHI-CONFIDENTIAL
Important NPI Information
See Instructions

Today's Date _____

Date Referral Begins _____
(If different from above)

MEDICAID RECIPIENT INFORMATION

Recipient Name	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____ Name of Parent/Guardian _____	

PRIMARY PHYSICIAN (PMP) INFORMATION | **SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)**

Primary Physician (PMP)	Screening Provider
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 _____	Signature _____

TYPE OF REFERRAL

☐ Patient 1st ☐ EPSDT Screening Date _____ ☐ Case Management/Care Coordination	☐ Lock-in ☐ Other

LENGTH OF REFERRAL

Referral Valid for _____ month(s) or _____ visit(s) from date referral begins.

REFERRAL VALID FOR

☐ Evaluation Only ☐ Evaluation and Treatment ☐ Referral by consultant to other provider for identified condition (cascading referral) ☐ Referral by consultant to other provider for additional conditions diagnosed by consultant (EPSDT Only)	☐ Treatment Only ☐ Hospital Care (Outpatient) ☐ Performance of Interperiodic Screening (if necessary)

Reason for referral by PMP	**Other conditions/diagnoses identified by PMP**

CONSULTANT INFORMATION

Consultant Name	
Address	Consultant Telephone # with Area Code

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to Primary Physician (PMP).

Findings should be submitted to Primary Physician (PMP) by

☐ Mail	☐ E-mail	☐ Fax	☐ In addition, please telephone