Alabama Medicaid Agency

Request for Medical Records
All fields must be completed to expedite requests.

Records Requested By ☐ Attorney ☐ Recipient ☐ Insurance Company ☐ Provider

Name/Firm _____

Address _____

Phone _____ FAX_____ Claim # (if applicable) _____

☐ I am requesting medical records from the following medical providers:

_____

(Medicaid will notify the requestor of any Medicaid subrogation/assignment interest. Medicaid will sign and return the form to you. Please present it to medical providers when requesting medical records.)

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.

Under HIPAA regulations, this request must be accompanied by a signed authorization releasing this information to you.

☐ I am forwarding a request for medical records received from an attorney / insurance company or other entity.

Direct requests for medical records relating to tort actions to:

Health Management Systems
Attention: AL Case Management Unit
2000 Interstate Park Dr., Suite 401
Montgomery, AL 36109
Toll Free Telephone: 1-877-252-8949

For Completion by Third Party Division/HMS
Medicaid acknowledges receipt of the Request for Medical Records related to the above-stated date of injury/medical care. (Any released records must have stamped or written in a prominent place the following statement: **MEDICAID HAS SUBROGATION/ASSIGNMENT RIGHTS**)

_____   _____

Zeffie Smith or LaTonya Jackson   Date

Revised 4-29-2015