Alabama Coordinated Health Network
Delivering Healthcare Professional Selection Referral Form

PCCM-E's Name: ______________________________________ **PCCM-E's NPI Number:** __________________________________

Date: ______________________

Type of Referral: □ Initial □ Change of DHCP □ High-Risk/Specialty □ Other ______________________

Medicaid Eligible Individual (EI) Information

Name: **Last** ______________________________ **First** ____________________________ **MI.**___	**Medicaid Number:** ______________________________	**DOB:** ______________________
Address: ______________________________________ ______________________________________	**Telephone Number (with area code):** ______________________________________	

Selected DHCP Information

DHCP's Name: ____	
Address: ____ ____	
Telephone Number (with the area code): ____ **Fax Number (with the area code):** ____ **Email Address:** ____	
NPI Number: ______________________________	**Medicaid Provider Number:** ______________________________

Name of the person completing the form (print): ____

Signature of the person completing the form: ____

Title of the person completing the form:____

Telephone Number (with the area code): ____