Alabama Medicaid NET Dialysis Validation Form

Dialysis Provider Name	City/State	Month/Year

Medicaid Recipient Name: _____

Medicaid Number: _____

Date Of Birth: _____

Wheelchair Eligible? ☐ **Yes** ☐ **No**

Request# For Week 1 _____

Request# For Week 2 _____

Request# For Week 3 _____

Request# For Week 4 _____

Request# For Week 5 _____
(If Applicable)

I attest the Medicaid recipient requesting mileage reimbursement was treated at this facility on the days circled below.

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Total Visits _____

Dialysis Representative (print)	Signature	Phone	Date