MENTAL HEALTH SERVICES PROGRAM
REQUEST FOR OVERRIDE OF WEEKLY VISIT LIMITATION
SAMPLE COVER LETTER

DATE: __________________

PROVIDER NAME: _________________________________________________________________

PROVIDER ADDRESS: ______________________________________________________________

CONTACT PERSON: ________________________________________________________________

CONTACT PHONE NUMBER: ________________________________________________________

CONTACT FAX NUMBER: ___________________________________________________________

RECIPIENT NAME: _________________________________________________________________

The documentation as attached is being submitted for consideration of visit(s) exceeding the weekly limit. (Please attach a separate sheet for each episode request).

Original Claim Form: ☐
Progress Note(s): ☐

Name of Primary Care Physician (or representative) notified: _____________________________
Method of notification: fax ☐ phone ☐ e-mail ☐

MAIL information to:
Institutional Services
Mental Health Program Director, Suite 3000
P.O. Box 5624
Montgomery, AL 36103-5624

For Medicaid Office Use Only:
☐ Approved: ____________________ ☐ Sent to HP for payment processing
☐ Denied: ______________________
☐ Further review required: ________________________________________________
   Approved ☐ Denied ☐

Reference: ALABAMA MEDICAID BILLING MANUAL CHAPTER 34