ALABAMA MEDICAID AGENCY
LONG TERM CARE REQUEST FOR ACTION FORM

Provider's Name: _____

NPI Number: _____ **Provider's Area Code & Fax Number:** _____

Contact Person: _____ **Provider's Area Code & Phone Number:** _____

Waiver Type: _____ **County Number:** _____ **Center Number:** _____

Recipient's Name: _____ **Recipient's Medicaid Number:** _____

Recipient's Last Four Digits of SSN: _____

REASON FOR CORRECTING LONG TERM CARE FILE:

1. **Incorrect Medicaid Admission Date Requested:**

   Change Date From: _____ **Change Date To:** _____

2. **Incorrect Discharge or Death Date Requested:**

   Change Date From: _____ **Change Date To:** _____

3. **Retro Financial Eligibility Awarded:**

   Change Date From: _____ **Change Date To:** _____

REASON FOR REQUESTED CHANGE AND/OR REJECTION REASON:

_____

_____

_____

FAX REQUEST TO: Kepro (833) 536-2134 or (833) 536-2136

FOR MEDICAID USE ONLY:

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Date Correction Made: _____ **Corrected By:** _____