

**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:

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

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