Once you have completed the Alabama Medicaid Referral Form and are ready to send it, please use either of the following methods.

Method 1: Share

1. At the top right of the Alabama Medicaid Referral Form, please select the "Share" button
2. This will open up a side pane that gives you the option to send an attachment as, "Default email application (Microsoft Outlook)" or "Webmail."
3. Please select the appropriate mailing option for your practice and select "Continue"
4. A box will appear that gives you the option of "Sending a link to the pdf file on the Web" or Send a copy of the entire PDF file as an attachment"
5. **Please do not send as a link**
6. **Please select "Send Copy"**
7. After you select "Send Copy," an email box will pop up to allow you to send the form to the email address located on the prefilled form.

Method 2: Save and Send

1. On the top left side of the Alabama Medicaid Referral Form, please select the "Save" icon
2. The "Save" Icon will allow you to save a copy of the form to your device
3. Once you've saved a copy of the form to your device, complete the form, and email the form to the email address located on the prefilled form.

Method 3: Print and Send

1. On the top left side of the Alabama Medicaid Referral Form, please select the "Print" icon
2. The "Print" Icon will allow you to print a copy of the form
3. Once you've printed a copy of the form, complete the form, and scan/email the form to the email address located on the prefilled form.

ALABAMA MEDICAID REFERRAL FORM
PHI-CONFIDENTIAL

Today's Date _____

Date Referral Begins _____
(if different from above)

Important NPI Information
See Instructions

Medicaid Recipient Information

Recipient Name	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____ Name of Parent/Guardian _____	

Primary Care Physician/Alabama Coordinated Health Network (ACHN) Information

Name My Care Alabama Central, Inc.	Name
Address 4465 Park Blvd. Montgomery, AL 36116	Address
Telephone # with Area Code 855-288-8361 Fax # with Area Code 205-402-9217 Email infoCentral@mycarealabama.org NPI # 1508421827 Medicaid Provider # _____ Signature _____	Telephone # with Area Code _____ Fax # with Area Code _____ Email _____ NPI # _____ Medicaid Provider # _____ Signature _____

Screening Provider (if different from PCP)

Type of Referral

☐ PCP/ACHN ☐ EPSDT Screening Date _____ ☐ Case Management/Care Coordination	☐ Lock-in ☐ Other (please describe) _____

Length of Referral

Referral valid for ____1____ month(s) or ___N/A____ visit(s) from date referral begins.

Referral Valid For

☐ ~~Evaluation Only~~ ☐ ~~Evaluation and Treatment~~ ☐ ~~Referral by consultant to other provider for identified condition (cascading referral)~~ ☐ ~~Referral by consultant to another provider for additional conditions diagnosed by consultant (cascading referral for EPSDT only)~~	☐ ~~Treatment Only~~ ☐ ~~Hospital Care (Outpatient)~~ ☐ ~~Performance of Interperiodic Screening (if necessary)~~ ☐ For Billing Purposes Only

Reason for referral by PCP/ACHN	Other conditions/diagnoses identified by PCP

Consultant Information

Consultant Name	
Address	Consultant Telephone # with Area Code _____

Note: Please, submit written report of findings including the date of examination/service, diagnosis, and consultant signature to PCP.

Findings should be submitted to Primary Care Physician (PCP) by

☐ Mail ☐ E-mail ☐ Fax ☐ In addition, please telephone