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

Option 1: Email from Adobe PDF

1. At the top left of the Referral for Care Coordination Form, please select the “Email” button
2. This will open up a side pane that gives you the option to send by email as, “Default emailapplication (Microsoft Outlook)” or “Webmail.”
3. Please select the appropriate mailing option for your practice and select “Next”
4. A draft email will appear that gives you the option to “Send a copy of the entire PDF file as an attachment”
5. In the “To” section, enter the email address that is located at the top left of the Referral for Care Coordination Services Form
6. Select “Send” on the email.

Option 2: Download and Email

1. On the top left side of the Referral for Care Coordination 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 tothe email address located on the prefilled form.

Option 3: Print and Email

1. On the top left side of the Referral for Care Coordination 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 theemail address located on the prefilled form.

Referral for Care Coordination Services

Email: infoNW@mycarealabama.org Call: 855-500-9470 Fax: 205-402-9243

Eligible Individual (EI) Information

Date of Referral: _____

Name: _____ Medicaid ID: _____

Parent/Guardian: _____ DOB: _____

Address _____ County: _____

City, State: _____ Phone: _____

Primary Language: _____ Cell #1: _____

Cell #2: _____

Referral Reason (check all that apply):

☐ Maternity

- ☐ Application Assistance
- ☐ Pregnancy
  - Date of LMP: _____
  - Date of First OB Appt: _____
- ☐ High Risk Pregnancy
- ☐ Delivery with no Prenatal Care
- ☐ Other _____

☐ Family Planning

- ☐ Cervical Cancer Screening
- ☐ Contraception
- ☐ STI
- ☐ Sterilization
- ☐ Other _____

☐ General

- ☐ EPSDT or Immunization Compliance
- ☐ Chronic Disease Management
  - Disease Detail: _____
- ☐ Transitional Care
- ☐ Behavioral Health Medication Management
- ☐ Substance Use Disorder Diagnosis & Treatment
- ☐ Other _____

Referral Source Information

Referral Source Name: _____ Phone: _____

Email: