Referral for Care Coordination Services

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

Eligible Individual (EI) Information

Name: ______________________ **Medicaid ID:** ______________

Parent/Guardian: ______________________ **DOB:** ______________

Address ______________________ **County:** ______________

City, State ______________________ **Phone** ______________

Primary Language ______________________ **Cell #1** ______________

Cell #2 ______________

Referral Source:

- ☐ **Hospital**
- ☐ **PCP**
- ☐ **DHCP**
- ☐ **PCCM-E**
- ☐ **Other**

Referral Source Name: ______________

Phone Number: ______________

Email Address: ______________

Note: If referral is from a PCCM-E, case management forms are required.

Referral Reason (check all that apply):

- ☐ **NET Coordination**
- ☐ **Medicaid Application Assistance**
- ☐ **Inpatient / Discharge**
- ☐ **Pregnancy**
- ☐ **Family Planning**
- ☐ **Child with Medical Complexity**
- ☐ **Behavioral Health**
- ☐ **Substance Use Disorder**
- ☐ **Medical Conditions**

Additional Info: