

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

### Screening Provider (if different from PCP)

Name	Name
Address	Address
Telephone # with Area Code _____	Telephone # with Area Code _____
Fax # with Area Code _____	Fax # with Area Code _____
Email _____	Email _____
NPI # _____	NPI # _____
Medicaid Provider # _____	Medicaid Provider # _____
Signature _____	Signature _____

### Type of Referral

<input type="checkbox"/> <b>PCP/ACHN</b> <input type="checkbox"/> EPSDT Screening Date _____ <input type="checkbox"/> Case Management/Care Coordination	<input type="checkbox"/> Lock-in <input type="checkbox"/> Other (please describe) _____
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### Length of Referral

Referral valid for \_\_\_\_\_ month(s) or \_\_\_\_\_ visit(s) from date referral begins.

### Referral Valid For

<input type="checkbox"/> <del>Evaluation Only</del> <input type="checkbox"/> <del>Evaluation and Treatment</del> <input type="checkbox"/> <del>Referral by consultant to other provider for identified condition (cascading referral)</del> <input type="checkbox"/> <del>Referral by consultant to another provider for additional conditions diagnosed by consultant (cascading referral for EPSDT only)</del>	<input type="checkbox"/> <del>Treatment Only</del> <input type="checkbox"/> <del>Hospital Care (Outpatient)</del> <input type="checkbox"/> <del>Performance of Interperiodic Screening (if necessary)</del> <input type="checkbox"/> <b>For Billing Purposes Only</b>
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Reason for referral by PCP/ACHN	Other conditions/diagnoses identified by PCP
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### 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