

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 email application (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 to the 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 the email address located on the prefilled form.



Referral for Care Coordination Services

Email: infoCentral@mycarealabama.org

Call: 855-288-8361

Fax: 205-402-9217

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):		
<input type="checkbox"/> Maternity	<input type="checkbox"/> Family Planning	<input type="checkbox"/> General
<input type="checkbox"/> Application Assistance <input type="checkbox"/> Pregnancy Date of LMP: _____ Date of First OB Appt: _____ <input type="checkbox"/> High Risk Pregnancy <input type="checkbox"/> Delivery with no Prenatal Care <input type="checkbox"/> Other _____	<input type="checkbox"/> Cervical Cancer Screening <input type="checkbox"/> Contraception <input type="checkbox"/> STI <input type="checkbox"/> Sterilization <input type="checkbox"/> Other _____	<input type="checkbox"/> EPSDT or Immunization Compliance <input type="checkbox"/> Chronic Disease Management Disease Detail: _____ <input type="checkbox"/> Transitional Care <input type="checkbox"/> Behavioral Health Medication Management <input type="checkbox"/> Substance Use Disorder Diagnosis & Treatment <input type="checkbox"/> Other _____

Referral Source Information	
Referral Source Name: _____	Phone: _____
Email: _____	