



# Referral for Care Coordination Services

Email: infoCentral@mycarealabama.org

Call: 855-288-8361

Fax: 205-402-9217

Recipient 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"/> General
<input type="checkbox"/> Application Assistance	<input type="checkbox"/> EPSDT or Immunization Compliance
<input type="checkbox"/> Pregnancy Date of LMP: _____ Date of First OB Appt: _____	<input type="checkbox"/> Medically Complex Diagnosis: _____
<input type="checkbox"/> High Risk Pregnancy	<input type="checkbox"/> Transitional Care
<input type="checkbox"/> Delivery with no Prenatal Care	<input type="checkbox"/> Behavioral Health Medication Management
<input type="checkbox"/> Other _____	<input type="checkbox"/> Substance Use Disorder Diagnosis & Treatment
	<input type="checkbox"/> Other _____
Referral Source Information	
Referral Source Name: _____	Phone: _____
Email: _____	