Referral for Care Coordination Services

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

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):	
☐ Maternity	☐ General
☐ Application Assistance ☐ Pregnancy Date of LMP: _____ Date of First OB Appt: _____ ☐ High Risk Pregnancy ☐ Delivery with no Prenatal Care ☐ Other _____	☐ EPSDT or Immunization Compliance ☐ Medically Complex Diagnosis:_____ ☐ Transitional Care ☐ Behavioral Health Medication Management ☐ Substance Use Disorder Diagnosis & Treatment ☐ Other_____

Referral Source Information

Referral Source Name: _____ Phone: _____

Email: