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	Medicaid #	Date of Birth
Address	Telephone # with Area Code (___)_____ Name of Parent/Guardian _____	

Screening Provider

Name	NPI #	Medicaid Provider ID #
Address	Email Telephone # with Area Code (___)_____ Fax # with Area Code (___)_____	
Signature _____ ☐ Electronic Signature		

Type of Referral

☐ Case Management / Care Coordination	☐ Lock-In
☐ EPSDT Screening Date _____ *Select one of the following types of EPSDT Screenings:* ☐ Periodic ☐ Interperiodic	☐ Other (Please Describe) _____

Length of Referral

Referral valid for 12 month(s) or _____ visit(s) from date referral begins.

Referral Valid For

☐ Evaluation Only	☐ Treatment Only
☐ Evaluation and Treatment	☐ Hospital Care (Outpatient)
☐ Referral by consultant to other provider for identified condition (cascading referral)	☐ Performance of Interperiodic Screening (if necessary)
☐ Referral by consultant to another provider for additional conditions diagnosed by consultant (cascading referral for EPSDT only)	☐ For Billing Purposes Only ☐ Other (please describe) _____

Reason for referral:	Other conditions/diagnoses identified:

Consultant Information (Consultant can be an individual provider or a provider group to whom a recipient is referred)

Consultant Name	Family Services Center	
Address	520 Madison Street SE Suite B Huntsville, AL 35801	Telephone # with Area Code (256) 551-1610 Fax #: (256)551-0722

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to the screening provider.

Findings should be submitted by

☐ Mail ☐ E-mail ☐ Fax ☐ In addition, please telephone

Instructions for Completing
The Alabama Medicaid Referral Form (Form 362)

TODAY'S DATE- Enter the date the form is completed.

REFERRAL DATE- Enter the date the referral becomes effective.

RECIPIENT INFORMATION- Enter the patient's name, Medicaid number, date of birth, address, telephone number and parent's/guardian's name.

SCREENING PROVIDER- The screening provider must complete and sign the referral form if an EPSDT screening results in the recipient's referral to another provider. Enter the name, NPI, Medicaid Provider ID#, address, email, telephone number, and fax number of the screening provider.

For hard copy referrals, the printed, typed, or stamped name of the screening provider with an original signature of the provider or designee is required. Stamped or copied signatures will not be accepted. For electronic referrals, provider certification is made via standardized electronic signature protocol. Ensure the electronic signature verification checkbox is selected to confirm the validity of the electronic signature.

TYPE OF REFERRAL: Check the box beside the type of referral being made.

- Case Management/Care Coordination - Referral for case management services through Network Care Coordinators (See *Chapter 40 for ACHN contact information).
- **EPSDT** - Referral resulting from an EPSDT screening – indicate screening date (See *Appendix A for Claim Filing Instructions).
  Select one of the following types of EPSDT Screenings:
  - **Periodic**- Well-child checkups that are based on a periodicity schedule.
  - **Interperiodic**- Problem-focused and abnormal screenings that are medically necessary for undiagnosed conditions outside the periodicity schedule.
- **Lock-In** - Referral for recipients on lock-in status who are locked in to one doctor and/or one pharmacy (See *Chapter 3 -3.3.2 for Claim Filing Instructions).
- **Other** – All other referral types (Describe referral type).

LENGTH OF REFERRAL- Indicate the number of visits or length of time for which the referral is valid. *(Note: Must be completed for the referral to be valid).*

REFERRAL VALID FOR- Indicate the reason or condition for which the recipient is being referred.

- **Evaluation Only** - Consultant will evaluate and provide findings to.
- **Evaluation and Treatment** - Consultant can evaluate and treat for diagnosis listed on the referral.
- **Referral by consultant to other Provider for identified condition (Cascading Referral)** - After evaluation, consultant may, using NPI, refer recipient to another specialist as indicated for the condition identified on the referral form without having to get an additional referral from the screening provider.
- **Referral by consultant to another Provider for additional conditions diagnosed by consultant (Cascading Referral)** – Consultant may refer recipient to another specialist for other diagnosed conditions without having to get an additional referral from the screening provider **(EPSDT ONLY).**
- **Treatment Only** - Consultant will treat for diagnosis listed on referral.
- **Hospital Care (Outpatient)** - Consultant may provide care in an outpatient setting.
- **Performance of Interperiodic Screening (if necessary)** - Consultant may perform an interperiodic screening if a condition was diagnosed that will require continued care or future follow-up visits.
- **For Billing Purposes Only—**
- **Other** – All other referral validation types (i.e., DME). (Describe referral validation type.)

OTHER CONDITIONS/DIAGNOSIS IDENTIFIED BY - Indicate any condition present at the time of initial exam by.

CONSULTANT INFORMATION - Enter the consultant's name, address, and telephone number. The consultant can be an individual provider or provider group.

FINDINGS SHOULD BE SUBMITTED BY - The screening provider should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.

***The Alabama Medicaid Provider Manual is available on the Alabama Medicaid website at www.medicaid.alabama.gov.**