

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

TODAY'S DATE: Date form completed

REFERRAL DATE: Date referral becomes effective

RECIPIENT INFORMATION:

Patient's name, Medicaid number, date of birth, address, telephone number and parent's/guardian's name

PRIMARY PHYSICIAN:* Provide all PMP information. For hard copy referrals, the printed, typed, or stamped name of the primary care physicians with an original signature of the physician or designee is required. Stamped or copied signatures will not be accepted. For electronic referrals provider certification is made via standardized electronic signature protocol.

SCREENING PROVIDER:* Screening provider (if different from primary physician) must complete and sign if the referral is the result of an EPSDT screening.

*NPI INFORMATION: Provide NPI number. For billing purposes indicate Medicaid Provider number, if available.

TYPE OF REFERRAL:

- ◆ Patient 1st - Referral to consultant for Patient 1st recipient only (See *Chapter 39 for Claim Filing Instructions).
- ◆ EPSDT - Referral resulting from an EPSDT screening of a child not in the Patient 1st program - indicate screening date (See *Appendix A for Claim Filing Instructions).
- ◆ Case Management/Care Coordination - Referral for case management services through Patient 1st Care Coordinators (See *Chapter 39 for Claim Filing Instructions).
- ◆ 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).
- ◆ Patient 1st/EPSDT - Referral is a result of an EPSDT screening of a child who is in the Patient 1st program - indicate screening date (See *Appendix A for Claim Filing Instructions).
- ◆ Other - For recipients who are not in Patient 1st program.

LENGTH OF REFERRAL: Indicate the number of visits/length of time for which the referral is valid.

Note: Must be completed for the referral to be valid.

REFERRAL VALID FOR:

- ◆ Evaluation Only - Consultant will evaluate and provide findings to Primary Physician (PMP).
- ◆ 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 Primary Physician's (PMP) provider number, refer recipient to another specialist as indicated for the condition identified on the referral form.
- ◆ Referral by Consultant To Other 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 Primary Physician (PMP).
- ◆ 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.

REASON FOR REFERRAL BY PRIMARY PHYSICIAN (PMP):

Indicate the reason/condition the recipient is being referred.

OTHER CONDITIONS/DIAGNOSIS IDENTIFIED BY PRIMARY PHYSICIAN:

Indicate any condition present at the time of initial exam by PMP.

CONSULTANT INFORMATION: Consultant's name, address and telephone number.

PLEASE SUBMIT FINDINGS TO PRIMARY PHYSICIAN BY: The Primary Physician (PMP) should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.

ALABAMA MEDICAID REFERRAL FORM PHI-CONFIDENTIAL

Today's Date _____

**Important NPI Information
See Instructions**

Date Referral Begins _____
(If different from above)

MEDICAID RECIPIENT INFORMATION

Recipient Name	Recipient #	Recipient DOB
Address	Telephone # with Area Code _____	Name of Parent/Guardian _____

PRIMARY PHYSICIAN (PMP) INFORMATION

SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)

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"/> Patient 1 st <input type="checkbox"/> EPSDT Screening Date _____ <input type="checkbox"/> Case Management/Care Coordination	<input type="checkbox"/> Lock-in <input type="checkbox"/> Other
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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"/> Evaluation Only <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> Referral by consultant to other provider for identified condition (cascading referral) <input type="checkbox"/> Referral by consultant to other provider for additional conditions diagnosed by consultant (EPSDT Only)	<input type="checkbox"/> Treatment Only <input type="checkbox"/> Hospital Care (Outpatient) <input type="checkbox"/> Performance of Interperiodic Screening (if necessary)
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Reason for referral by PMP	Other conditions/diagnoses identified by PMP
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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 Primary Physician (PMP).

Findings should be submitted to Primary Physician (PMP) by

<input type="checkbox"/> Mail	<input type="checkbox"/> E-mail	<input type="checkbox"/> Fax	<input type="checkbox"/> In addition, please telephone
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