MENTAL HEALTH SERVICES PROGRAM
REQUEST FOR OVERRIDE OF WEEKLY VISIT LIMITATION
SAMPLE COVER LETTER

DATE: _____

PROVIDER NAME: _____

PROVIDER ADDRESS: _____

CONTACT PERSON: _____

CONTACT PHONE NUMBER: _____

CONTACT FAX NUMBER: _____

RECIPIENT NAME: _____

The documentation as attached is being submitted for consideration of visit(s) exceeding the weekly limit. (*Please attach a separate sheet for each episode request*).

Original Claim Form: □
Progress Note(s): □

Name of Primary Care Physician (or representative) notified: _____
Method of notification: fax □ phone □ e-mail □

MAIL information to:
Institutional Services
Mental Health Program Director, Suite 3000
P.O. Box 5624
Montgomery, AL 36103-5624

For Medicaid Office Use Only:
□ Approved: _____ □ Sent to HP for payment processing
□ Denied: _____
□ Further review required: _____
Approved □ Denied □

Reference: ALABAMA MEDICAID BILLING MANUAL CHAPTER 34