10-12-2018

ALABAMA MEDICAID PSYCHOLOGY REFERRAL FORM
PHI-CONFIDENTIAL

Today's Date ____________________

Date Referral Begins ________________
(If different from above)

Important NPI Information
See Instructions

MEDICAID RECIPIENT INFORMATION

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

PSYCHOLOGIST INFORMATION / BEHAVIORAL HEALTH PROVIDER

Psychologist Information	Behavioral Health Provider
Name	Name/Credentials
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 ______________

EPSDT INFO / LENGTH OF REFERRAL

EPSDT Info	Length of Referral
☐ EPSDT Screening Date: ______________ Completed by: ______________	Referral Valid for __________ month(s) or __________ visit(s) from date referral begins.

REFERRAL REASON

Reason for referral by psychologist: ____
____
____
Other diagnoses/conditions identified by PMP: ____

PRIMARY PHYSICIAN INFORMATION

Physician Name	Preferred method of communication:
Address	Telephone # with Area Code ______________ Fax # with Area Code ______________ E-mail Address ______________

Note: Please submit written report of findings including the date of exam/service, diagnosis, treatment plan(s), progress notes and any other pertinent information to Primary Physician (PMP). Please document information and the delivery method(s) utilized.

METHOD(s) USED TO SUBMIT FINDINGS TO PRIMARY PHYSICIAN (PMP)

☐ Mail ☐ E-mail ☐ Fax ☐ Telephone Date: