

**PETITION FOR RULE CHANGE
OF THE ALABAMA MEDICAID AGENCY**

In accordance with Ala. Code (1975) § 41-22-8 and ALA. ADMIN. CODE r. 560-X-32-.02, the undersigned herein petitions the Alabama Medicaid Agency to adopt, amend, and/or repeal its rules:

PETITIONER:

PETITIONER'S REPRESENTATIVE:

Name: _____

Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Email: _____

Email: _____

REAL PARTY IN INTEREST:

Is the Petitioner the real party in interest? Yes No

Medicaid Recipient (Medicaid # _____)

Medicaid Applicant (Medicaid or SSN # _____)

Medicaid Provider (Provider # _____)

Physician

Dentist

Pharmacy

Hospital

Nursing Facility

Other: _____

If no, then who is the real party in interest? _____

In what capacity does the Petitioner represent the real party in interest? _____

If you are not the real party in interest or representative, specify how a Medicaid rule substantially affects you and indicate what legal standing you have to request a ruling: _____

Check at least one of the following:

PETITION TO ADOPT NEW RULES

Briefly discuss the purpose and scope of the proposed rule, including all existing rules it would affect and in which chapter of the ALABAMA ADMINISTRATIVE CODE it should be included:

PETITION TO AMEND AND/OR REPEAL EXISTING RULES

List the rules that this Petition is seeking to amend or repeal:

ALA. ADMIN. CODE r. 560-X-_____

STATEMENT AND DOCUMENTATION IN SUPPORT OF PETITION

Attach (as “*Exhibit A*”) a typed narrative detailing why the adoption, amendment, or repeal is needed, specifying:

- (1) The persons or class of persons it would affect and how it would affect them;
- (2) The benefits and disadvantages of the proposed adoption, amendment, or repeal;
- (3) The estimate cost or cost savings to the Alabama Medicaid Agency;
- (4) Other reasons why the adoption, amendment, or repeal should be accepted by the Alabama Medicaid Agency;
- (5) The legal authority for the proposed adoption, amendment, or repeal; and,
- (6) The names and addresses of any persons, organization, and the identity of any class of persons who would be or could be adversely affected by the proposed adoption, amendment, or repeal.

Attach (as “*Exhibit B*,” “*Exhibit C*,” etc.) any other relevant documentation that you want the Alabama Medicaid Agency to consider in reaching its decision.

Dated this the _____ day of _____, 20_____.

Signature of Petitioner or Representative

Note: Send the original and five (5) copies of all documentation to:

**Alabama Medicaid Agency
Administrative Procedures Office
501 Dexter Avenue
Montgomery, AL 36104**