Alabama Medicaid Out-of-State Service Request Form

Date: _____

Part I: Recipient Information:

Name: _____ Address: _____
Date of Birth: _____ Age: _____ AL Medicaid Number: _____

Part II: Referring Provider Information:

Name: _____ NPI: _____ AL Medicaid Provider ID: _____
Clinic/Practice Name: _____ Phone Number: _____
Address: _____ Fax Number: _____

Part III: Out-of-State Provider Information: *Please indicate the following:*

☐ *Provider is Enrolled, or willing to enroll, as an Alabama Medicaid Provider;* ***AND***

☐ *Agreeable to Alabama Medicaid's per diem rate and provider fee schedules*

Name: _____ NPI: _____ AL Medicaid Provider ID: _____
Clinic/Practice Name: _____ Phone Number: _____
Address: _____ Fax Number: _____

Part IV: Out-of-State Provider Representative:

Contact name: _____ Title: _____
Email: _____ Phone number: _____ Fax Number: _____

Part V: Type of Referral:

Please provide the type of service for which you are requesting out-of-state coverage:

☐ Hospital Services ☐ Medical Services ☐ Dental Services ☐ Eye Care Services ☐ Hearing Services

☐ Psychiatric Services ☐ Mental Health Services ☐ Transplant Services ☐ Maternity Services

☐ Other: _____

Part VI: Reason for Referral:

Please provide the reason for requesting an out-of-state service:

_____

_____

_____

Part VII: Individual completing this form:

Name: _____ Title: _____ Phone Number: _____
Address: _____ Fax Number: _____

Part VIII: Declaration:

I hereby declare that the information provided in, and attached to, this request form is accurate and complete to the best of my knowledge. I understand that providing false or misleading information may result in the denial of the out-of-state service request.

Signature: _____ Date: _____

Alabama Medicaid Out-of-State Service Request Form

Part IX: Supporting Medical Documentation:

Please attach the following information to support your request:

1. Letter of Medical Necessity supporting the need for out-of-state service along with documentation ensuring all local and state resources have been exhausted.
2. Consult note from University of Alabama at Birmingham, University of South Alabama, or Children's of Alabama detailing evaluation and professional treatment plan recommendation.
3. Any relevant medical, surgical, and/or consultation notes, lab/radiology results, pathology reports, and/or recent hospital History and Physical (H&P) and discharge summary.
4. Detailed care plan from the out-of-state provider.

NOTE: Medical care and services that require prior authorization for in-state providers will continue to require prior authorization for out-of-state providers.

Part X: Submission:

Submit this form along with all supporting documentation via one of the following methods:

- Send an encrypted email securely to: out-of-state-request@medicaid.alabama.gov

- Or mail the documents directly to the following address:

  Alabama Medicaid Agency
  Attn: Out-of-State Service Request
  501 Dexter Avenue
  PO Box 5624
  Montgomery, AL 36103-5624

Please ensure that all sections of this form are filled in completely and accurately before submitting to the Agency for review. Incomplete submissions will be returned to the requesting provider for completion.

Thank you for submitting an Alabama Medicaid Out-of-State Service Request form. Our team will review your request and communicate with you regarding next steps.