E Medicaid Forms

This section contains examples of various Alabama Medicaid forms used in documenting medical necessity and claims processing.

The following forms may be obtained by contacting the following:

Form Name	*Contact*	*Phone*
Certification and Documentation of Abortion	Program Support Outreach and Education	(334) 353-5203
Check Refund Form	EDS Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	Dental Program	(334) 242-5997
Hysterectomy Consent Form	Program Support Outreach and Education	(334) 353-5203
Medicaid Adjustment Request Form	EDS Provider Assistance Center	(800) 688-7989
Patient Status Notification (Form 199)	Long Term Care Customer Service	(800) 362-1504
Prior Authorization Form	EDS Provider Assistance Center	(800) 688-7989
Sterilization Consent Form	Program Support Outreach and Education	(334) 353-5203
Family Planning Services Consent Form	Program Support Outreach and Education	(334) 353-5203
Prior Authorization Request	Pharmacy Management	(334) 242-5050
Early Refill DUR Override	Pharmacy Management	(334) 242-5050
Growth Hormone For AIDS Wasting	Pharmacy Management	(334) 242-5050
Growth Hormone For Children	Pharmacy Management	(334) 242-5050
Adult Growth Hormone	Pharmacy Management	(334) 242-5050
Maximum Unit Override	Pharmacy Management	(334) 242-5050
Miscellaneous Medicaid Pharmacy PA Request Form	Pharmacy Management	(334) 242-5050
EPSDT Child Health Medical Record	Program Support Outreach and Education	(334) 353-5203
Alabama Medicaid Agency Referral Form	Program Support Outreach and Education	(334) 353-5203
Residential Treatment Facility Model Attestation Letter	Institutional Services Unit	(334) 242-5588
Certification of Need for Services: Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 242-5588
Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 242-5588
Patient 1st Medical Exemption Request Form	Patient 1st Program	(334) 353-5907
Patient 1st Complaint/Grievance Form	Patient 1st Program	(334) 353-5907
Patient 1st Override Request Form	Patient 1st Program	(334) 353-5907
Request for Administrative Review of Outdated Medicaid Claim	System Support Unit	(334) 242-5501

E.1 Certification and Documentation of Abortion

ALABAMA MEDICAID AGENCY

Certification and Documentation

For Abortion

I,_____, certify that the woman, _____

_____, suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

Name of Patient	*Patient's Medicaid Number*		
Patient's Street Address	*City*	*State*	*Zip*
Printed Name of Physician	*Physician's Provider Number*		
Signature of Physician	*Date Physician Signed*		
Date of Surgery			

INSTRUCTIONS: The physician must send this form with the medical records and claim to:

EDS
P.O. Box 244032
Montgomery, AL 36124-4032

PHY-96-2 (Revised 10/01/99) Alabama Medicaid Agency
Formerly MSA-PP-81-1 Revised 10/11/96

E.2 Check Refund Form

Mail To: EDS
Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Check Refund Form (REF-02)

Provider Name _____ Provider Number _____

Check Number _____ Check Date _____ Check Amount _____

Information needed on each claim being refunded	Claim 1	Claim 2	Claim 3
13-digit Claim Number (from EOP)			
Recipient's ID Number (from EOP)			
Recipient's name (Last, First)			
Date(s) of service on claims			
Date of Medicaid payment			
Date(s) of service being refunded			
Service being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made
2. DUP: A payment was made by Alabama Medicaid more than once for the same service(s)
3. INS: A payment was received by a third party source other than Medicare
4. MC ADJ: An over application of deductible or coinsurance by Med icare has occurred
5. PNO: A payment was made on a recipient who is not a client in your office
6. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone _____

10/99

E.3 Alabama Prior Review and Authorization Dental Request

Section I – Must be completed by a Medicaid provider.	**Section II**
Requesting Provider License No. _____	Medicaid Recipient Identification Number _____
Phone( ) _____	(13-digit RID number is required.)
Name_____	Name as shown in Medicaid system _____
Address_____	Address _____
City/State/Zip_____	City/State/Zip _____
Provider Medicaid Number _____	Telephone Number _____

Section III DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	REQUIRED PROCEDURE CODE	QUANITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
PLACE OF SERVICE (Circle one) 11 = DENTAL OFFICE 22 = OUTPATIENT HOSPITAL 21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

_____

_____

3. Brief Dental/Medical History:_____

_____

_____

NOTE :When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked "Confidential." Make sure the recipient's name and Medicaid number are included with the X-rays or photos.

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist_____ Date of Submission_____

FORWARD TO: EDS, P.O. Box 244032, Montgomery, Alabama 36124-4032

Form 343 05/05

Alabama Medicaid Agency

E.4 Hysterectomy Consent Form

ALABAMA MEDICAID AGENCY

HYSTERECTOMY CONSENT FORM

PART I. **P H Y S I C I A N**

Certification by Physician Regarding Hysterectomy

I hereby certify that I have advised **Field 1** Medicaid Number **Field 2** to
Typed or Printed Name of Patient
undergo a hysterectomy because of the diagnosis of **Field 3** **Field 4** .
diagnosis code
Further, I have explained orally and in writing to this patient and/or her representative (**Field 5**) that she will be
Name of Representative, if any
permanently incapable of reproducing as a result of this operation which is medically necessary. This explanation was given before the operation was performed.

Field 6
Typed or Printed Name of Physician

Field 7
Medicaid Provider Number

Field 8
Signature of Physician

Field 9
Date of Signature

PART II. **P A T I E N T**

Acknowledgment by Patient (and/or Representative) of Receipt of Above Hysterectomy Information

I, **Field 10** and/or **Field 11** hereby acknowledge that
Name of Patient *Date of Birth* *Name of Representative, if any*

I have been advised orally and in writing that a hysterectomy will render me permanently incapable of reproducing and that I have agreed to this operation. This oral and written explanation that the hysterectomy would make me sterile was given to me before the operation.

Field 12
Signature of Patient

Field 13
Date

Field 14
Signature of Representative, if any

Field 15
Date

PART III. **P H Y S I C I A N**

Date of Surgery **Field 16**

PART IV. **U N U S U A L C I R C U M S T A N C E S**

Recipient Name: _____ Recipient ID: _____

I _____ certify
Printed name of physician

☐ patient was already sterile when the hysterectomy was performed. Cause of sterility _____.
Medical records are attached.

☐ hysterectomy was performed under a life threatening situation. Medical records are attached.

☐ hysterectomy was performed under a period of retroactive Medicaid eligibility. Medical records are attached.

Before the operation was performed, I informed the recipient that she would be permanently incapable of reproducing as a result of this operation. ☐ Yes ☐ No

Signature: _____ Date: _____

PART V. **S T A T E R E V I E W D E C I S I O N**

Signature of Reviewer: _____ Date of Review: _____ ☐ Pay ☐ Deny

Reason for denial: _____

INSTRUCTIONS: Before payment can be made for any services (physicians, hospitals, etc.) a copy of this consent form must be on file at EDS. Therefore, send this completed from to:

EDS
P.O. Box 244032
Montgomery, AL 36124-4032*y*

PART I.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Type or print the name of the patient
- Record the recipient's 13 digit Medicaid Number
- Record the diagnosis requiring hysterectomy
- Record the diagnosis code
- Record the name of representative, if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field
- Type or print the name of the physician who will perform the hysterectomy
- Record the provider number of the physician who will perform the hysterectomy
- Physician must sign and record the date of signature. Date must be the date of the surgery or a prior date. If any date after surgery is recorded, the form will be denied.

PART II.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Type or print the name of the patient and the patient's date of birth including the day/month/year
- Record the name of representative, if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field
- Patient must sign and record the date of signature unless a representative is being used to complete the form. Date must be the date of surgery or a prior date. If any date after surgery is recorded, the form will be denied.
- Representative must sign and record the date of signature, if the recipient is unable to sign the consent form. Date must be the date of the surgery or a prior date. If any date after surgery is recorded, the form will be denied.

PART III.

This section is required for all hysterectomies.

- Record the date of surgery once the surgery has been performed

PART IV

This section is for use when a hysterectomy was performed on a patient who was already sterile, under a life-threatening emergency in which prior acknowledgement was not possible or during a period of retroactive Medicaid eligibility. Medical records must be submitted for any hysterectomy recorded under this section. In lieu of this form, a properly executed informed consent and medical records may be submitted for these three circumstances.

- Type or print the name of the patient
- Record the recipient's 13 digit Medicaid Number
- The physician who performed the surgery must record their name
- Check the appropriate box to indicate the specific unusual circumstance
- Check the appropriate box regarding whether or not the patient was informed she would be permanently incapable of reproducing as a result of the operation.
- Attach medical records including Medical History; Operative Records; Discharge Summary and a Hospital Consent Form for the Hysterectomy.

PART V

The reviewer at the State completes this section whenever unusual circumstances are identified. EDS will send a copy of the consent form containing the State payment decision to the surgeon following State review.

E.5 Medicaid Adjustment Request Form

Mail to: Adjustments
P. O. Box 241684
Montgomery, AL 36124-1684

Section I: Provider Pay-To Information

Provider Number: _____
Provider Name: _____
Address: _____
_____

Section II: Paid Claims Information
(Please enter data from your remittance advice)

ICN Number: _____
Recipient Number:_____
Recipient Name:_____
Date(s) of Service:_____
Billed Amount:_____
Paid Amount:_____

Section III:

Reason for Recoupment

_____Duplicate payment.
_____Claim billed in error.
_____Recoup/delete line item____.
_____Billed under wrong Recipient.
_____Primary insurance payment received
_____Provider to rebill.
_____Medicare paid primary.
Other_____
_____

-or-

Reason for Adjustment

_____Change the number of units from ____ to ____ for procedure code_____.
_____Change the procedure code from _____ to _____ on line item_____.
_____Change the submitted charge from _____ to _____.
_____Change_____(place/date) of service from _____ to _____ on line item _____.
_____Add/delete modifier on line item_____.
_____Add/adjust primary insurance payment to _____.
_____Adjust coinsurance/deductible from _____ to _____.
_____Change the performing/provider number from _____ to _____.
_____Correct the diagnosis code from _____ to _____.
_____Re-release claim to pay at correct liability/provider rate.
Other _____
_____

Signature_____ Date_____ Telephone#_____

E.6 Patient Status Notification (Form 199)

MEDICAID PATIENT STATUS NOTIFICATION

(To be submitted when a patient is admitted, discharged, transferred or expires)

TO: Alabama Medicaid Agency Date: _____

P.O. Box 5624 - 36103
501 Dexter Avenue
Montgomery, Alabama 36104

FROM: _____ Provider Number: _____
(Name of Facility)

_____ Telephone Number: _____
(Address of Facility)

CURRENT PATIENT STATUS

Patient's First Name M.I. Patient's Last Name _____ / _____ / _____ Birthdate _____

Patient's Social Security No. ☐☐☐☐☐☐☐☐☐ Female ☐

Patient's Medicaid No: ☐☐☐☐☐☐☐☐☐☐☐☐☐ Male ☐

Date admitted _____ / _____
(Medicare Admission) (Medicaid Admission)

Number of Medicare Days this Admission: _____

☐ New Admission ☐ Hospital ☐ Mental Institution

☐ Re-Admission From: ☐ Home

☐ Transferred Admission ☐ Other Home _____

For Medicaid Use Only
Over 60-days late _____

Medicare Denial

Reference Information: _____
Name of Sponsor

_____
Address of Sponsor

☐ Mental Illness ☐ Developmentally Disabled

☐ Convalescent Care ☐ Post Extended Care Days ☐ Swing Bed Approved By _____

☐ Dual Diagnosis ☐ Mental Retardation Date Approved: _____

PATIENT DISCHARGE STATUS

Discharged to: _____ Date: _____

Death (Date) _____

Signed _____

Title _____

Distribution:
White: Alabama Medicaid Agency

Blue: Office of determination for Medicaid Eligibility - Check One: ☐ SSI ☐ D.O.

Pink: Nursing Home File Copy

_____
District Office

Form 199 (Formerly XIX - LTC - 4)
Revised 7/01/94

E.7 Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )
Requesting Provider
License # or Provider # _____
Phone ( ) _____
Name _____

Recipient Medicaid # _____
Name _____
Address _____
City/State/Zip _____
EPSDT Screening Date _____ DOB _____
Prescription Date CCYYMMDD _____

Rendering Provider Medicaid # _____
Phone ( )_____
Fax ( )_____

Name _____

Address _____

City/State/Zip _____
Ambulance Transport Code_____
Ambulance Transport Reason Code _____
DME Equipment: _____ New _____Used

First Diagnosis _____._____ Second Diagnosis _____._____
Service Type _____ Patient Condition _____ Prognosis Code _____

(01) Medical Care	(48) Hospital Inpatient Stay*	(75) Prosthetic Device
(02) Surgical	(54) LTC Waiver	(A7) Psychiatric-Inpatient*
(12) DME-Purchase	(56) Ground Transportation	(AC) Targeted Case Management
(18) DME-Rental	(57) Air Transportation	(AD) Occupational Therapy
(35) Dental Care	(69) Maternity	(AE) Physical Therapy
(42) Home Health Care	(72) Inhalation Therapy	(AF) Speech Therapy
(44) Home Health Visits	(74) Private Duty Nursing	(AL) Vision-Optometry

Line Item	DATES OF SERVICE START CCYYMMDD	STOP CCYYMMDD	PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

_____
_____
_____
_____
_____
_____

*** If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.**

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider_____ Date_____

FORWARD TO: EDS, P.O. Box 244032 Montgomery, Alabama 36124-4032

Form 342
Revised 08/30/05

Alabama Medicaid Agency

E.8 Sterilization Consent Form

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (Doctor/Clinic) _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (Month/Day/Year) _____. I, _____, hereby consent of my own free will to be sterilized by (Doctor) _____, by the method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to: Representative of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature) _____ (Date) _____

(Typed/Printed Name) _____

Recipient's Medicaid Number) _____

You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation (please check)

_____ American Indian or Alaska Native
_____ Hispanic
_____ Asian or Pacific Islander
_____ Black (not of Hispanic origin)
_____ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized) I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining the consent. I have also read him/her the consent form in the _____ Language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter) _____ (Date) _____

Original – Patient
Copy 2 –EDS
Copy 3 – Patient's Permanent Record
Form 193 (Revised 8-30-02)

STATEMENT OF PERSON OBTAINING CONSENT

Before (Patient's Name) _____ signed the consent form, I explain to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Signature) _____ (Date) _____

(Title of Person Obtaining Consent) _____

(Typed/Printed Name) _____

(Facility) _____

(Address) _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (Patient's Name) _____ on (Date) _____, I explained to him/her the nature of the sterilization operation (Specify Type of Operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph, which is not used.)

1. At least thirty days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

2. This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

(1) _____ Premature Delivery:
Individual's expected date of delivery: _____

(2) _____ Emergency abdominal surgery:
(Describe circumstances using an attachment)

(Signature) _____ (Date) _____
(Typed/Printed Name of Physician) _____
(Medicaid Provider Number) _____

E.9 Family Planning Services Consent Form

Name: ___________________________________
Medicaid Number: _________________________
Date of Birth: _____________________________

I give my permission to ___________________________________ to provide family planning services to me. I understand that I will be given a physical exam that will include a pelvic (female) exam, Pap smear, tests for sexually transmitted diseases (STDs), tests of my blood and urine and any other tests that I might need. I have been told that birth control methods that I can pick from may include oral contraceptives (pills), Depo-Provera shots, intrauterine devices (IUDs), Norplant implant, diaphragms, foams, jellies, condoms, natural family planning or sterilization.

Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
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Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
Date: ____________________________________

Signature: ________________________________
Date: ____________________________________

Form 138 (Formerly MED-FP9106)
Revised 2/99

E.10 Prior Authorization Request Form

Page 1 ❒ Page 1 of 1 ❒ Page 1 of 2

Medicaid Pharmacy
Prior Authorization Request Form

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3210**
Phone: (800) 748-0130	**Health Information Designs**	**Auburn, AL 36823-3210**

PATIENT INFORMATION

Patient Name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

Nursing Home Resident ❒ Yes

PRESCRIBER INFORMATION

Prescribing practitioner _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____

Street or PO Box /City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____

Prescribing practitioner signature **Date**

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing pharmacy _____ Provider # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____

CLINICAL INFORMATION

Drug Requested _____ Strength _____

J Code _____ (If applicable) Qty. per month _____ Refills: 0 1 2 3 4 5

Diagnosis or ICD-9 Code* _____ Diagnosis or ICD-9 Code* _____

❒ Initial Request ❒ Renewal

Medical justification _____

_____

❒ **Additional medical justification attached.**

*See Instruction Sheet, Section 5

DRUG SPECIFIC INFORMATION

❒ **NSAID** ❒ **Antihistamine** ❒ **H2 Antagonist** ❒ **PPI** ❒ **Antidepressants** ❒ **Narcotic Analgesics**
❒ **Platelet Aggregation Inhibitors**

❒ **Acute Therapy** ❒ **Maintenance Therapy**

List previous drug usage for drug class requested

Generic/Brand/OTC _____ Reason for d/c _____

Generic/Brand/OTC _____ Reason for d/c _____

If no previous drug usage, additional medical justification must be provided.

NOTE: See Instruction sheet for specific PA requirements on the Medicaid website at www.medicaid.state.al.us

Form 369
Revised 10/16/03 Alabama Medicaid Agency

Page 2 Patient Medicaid # _____

❒ **Sustained Release Oral Opioid Agonist**

Proposed duration of therapy _____ Is medicine for PRN use? ❒ Yes ❒ No

Type of pain ❒ Acute ❒ Chronic Severity of pain: ❒ Mild ❒ Moderate ❒ Severe

Is there a history of substance abuse or addiction? ❒ Yes ❒ No

If yes, is treatment plan attached? ❒ Yes ❒ No

Indicate prior and/or current analgesic therapy and alternative management choices

Drug/therapy _____ Reason for d/c _____

Drug/therapy _____ Reason for d/c _____

❒ **TNF Blocker** ❒ Remicade^{R} ❒ Enbrel^{TM} ❒ Kineret^{TM} ❒ Humira^{TM}

If Rheumatoid Arthritis, is therapy approved by a board certified Rheumatologist? ❒ Yes ❒ No

Prior and/or current DMARD therapy? ❒ Yes ❒ No If yes, attach documentation.

If Crohn's disease, is therapy approved by a board certified Gastroenterologist? ❒ Yes ❒ No

If Remicade^{R} is requested for Rheumatoid Arthritis, will patient be on Methotrexate? ❒ Yes ❒ No

If no, contraindication to use _____

If Psoriatic Arthritis, is therapy approved by a board certified Dermatologist? ❒ Yes ❒ No

❒ **Xenical**

❒ If initial request Weight _____lbs. Height _____inches BMI _____kg/m^2

❒ If renewal request Previous weight _____lbs. Current weight _____lbs.

Documentation MD supervised exercise/diet regimen ≥ 6 mo.? ❒ Yes ❒ No Planned adjunctive therapy? ❒ Yes ❒ No

❒ **Erectile Dysfunction Drugs** Gender ❒ Male ❒ Female Age: ❒ <18 years

Prior drugs or devices used within past 12 months ❒ 18 years or older

1. _____ Date _____ Reason for d/c _____

2. _____ Date _____ Reason for d/c _____

Active or recent history of sexually transmitted disease? ❒ Yes ❒ No

Etiology of dysfunction confirmed by H & P

❒ Spinal cord injury ❒ Diabetic neuropathy ❒ TURP associated neuropathy (irreversible)

❒ Radical prostatectomy ❒ Other (specify) _____

❒ **Synagis** (Check applicable age, condition and risk factors) Current weight _____lbs.

❒ Gestational age ≤ 28 wks & infant is < 12 months ❒ Child is < 24 months old with Chronic Lung Disease*

❒ Gestational age 29-32 wks & infant is < 6 months ❒ Child is < 24 months old with Congenital Heart Disease*

❒ Gestational age 33-35 wks & infant < 6 months with AAP risk factors*

AND

❒ Currently outpatient with no inpatient stay in the last 2 weeks.

*Document AAP risk factor(s) and/or other required medical justification in the Drug/Clinical Information Section of this form.

❒ **Specialized Nutritionals** Height _____ inches Current weight _____lbs.

❒ If < 21 years of age, record supports that > 50% of need is met by specialized nutrition

❒ If ≥ 21 years of age, record supports 100% of need is met by specialized nutrition

Method of administration _____ Duration _____ # of refills _____

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____

Reviewer's Signature Response Date/Hour

Form 369
Revised 10/16/03 Alabama Medicaid Agency

E.11 Early Refill DUR Override Request Form

OVERRIDE

REQUEST FORM

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3210**
Phone: (800) 748-0130	**HEALTH INFORMATION DESIGNS**	**Auburn, AL 36832-3210**

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ (if applicable) Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

❒ **Early Refill** ❒ **Maximum Unit** ❒ **Theraputic Duplication**

Drug name: _____ Date of last refill: _____

For Early Refill

❒ Medication lost
❒ Medication destroyed
❒ Patient going out of town for period greater than the day's supply remaining of the previous refill.
❒ Physician changed the dosage (documentation required below)
❒ Medication stolen

Documentation: _____

For Maximum Unit

Diagnosis: _____

Medical Justification: _____

For Theraputic Duplication

Indicate drugs to be discontinued

❒ Drug name: _____ Diagnosis: _____ Stop date: _____ (if applicable)

❒ Drug name: _____ Diagnosis: _____ Stop date: _____ (if applicable)

Attach medical justification if both drugs are to be continued.

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____

_____ _____
Reviewer's Signature Response Date/Hour

Form 372
Revised 11/02

Alabama Medicaid Agency

E.12 Growth Hormone for AIDS Wasting

GROWTH HORMONE FOR AIDS WASTING

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3210**
Phone: (800) 748-0130	**HEALTH INFORMATION DESIGNS**	**Auburn, AL 36832-3210**

PATIENT INFORMATION

Patient Name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ (if applicable) Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

❒ Initial Request ❒ Renewal (documentation attached to demonstrate effectiveness[1])

Proposed Duration of Therapy: _____ Strength/Quantity: _____ Daily Dose: _____

Height: _____ Weight: _____ BMI: _____

Diagnosis: _____ **ICD-9:** _____

1.	Is there documentation of an unintentional weight loss and loss of muscle mass due to AIDS wasting[2]?	❒ Yes	❒ No
2.	Is there documentation of a failed trial with appetite stimulants or weight gain agents[3]?	❒ Yes	❒ No
3.	Has the patient been on anti-retroviral therapy for the past 120 days?	❒ Yes	❒ No
4.	Has the patient been screened for intracranial malignancy or tumor?	❒ Yes	❒ No

5. If a history of malignancy exists, has the patient been free of recurrence for at least the past 6 months?

❒ Yes ❒ No ❒ No malignancy

If any of the above is answered NO, request will be denied.

6. Does the patient have any of the following contraindications? Check all that apply.

❒ Proliferative or preproliferative diabetic retinopathy

❒ Pseudotumor cerebri or benign intracranial hypertension

❒ Pregnancy

If any of the above contraindications apply, the request will be denied.

[1] Weight stabilization or weight gain must be reported to continue therapy.

[2] There must be an unintentional weight loss of 10% over 12 months or 7.5% over 6 months or BMI < 20 kg/m^2.

[3] Drugs to stimulate appetite and/or promote weight gain, such as Periactin®, Marinol®, Megace®, Oxandrin®, or androgenic steroids.

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 366
Revised 5/16/03

Alabama Medicaid Agency

E.13 Growth Hormone for Children Request Form

GROWTH HORMONE[1] FOR CHILDREN

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3210**
Phone: (800) 748-0130	**HEALTH INFORMATION DESIGNS**	**Auburn, AL 36832-3210**

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ (if applicable) Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

☐ Initial request ☐ Renewal Drug requested: _____ Proposed duration of therapy: _____

Strength/Quantity: _____ Daily dose: _____ Height: _____ Weight: _____

Patient must have one of the following primary indications listed below, confirmed by a board certified endocrinologist:

☐ Documented growth hormone deficiency ☐ Turner Syndrome ☐ Growth Deficiency due to Chronic Renal Insufficiency

Diagnostic testing required:

1. Growth Hormone Deficiency[2]: Confirmed with provocative testing and IGF-1 levels: IGF-1 Level: _____ Date: _____
   Provocative Testing: Test 1: type: _____ Result: _____ Date: _____
   Test 2: type: _____ Result: _____ Date: _____
2. Turner Syndrome[3]: Karyotyping: Date_____ Results: _____
3. Chronic Renal Insufficiency: Is the patient currently receiving dialysis? ☐ Yes ☐ No (If no, request will be denied)
   IGF-1 Level: _____ Date: _____
4. Is patient's thyroid function normal ☐ Yes ☐ No
5. Is patient's height less than 5th percentile? ☐ Yes ☐ No
6. Has the patient been screened for intracranial malignancy or tumor[4]? ☐ Yes ☐ No (If no, request will be denied)
7. If a history of malignancy exists, has patient been free of recurrence for at least the past 6 months?
   ☐ Yes ☐ No (If no, request will be denied) ☐ No malignancy
8. Does the patient have any of the following contraindications? Check all that apply.
   ☐ Pregnancy ☐ Proliferative or preproliferative diabetic retinopathy ☐ Pseudotumor cerebri or benign intracranial HTN
   ☐ Closed epiphyses (After epiphyseal closure use Adult Growth Hormone Therapy criteria.)

[1] Nutropin AQ®, Nutropin®, Humatrope®, Genotropin®, and Protropin®

[2] As provocative testing, Insulin Tolerance Test is **required** unless contraindicated. ITT is contraindicated in patients with seizures, CAD, abnormal EKG with history of IHD or CVD. If ITT is contraindicated, documentation must be provided and an alternative test performed. Results from other stimulation tests (arginine, glucagon, L-dopa, growth hormone-releasing hormone [GHRH], and combinations of these agents, excluding clonidine), may be submitted for those patients with documented contraindication to ITT. GH peak levels of ≤ 10 ng/ml after provocative testing support GH deficiency and justify treatment. For patients with CRI on dialysis, only an IGF-1 level is required.

[3] Short stature in girls with Turner Syndrome is not due to GH deficiency, but growth failure due to an intrinsic skeletal dysplasia. The decision to treat these patients is not based on provocative testing but on the diagnosis of Turner Syndrome using karyotyping.

[4] Children being considered for treatment with growth hormone must be screened prior to initiation of therapy to verify the absence of any malignant condition. If growth failure results from an intracranial tumor, absence of tumor growth or tumor recurrence must be documented for at least 6 months before initiating growth hormone therapy.

FOR HID USE ONLY

☐ Approve request ☐ Deny request ☐ Modify request ☐ Medicaid eligibility verified

Comments: _____

_____
Reviewer's Signature

_____
Response Date/Hour

Form 410
Revised 1/23/03

Alabama Medicaid Agency

E.14 Adult Growth Hormone Request Form

ADULT GROWTH HORMONE[1]

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3210**
Phone: (800) 748-0130	**HEALTH INFORMATION DESIGNS**	**Auburn, AL 36832-3210**

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ (if applicable) Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

❒ Initial request ❒ Renewal Drug requested: _____ Proposed duration of therapy: _____

Strength/Quantity: _____ Daily dose: _____ Height: _____ Weight: _____

Patient must have one of the following primary indications listed below, confirmed by a board certified endocrinologist:

- ❒ Adult with childhood onset of growth hormone deficiency
- ❒ Adult onset of growth hormone deficiency with no other deficiencies
- ❒ Adult onset of growth hormone deficiency without other pituitary hormone deficiencies

Diagnostic testing required:

1. IGF-1 Level: _____ ng/ml Date: _____
2. Is there a contraindication to ITT[2]? ❒ Yes ❒ No
   If yes, indicate reason: _____
3. Provocative Testing: Check appropriate selection
   ❒ Adult with childhood onset GHD or with additional pituitary hormone deficits (one {1} stimulation test required)
   ❒ Adult with suspected GHD with no other pituitary hormone deficits (two {2} stimulation tests required)
   Test 1: type _____ Results: _____ng/ml Date: _____
   Test 2: type _____ Results: _____ng/ml Date: _____
4. Has the patient been screened for intracranial malignancy or tumor? ❒ Yes ❒ No (If no, request will be denied)
5. If a history of malignancy exists, have they been free of recurrence for at least the past six (6) months?
   ❒ Yes ❒ No (If no, request will be denied) ❒ No malignancy
6. Does the patient have any of the following contraindications? Check all that apply. **If any apply, deny request. If not, approve.**
   ❒ Pregnancy ❒ Proliferative or preproliferative diabetic retinopathy ❒ Pseudotumor cerebri or benign intracranial HTS

[1] Nutropin AQ®, Nutropin®, Humatrope®, Genotropin®, and Protropin®

[2] As provocative testing, Insulin Tolerance Test is **required** unless contraindicated. If contraindicated (seizures, CAD, abnormal EKG with history of IHD or CVD, and not advised for those > age 60), documentation must be provided and an alternative test result (arginine, glucagon, growth hormone-releasing hormone {GHRH}, L-dopa and combinations of these agents, excludin clonidine) may be substituted.

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 411
Revised 12/05/02

Alabama Medicaid Agency

E.15 Maximum Unit Override

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

Requester: _____
Name and title (MD, RN, RPh)

PATIENT INFORMATION

Patient's Name: _____ Patient's Medicaid #: _____

Diagnosis: _____ Patient's DOB: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License Number: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider Number: _____

NDC #: _____

Phone #: _____ Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name: _____ Quantity/month: _____

Diagnosis: _____

Medical Justification: _____

_____

_____

_____

***Supporting documentation should be available in the patient record.

FOR AQAF USE ONLY _____ MEDICIAID ELIGIBILITY VERIFIED

_____ Approve request _____ Deny request _____ Deny/Request Additional Information

Authorization effective _____ through _____

Authorization #: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 349
Revised 8/99

Alabama Medicaid Agency

E.16 Miscellaneous Medicaid Pharmacy PA Request Form

MISCELLANEOUS DRUGS

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3210**
Phone: (800) 748-0130	**HEALTH INFORMATION DESIGNS**	**Auburn, AL 36832-3210**

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ (if applicable) Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

Drug requested: _____ Quantity requested: _____

Number of refills requested: _____ Diagnosis: _____

Explanation of medical necessity: _____

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments: _____

_____ _____
Reviewer's Signature Response Date/Hour

Form 365
Revised 9/19/02

Alabama Medicaid Agency

E.17 EPSDT Child Health Medical Record (4 pages)

EPSDT CHILD HEALTH MEDICAL RECORD

Name_____ Medicaid Number _____
Last First Middle

Sex Race
___M ___White ___Black ___Am. Indian Birth Date _____
___F ___Latino ___Asian ___Other

I give permission for the child whose name is on this record to receive services in the _____
I understand that he/she will receive tests, immunizations, and exams. I understand that I will be expected to follow plans that are mutually agreed upon between the health staff and me.

Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____
Date_____ Relationship_____ Date_____ Relationship _____
Signature_____ Signature_____

FAMILY HISTORY
(Code Member Having Disease)
(F-Father, M-Mother, S-Sibling, GP-Grandparent,O-Other)
If Negative, place an N in the blank

____ heart disease	____ high blood pressure	____ tuberculosis	____ cancer
____ stroke	____ blood problem/disease	____ birth defects	____ stroke
____ asthma	____ nerve/mental problem	____ mental retardation	____ diabetes
____ alcohol/drug abuse	____ foster care	____ Other	

Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____
Update (annually)_____ Update (annually)_____

MEDICAL HISTORY

HISTORY	0-Neg +-Pos	DETAIL POSITIVES	HISTORY	0-Neg +-Pos	DETAIL POSITIVES
Childhood Diseases			Frequent Colds		
Diabetes Mellitus			Tonsilitis		
Epilepsy			Bronchitis		
Thyroid Dysfunction			Ear Infection		
Mental I Illness			Pneumonia		
Rheumatic Fever			Convulsions		
Heart Disease			Headache		
Hepatitis			Drug Sensitivity		
Blood Dyscrasia			Allergies		
Anemia			Medications		
Eczema			Operation, Accident		
Tuberculosis			Drug Abuse		
Asthma			Chronic Problems		

Hospitilizations (year & reason)_____

Updates (each screening)_____

Form 172
Revised 1/1/97 Alabama Medicaid Agency

Page 2

DEVELOPMENTAL ASSESSMENT

DATE	NORMAL	ABNORMAL (detail)	DATE	NORMAL	ABNORMAL (detail)

ANTICIPATORY GUIDANCE

(Should be done at each screening and documented with a date)

2 Weeks to 3 Months_____
Dates completed

_____Nutrition
_____Safety
_____Spitting up, hiccoughs, sneezing, etc.
_____Immunizations
_____Need for affection
_____Skin & scalp care, bathing frequency
_____Teach how to use the thermometer and when to call the doctor

4 to 6 Months_____
Dates Completed

_____Nutrition
_____Safety
_____Teething & drooling/dental hygiene
_____Fear of strangers
_____Lead poisoning
_____

7 to 12 Months_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygiene
_____Night crying
_____Separation anxiety
_____Need for affection
_____Discipline
_____Lead poisoning
_____

13 to 18 Months_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygeine
_____Temper tantrums
_____Obedience
_____Speech development
_____Lead poisoning
_____Toilet training counseling begins

19 to 24 Months_____
Dates Completed

_____Nutrition
_____Safety
_____Need for peer relationships
_____Sharing
_____Toilet training should be in progress
_____Dental hygeine
_____Need for affection and patience
_____Lead poisoning

3 to 5 Years_____
Dates completed

_____Nutrition
_____Safety
_____Dental hygiene
_____Assertion of independence
_____Need for attention
_____Manners
_____Lead poisoning
_____Alcohol & drugs

6 to 13 Years_____
Dates completed

_____Nutrition
_____Safety (auto passenger safety)
_____Dental care
_____School readiness
_____Onset of sexual awareness
_____Peer relationships (male & female)
_____Parent-child relationships
_____Prepubertal body changes (menst.)
_____Alcohol, drugs and smoking
_____Contraceptive information if sexually active
_____
_____
_____

14 to 21 Years_____
Dates completed

_____Nutrition/dental
_____Safety (automobile)
_____Understanding body anatomy
_____Male-female relationships
_____Contraceptive information
_____Obedience and discipline
_____Parent-child relationships
_____Alcohol, drugs and smoking
_____Occupational guidance
_____Substance abuse
_____
_____
_____

NUTRITIONAL ASSESSMENT

DATE	ADEQUATE	INADEQUATE (detail)	DATE	ADEQUATE	INADEQUATE (detail)

Form 172 Revised 1/1/97 **Alabama Medicaid Agency**
Page 2 of 4

Page 3

LABORATORY TESTING

	Hematocrit Hemoglobin	Urine Sugar/Albumin	Lead	Sickle Cell Screen	Other
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					
Date					
Results					

Date	PROGRESS NOTES	SIGNATURE

Form 172 Revised 1/1/97
Page 3 of 4

Alabama Medicaid Agency

Page 4

PHYSICAL ASSESSMENT

(UC=Under the care)

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ___ *UC ___		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___	
Physical Examination		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:	
Signature									

PHYSICAL ASSESSMENT

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___		Referral ___ UC ___	
Physical Examination		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:		WNL ☐ Abnormal:	
Signature									

Form 172 Revised 1/1/97
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Alabama Medicaid Agency

E.18 Alabama Medicaid Agency Referral Form

Today's Date _____ Referral Date _____

RECIPIENT INFORMATION

Recipient Name	Recipient #:	Recipient DOB:

PRIMARY PHYSICIAN	**SCREENING PROVIDER (IF DIFFERENT)**
Name:	Name:
Address:	Address:
Telephone #:( )	Telephone #:( )
Fax #: ( )	Fax #:( )
Provider #:	Provider #:
Signature:	Signature:

TYPE OF REFERRAL

Patient 1st	❑ Lock-in
❑ EPSDT Screening Date _____	❑ Patient 1st/EPSDT Screening Date _____
❑ Targeted Case Management (TCM)	

LENGTH OF REFERRAL

Referral Valid for _____month (s) or _____visit (s) from referral date

REFERRAL VALID FOR

❑ Evaluation Only	❑ Treatment Only
❑ Evaluation and Treatment	❑ Hospital Care (Outpatient)
❑ Referral to other provider for identified condition	❑ Performance of Interperiodic Screening (if necessary)
Referral to other provider for additional conditions (diagnosed by consultant)	

Reason for Referral:

Co-morbid Diagnosis:

CONSULTANT INFORMATION

Consultant Name: Consultant Telephone # ( )

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to primary physician.

Please submit findings to Primary Physician by:

❑ Mail	❑ Fax # ( )
❑ E-mail	❑ In addition, please telephone

Form 362 **Alabama Medicaid Agency**

Rev. 4/01

Please find below information regarding the new Medicaid Referral Form that was implemented on 7/1/01. This information is being provided so that providers have a reference tool when utilizing this form. Questions regarding policy should be referred to the Customer Service Unit for the Patient 1st program at 1-800-362-1504. Should you need an inservice for your staff on the form, you may contact the Outreach and Education Unit at (334) 353-5203.

General Information

Maintenance of Original Documentation:

1. The PMP should maintain the "original" referral form. Therefore, it is ok for consulting providers to receive copies, faxes or e-mailed versions of the referral form.
2. If the PMP completes, it will have his original signature and the PMP will copy and forward as necessary.
3. If the PMP has an MOU or a contract with someone else to complete the referral form, the PMP will receive a copy of the form from that person and the PMP should initial approval and keep in his/her file and this will become the "original".
4. If the PMP has an outside person performing the screening - the screener will complete their part of the form, sign, and keep this original for their file and forward a copy to the PMP. The PMP will then sign the copy and keep as his original. Therefore, each provider (PMP and screener) will have an original. But, if the referral needs to be forwarded on, a copy with the PMP's signature should be the one to send.

Memorandum of Understanding (MOU)

1. If the PMP has another physician take call for him and they have the understanding that it is ok to use the PMP's referral number, then the covering physician will not have to obtain a written referral. However, if the recipient needs to receive other care from a different provider, the consulting provider will need a written referral from the PMP. If the covering physician has approval from the PMP, the covering physician can sign the referral form on behalf of the PMP.
2. When operating under an MOU, each party must clearly understand what the agreement is so there is not a misunderstanding when it comes time to bill for the services. These parties need to have an agreement/contract in writing.

Completion Instructions

Today's Date – the date the form is completed and signed.

Referral Date – the date the referral is effective. This **is not a required field** but is appropriate to be used when the referral is/was needed for date other than today's date.

Primary Physician – the PMP in most cases. If for a lock-in recipient, it will be for the physician they are assigned to. **Primary Physician Signature**: It is ok to have a stamped signature with initials. It is ok to have someone else sign on behalf of the PMP as long as they have the PMP permission/MOU (memorandum of understanding) and it is indicated on the referral form. If targeted case managers have an agreement with the PMP and are filling out the form for the PMP they should indicate "Signature On File/MOU". On forms that are sent via e-mail the PMP will indicate signature on file. ***Note: The provider number is the number the recipient is assigned to (if a clinic, it will be the clinic number).***

Screening Provider – to be completed only if the person performing a screening is not the PMP or if it is for a child who **is not enrolled in** the Patient 1st program. ***Note: The provider number in this situation is the screening provider number.***

Type of Referral –

Patient 1st – is for a referral that is Patient 1st only (not an EPSDT).

Lock-in – is for a referral for a recipient that is locked into one physician/pharmacy and must have referral for other services.

EPSDT – is for a referral resulting from an EPSDT screening of a recipient who is not enrolled in the Patient 1st program. Date of screening (which is the date the actual screening was performed) needs to be written here. **This is a mandatory field.**

Note: The same screening date should be used for all services provided as the result of the screening – there cannot be retro dates. Also, the referral date may be different from the date of the screening.

Patient 1st/EPSDT – is for a referral resulting from an EPSDT screening of a recipient who is enrolled in the Pt.1st program. Indicate date of the screening **(this is a mandatory field)**.

Note: The same screening date should be used for all services provided as the result of the screening – there cannot be retro dates. Also, the referral date may be different from the date of the screening.

Targeted Case Management – is for a referral to a case manager of the Targeted Case Management Program for the medically at risk. To be used in order for the recipient to receive case management services.

Note: It is possible for more than one referral to be checked - i.e. Patient 1st and TCM

Length of Referral – is the amount of time the referral is good for from the referral date. ***This is a mandatory field and must be completed in order for the referral to be valid***. How this section is completed is up to the physician completing the form. In some situations it may be more appropriate to utilize a specific number of visits if the physician knows how many it would take to resolve the problem or if it is for a one-time consultation he/she would indicate one visit. If it is for a condition that may take several months to resolve and it is not known how many visits are needed, then the PMP may prefer to indicate months.

Note: If the referral is to be used for more than one type of referral and the physician wishes the number of visits to be different, then a separate form should be filled out for each type of referral.

Referral Valid For (Check all that apply):

Evaluation only – this would be used in a situation where the physician is sending the recipient for a consultation and wants an evaluation or input on how to formulate the treatment plan. *Example*: A physician who has a recipient with diabetes who is not responding to treatment would be referred to an endocrinologist to determine the best type of Insulin to use.

Treatment Only – this is to be used in a situation where the physician has made the diagnosis but needs treatment to be provided elsewhere. *Example*: A recipient with a back injury who needs physical therapy.

Evaluation and Treatment – this would be used in a situation where the physician determines the recipient's condition could be better treated by another physician. *Example*: A recipient with cancer would be referred to an oncologist for evaluation and chemotherapy.

Hospital Care (outpatient) – this would be used in a situation where the recipient needs care provided in the outpatient setting. *Example*: Non-emergency care provided in the emergency room, therapies performed as an outpatient, or care provided through ambulatory surgical centers.

Referral to other provider for identified condition – this would be used in a situation where the physician thinks more than one consultant may be needed to provide treatment for the identified condition. It gives permission to the consultant to refer on to another consultant for the identified diagnosis listed on the referral form without having to call the PMP for another referral. *Example*: Recipient who has been involved in a car wreck and may need care by a cardiologist, an orthopedic, a plastic surgeon, etc.

Performance of Interperiodic screening (for children under age 21) if necessary – to be used in the situation where the physician thinks the recipient may have a condition that has not previously been identified or a condition that has changed significantly that may require continued care or follow-up. *Example*: a recipient who is referred to a pulmonologist for respiratory problems and is suspected to have asthma.

Note: Do not perform a screening unless this checked.

Referral to other provider for additional conditions (diagnosed by consultant) – this would be used in the situation where the physician thinks that there may be more than one problem and would like for the consultant to refer the recipient as necessary without having to contact the PMP for permission. *Example*: A recipient who is referred to a cardiologist for chest pain and it is discovered that the recipient has gallstones.

Note: If a recipient is in the hospital and you know that care will be needed outside the hospital please obtain a referral for any follow-up services that will be needed.

Blank space: may be utilized for the appointment date and time of the referral.

Reason for referral/co-morbid diagnosis – the physician should indicate the reason the recipient is being referred. The physician should also list any other conditions that the recipient currently has that might affect or be affected by treatment. *Example*: A recipient who is being referred for treatment of asthma also has diabetes. It is very important to know that because some of the drugs used for treating asthma can affect blood sugars significantly and if it is not known that the recipient has diabetes, the recipient could have severe adverse reactions.

Consultant information – indicate the name of the provider the recipient is being referred to. If the recipient is to be referred to more than one consultant, they may be listed in other available spaces on the form or listed on another page. The consultant may also indicate in his findings that the recipient is being referred on to another consultant.

Written report – findings of the consultation should be sent to the primary physician unless the physician has an agreement with the EPSDT screener to do the follow-up. The findings should be reported within 30 days.

Submit findings by – the primary physician should indicate whether he wants to be called with the findings, have them mailed, etc.

E.19 Residential Treatment Facility Model Attestation Letter

Residential Treatment Facility
Model Attestation Letter

(RTF LETTERHEAD)
NAME OF THE RTF
ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER
PROVIDER NUMBER (IF APPLICABLE)

Dear (ALABAMA MEDICAID COMMISSIONER):

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the (NAME OF FACILITY) hereby complies with all of the requirements set forth in the interim final rule governing use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (Psych Under 21 rule).

I understand that the Centers for Medicare and Medicaid Services (CMS, formerly HCFA), the Alabama Medicaid Agency, or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 42 CFR, Section 431.610, have the right to validate that (NAME OF FACILITY) is in compliance with the requirements set forth in the Psych Under 21 rule, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the Alabama Medicaid Agency immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify the Alabama Medicaid Agency if it is my belief that (NAME OF FACILITY) is out of compliance with the requirements set forth in the Psych Under 21 rule.

Signature,

Printed Name
Title
Date

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Revised 10/01/01
This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov.

E.20 Certification of Need for Services: Emergency Admission to a Residential Treatment Facility

Certification of Need for Services: Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 who are admitted to an Alabama residential treatment facility (RTF) on an emergency basis or for individuals who become eligible for Medicaid after admission to the RTF. The interdisciplinary team shall complete and sign this form within 14 days of the emergency admission. This form shall be completed on or before the date of the application for Medicaid coverage for individuals who become eligible after admission. This form shall be filed in the recipient's medical record upon completion to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name **Recipient Medicaid Number**

Date of Birth **Race** **Sex** **County of Residence**

Facility Name and Address **Admission Date**

INTERDISCIPLINARY TEAM CERTIFICATION:

1. **Ambulatory care resources available in the community do not meet the treatment needs of this recipient.**
2. **Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
3. **The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.**

Printed Name of Physician Team Member **Signature** **Date**

Printed Name of Other Team Member **Signature** **Date**

Printed Name of Other Team Member **Signature** **Date**

Form 371 Revised 10/01/01
This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

E.21 Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility

Certification of Need for Services:
Non-Emergency Admission to a
Residential Treatment Facility

This form is required for Medicaid recipients under age 21 seeking non-emergency admission to an Alabama residential treatment facility (RTF). The independent team shall complete and sign this form not more than 30 days prior to admission. This form shall be filed in the recipient's medical record upon admission to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name **Recipient Medicaid Number**

Date of Birth **Race** **Sex** **County of Residence**

Facility Name and Address **Planned Admission Date**

PHYSICIAN CERTIFICATION:

1. **I am not employed or reimbursed by the facility.**
2. **I have competence in diagnosis and treatment of mental illness.**
3. **I have knowledge of the patient's situation.**
4. **Ambulatory care resources available in the community do not meet the treatment needs of this recipient.**
5. **Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
6. **The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.**

Printed Name of Physician **Physician Signature** **Phone Number** **Date**

Physician Address **License Number**

Printed Name of Other Team Member **Signature** **Phone Number** **Date**

Printed Name of Other Team Member **Signature** **Phone Number** **Date**

Form 370 ***Revised 10/01/01***
This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

E.22 Patient 1st Medical Exemption Request Form

The Patient 1st Program is based on the premise that patient care is best served by a medical home where a Primary Medical Provider (PMP) may coordinate care. The purpose of this form is for the provider to list the reasons why a patient would not benefit from this system of care.

(Recipient's Name) (Medicaid Number) (Date of Birth)

Attention Physician: This section is to be completed only by the physician. Please check all blocks that apply regarding the patient's medical condition, and mail to the address below. (**Note:** At least one block should be checked, and the physician information requested below completed.

- ☐ **Terminal Illness** (**Note:** The enrollee has a six month or less life expectancy and/or is currently a hospice patient.)
- ☐ **Impaired Mental Condition** which makes it impossible for the adult enrollee to understand and participate in Patient 1st. (**Note:** This statement is not a determination of the patient's legal mental competence.
- ☐ Currently undergoing **Chemotherapy** or **Radiation treatments.** (**Note:** Exemption for this is temporary and will end with the completion of the therapy).
- ☐ **Diagnosis/Other information**: (Specify reasons why this recipient would not benefit from having a medical home with a local PMP who would coordinate his/her care.)

_____

_____

_____

(Physician Signature) (Medicaid Provider Number) (Date)

(Print Physician Name) (Telephone Number)

If you have any questions or would like to apply to become a Patient 1st provider, please contact the Patient 1st Program at (334) 353-5907. Send this completed and signed form via Fax to (334)353-3856 or mail to:

Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103

Form 392 Alabama Medicaid Agency

E.23 PATIENT 1st Complaint/Grievance Form

**Note: for reporting complaints regarding Patient 1st Providers Only*

Mail the completed, ***signed*** form to: Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103

Name of Person Completing this Form: _____
(May be the recipient, designated friend/family member, medical provider, hospital, community member, etc.)

Date Form Completed: _____ Relationship to Recipient: _____

Recipient Name: _____ DOB: _____

Medicaid Number: _____ County of Residence: _____

Address: _____

Telephone Number:_____

Name of Doctor: _____ Practice: _____

Please describe your complaint in detail including dates/names: (please attach any additional documentation)

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Over (See Consent Statement and Signature)

Form 393 Alabama Medicaid Agency

PATIENT 1ST COMPLAINT/GRIEVANCE FORM

Patient 1st staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place to address them. It is not necessary to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint. **PLEASE DO NOT SIGN BOTH STATEMENTS.**

1. If you agree to allow us to use your name in investigating this complaint, please sign the following:

I give the Patient 1st staff permission to use my name when sharing my complaint with the Primary Medical Provider (PMP) named in my complaint. The PMP has my permission to respond to the Patient 1st staff concerning my complaint and release medical records regarding the patient when necessary.

_____ _____
Signature of Complainant Date

_____ _____
Signature of Patient/Parent/Legal Guardian Complainant's Date of Birth

OR

2. If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:

_____ _____
Signature of Complainant Date

_____ _____
Signature of Patient/Parent/Legal Guardian Complainant's Date of Birth

If you have any questions regarding the use of this form or the Patient 1st complaint process, please contact the Patient 1st Program in Montgomery at 334-353-5907. *Thank you for giving us this opportunity to serve you better.*

Please Do Not Write Below This Line

Patient 1st PMP Name: _____ PMP# _____

Patient 1st Practice Name: _____

County Where Patient 1st Practice is Located: _____

Comments: _____

_____

Form 393 Alabama Medicaid Agency

E.24 PATIENT 1ST Override Request Form

Complete this form to request a Patient 1st override when you have received a denial for referral services **or** the Primary Medical Provider (PMP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted to Medicaid's System Support Unit within 45 days of the date of service. Overrides will not be considered unless the PMP has been **contacted and refused** to authorize treatment. Attach a "clean claim" with any supporting documentation to this form and mail to System Support at the address below. System Support will process your request within 30 days of receipt. If your request is approved, the corrected claim will be sent to EDS and will be processed. If your request is denied, System Support will notify you by mail of the denial. This form is available in Appendix E of the Alabama Medicaid Provider Manual and at 3Hwww.medicaid.alabama.gov.

Mail To:
Alabama Medicaid Agency
System Support
501 Dexter Avenue
Montgomery, AL 36103

Recipient's Name: _____ Medicaid Number: _____

Date(s) of Service: _____

Name of PMP: _____

Name of person contacted at PMP's office: _____Date contacted: _____

Reason PMP stated he would not authorize treatment:

I am requesting an override due to:

☐ Recipient assigned incorrectly to PMP. Please explain: _____

☐ This recipient has moved.

☐ Unable to contact PMP. Please explain: _____

_____

☐ Other. Please explain:_____

_____

Provider Name: _____ Provider Number: _____

Provider Contact: _____ Telephone :( ) _____ Fax:( ) _ _____

Form 391 Alabama Medicaid Agency

E.25 Request for Administrative Review of Outdated Medicaid Claim

Alabama Medicaid Agency

REQUEST FOR ADMINISTRATIVE REVIEW OF OUTDATED MEDICAID CLAIM

This form is to be completed only if the claim is more than one year old as specified on the reverse side.

Section A

Print or Type

Provider's Name	Provider Number
Recipient 's Name	Recipient's Medicaid Number
Date of Service	ICN #

I do not agree with the determination you made on my claim as described on my Explanation of Payment dated:

Section B

My reasons are:

Section C

Signature of **either** the provider **or** his/her representative

Provider Signature	Representative Signature
Address	Address
City, State and ZIP Code	City, State and ZIP Code
Telephone Number	Telephone Number
Date	Date

Form # 402
Created 11/22/04

This form may be downloaded from the Medicaid website at: www.medicaid.alabama.gov

Alabama Medicaid Agency

7.2.1 - *Administrative Review and Fair Hearings*
Alabama Medicaid Provider Manual

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code*.

When a denial of payment is received for an outdated claim, the provider may request an *administrative review* of the claim. A request for administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated.** In addition to a clean claim, the provider should send all relevant EOPs and previous correspondence with EDS or the Agency in order to demonstrate a good faith effort at submitting a timely claim. This information will be reviewed and a written reply will be sent to the provider.

In the case that the administrative review results in a denial of a timely request, the provider has the option to request a fair hearing. This written request must be received within 60 days of the administrative review denial.

In some cases, providers should not send requests for fair hearing for denied claims. An administrative review denial is the **final** administrative remedy for the following reasons:

- Recipient has exceeded yearly benefit limits.
- Recipient was not eligible for dates of service.
- Claim was received by the Agency more than 60 days after the claim became outdated.

Send requests for Administrative Review to the following address, care of the specific program area:

Administrative Review
Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery AL 36103-5624

Include the program area in the address (for instance, write “Attn: System Support”).

NOTE:

If all administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the Administrative Review does not result in a favorable decision, the provider may request an informal conference before proceeding to a Fair Hearing.