



## E 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:**

<i>Form Name</i>	<i>Contact</i>	<i>Phone</i>
Certification and Documentation of Abortion	Communications	(334) 353-5203
Check Refund Form	HPE Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	HPE Provider Assistance Center	(800) 688-7989
Hysterectomy Consent Form	Communications	(334) 353-5203
Patient Status Notification (Form 199)	HPE Provider Assistance Center	(800) 688-7989
Prior Authorization Form	HPE Provider Assistance Center	(800) 688-7989
Sterilization Consent Form	Communications	(334) 353-5203
Family Planning Services Consent Form	Communications	(334) 353-5203
Prior Authorization Request	Clinical Services and Support	(334) 242-5050
Prior Authorization Change Request	Clinical Services and Support	(334) 242-5149
Early Refill DUR Override	Clinical Services and Support	(334) 242-5050
Growth Hormone For AIDS Wasting	Clinical Services and Support	(334) 242-5050
Growth Hormone For Children	Clinical Services and Support	(334) 242-5050
Adult Growth Hormone	Clinical Services and Support	(334) 242-5050
Maximum Unit Override	Clinical Services and Support	(334) 242-5050
Miscellaneous Medicaid Pharmacy PA Request Form	Clinical Services and Support	(334) 242-5050
EPSDT Child Health Medical Record	Communications	(334) 353-5203
Alabama Medicaid Agency Referral Form	Communications	(334) 353-5203
Residential Treatment Facility Model Attestation Letter	Institutional Services Unit	(334) 353-3206
Certification of Need for Services: Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-3206
Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-3206
Patient 1 <sup>st</sup> Recipient Dismissal Form	Patient 1 <sup>st</sup> Program	(334) 353-4257
Patient 1 <sup>st</sup> Medical Exemption Request Form	Patient 1 <sup>st</sup> Program	(334) 353-4257
Patient 1 <sup>st</sup> Complaint/Grievance Form	Patient 1 <sup>st</sup> Program	(334) 353-5907
Patient 1 <sup>st</sup> Override Request Form	Patient 1 <sup>st</sup> Program	(334) 353-5907
Request for Administrative Review of Outdated Medicaid Claim	System Support Unit	(334) 242-5562
Request for National Correct Coding Initiative (NCCI) Administrative	System Support Unit	(334) 353-1747

October 2016

E-1

<b>Form Name</b>	<b>Contact</b>	<b>Phone</b>
Review		
Request for NCCI Redetermination Review	HPE Provider Assistance Center	(800) 688-7989
Medicaid Other Insurance Attachment Form	HPE Provider Assistance Center	(800) 688-7989
Medical Medicaid/Medicare Related Claim Form	HPE Provider Assistance Center	(800) 688-7989
Request for Medical Utilization Redetermination (First Level of Appeal)	System Support Unit	(334) 353-1747
Request for Medical Utilization Redetermination (Second Level of Appeal)	System Support Unit	(334) 353-1747

**E.1 Certification and Documentation of Abortion**

**ALABAMA MEDICAID AGENCY**

Replaced form

**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.

<input type="text"/>		<input type="text"/>	
<i>Name of Patient</i>		<i>Patient's Medicaid Number</i>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Patient's Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<i>Printed Name of Physician</i>		<i>Physician's NPI #</i>	
<input type="text"/>		<input type="text"/>	
<i>Signature of Physician</i>		<i>Date Physician Signed</i>	
<i>By entering my name above I agree to the contents of this document.</i>			
<input type="text"/>			
<i>Date of Surgery</i>			

**INSTRUCTIONS:** The physician **must** submit this form via Provider Web Portal upload or fax with the supporting medical records and claim to HPE.

Refer to Chapter 5, Filing Claims, for instructions on the digital submission of this form and supporting documentation.

**NOTE:** If submitting this form via fax, a barcode fax coversheet is required with each submission and should be included as page one of the fax transmission for the corresponding Record ID.

Fax form to HPE at: (334) 215-7416.

## E.2 Check Refund Form

### Check Refund Form (REF-02)

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

Provider Name \_\_\_\_\_ NPI 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 Medicare 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 \_\_\_\_\_

Revised 01/06/16





## Hysterectomy Form Instructions

Replaced  
form

### Part I.

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

- Enter the name of the patient.
- Enter the recipient's 13 digit Medicaid Number.
- Enter the diagnosis description requiring hysterectomy.
- Enter the diagnosis code.
- Enter the name of the representative if the recipient is unable to sign the consent form. If a representative is not used enter N/A in the field.
- Enter name of the physician who will perform the hysterectomy.
- Enter the NPI Number of the physician who will perform the hysterectomy.
- Physician must sign their name and enter 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.

- Enter the name of the patient and the patient's date of birth including the day/month/year.
- Enter 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 enter 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 enter 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.

- Enter the date of surgery once the surgery has been performed.

# E.5 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  
P.O. Box 5624-36103  
501 Dexter Avenue  
Montgomery, Alabama 36104

Date \_\_\_\_\_

FROM: \_\_\_\_\_ NPI Number \_\_\_\_\_  
(Name of Facility)  
\_\_\_\_\_  
(Address of Facility) Telephone Number \_\_\_\_\_

### 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
- Re-Admission
- Transferred Admission
- Hospital
- Home
- Other Nursing Home \_\_\_\_\_
- Mental Institution

<b>For Medicaid Use Only:</b>
Over 60 - days late _____
Medicare Denial: _____

Reference Information: \_\_\_\_\_  
Name of Sponsor \_\_\_\_\_  
Address of Sponsor \_\_\_\_\_

- Mental Illness
  - Convalescent Care
  - Dual Diagnosis
  - Developmentally Disabled
  - Post Extended Care Days
  - Mental Retardation
  - Swing Bed
- Approved By \_\_\_\_\_  
Date Approved: \_\_\_\_\_

### PATIENT DISCHARGE STATUS

Discharged to: \_\_\_\_\_ Date \_\_\_\_\_

Death (Date) \_\_\_\_\_

Signed \_\_\_\_\_

Title \_\_\_\_\_

**Distribution:**

White: Alabama Medicaid Agency  
Canary: Office of Determination for Medicaid Eligibility - check one:  
Pink: Nursing Home File Copy

SSI  D.O.

\_\_\_\_\_  
District Office

**Form 199 (Formerly XIX-LTC-4)**  
Revised 2-13-08



## E.6 Alabama Prior Review and Authorization Request Form

You may fill in the blanks on the computer. Print the form and add signature and date. Mail completed form to HPE at the address below. Information that is typed in will not be saved in the form once the document is closed.

### ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP <input type="checkbox"/> Requesting Provider NPI # _____ Phone with Area Code _____ Name _____	Recipient Medicaid # _____ Name _____ Address _____ City/State/Zip _____ EPSDT Screening Date _____ DOB _____ Prescription Date CCYYMMDD _____																					
Rendering Provider NPI # _____ Phone with Area Code _____ Fax with Area Code _____ Name _____ Address _____ City/State/Zip _____ Ambulance Transport Code _____ Ambulance Transport Reason Code _____ DME Equipment: <input type="checkbox"/> New <input type="checkbox"/> Used	First Diagnosis _____ Second Diagnosis _____ Assignment/Service Code _____ Patient Condition _____ Prognosis Code _____ <table style="width:100%; font-size: small;"> <tr> <td><input type="checkbox"/> Medical Care</td> <td><input type="checkbox"/> Home Health Visits</td> <td><input type="checkbox"/> Occupational Therapy</td> </tr> <tr> <td><input type="checkbox"/> Surgical</td> <td><input type="checkbox"/> LTC Waiver</td> <td><input type="checkbox"/> Physical Therapy</td> </tr> <tr> <td><input type="checkbox"/> DME-Purchase</td> <td><input type="checkbox"/> Medically-Related Transportation</td> <td></td> </tr> <tr> <td><input type="checkbox"/> DME-Rental</td> <td><input type="checkbox"/> Maternity</td> <td><input type="checkbox"/> Psychiatric*</td> </tr> <tr> <td><input type="checkbox"/> Dental Care</td> <td><input type="checkbox"/> Inhalation Therapy</td> <td><input type="checkbox"/> Speech Therapy</td> </tr> <tr> <td><input type="checkbox"/> Oral Surgery</td> <td><input type="checkbox"/> Private Duty Nursing</td> <td><input type="checkbox"/> Vision-Optometry</td> </tr> <tr> <td><input type="checkbox"/> Home Health Care</td> <td><input type="checkbox"/> Prosthetic Device</td> <td><input type="checkbox"/> Case Management</td> </tr> </table>	<input type="checkbox"/> Medical Care	<input type="checkbox"/> Home Health Visits	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Surgical	<input type="checkbox"/> LTC Waiver	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> DME-Purchase	<input type="checkbox"/> Medically-Related Transportation		<input type="checkbox"/> DME-Rental	<input type="checkbox"/> Maternity	<input type="checkbox"/> Psychiatric*	<input type="checkbox"/> Dental Care	<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Speech Therapy	<input type="checkbox"/> Oral Surgery	<input type="checkbox"/> Private Duty Nursing	<input type="checkbox"/> Vision-Optometry	<input type="checkbox"/> Home Health Care	<input type="checkbox"/> Prosthetic Device	<input type="checkbox"/> Case Management
<input type="checkbox"/> Medical Care	<input type="checkbox"/> Home Health Visits	<input type="checkbox"/> Occupational Therapy																				
<input type="checkbox"/> Surgical	<input type="checkbox"/> LTC Waiver	<input type="checkbox"/> Physical Therapy																				
<input type="checkbox"/> DME-Purchase	<input type="checkbox"/> Medically-Related Transportation																					
<input type="checkbox"/> DME-Rental	<input type="checkbox"/> Maternity	<input type="checkbox"/> Psychiatric*																				
<input type="checkbox"/> Dental Care	<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Speech Therapy																				
<input type="checkbox"/> Oral Surgery	<input type="checkbox"/> Private Duty Nursing	<input type="checkbox"/> Vision-Optometry																				
<input type="checkbox"/> Home Health Care	<input type="checkbox"/> Prosthetic Device	<input type="checkbox"/> Case Management																				

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

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: HPE, P.O. Box 244036 Montgomery, Alabama 36124-4032

Form 342  
Revised 4-2016

Alabama Medicaid Agency  
www.medicaid.alabama.gov

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## E.7 Sterilization Consent Form

Replaced form

**ALABAMA MEDICAID AGENCY 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

Physician or Clinio

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 Temporary Assistance for Needy Families (TANF) 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

Specify Type of Operation

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, Name of the Recipient

hereby consent of my own free will to be sterilized by

Physician or Clinio

by the method called

Specify Type of Operation

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: Representatives 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.

X Recipient's Signature X Date

Type/Print Recipient's Name

Recipient's Medicaid Number

**INTERPRETER'S STATEMENT**

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

Interpreter's Signature

Date

Form 193 (Rev. 9-26-2016)

**STATEMENT OF PERSON OBTAINING CONSENT**

Before Name of the Recipient

signed the consent form, I explained to him/her the nature of the sterilization operation Specify Type of Operation

fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the recipient 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 recipient 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 recipient 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.

X Signature of Person Obtaining Consent X Date

Type or Print Name

Facility

Address

**PHYSICIAN'S STATEMENT**

Shortly before I performed a sterilization operation upon

Name of the Recipient on X Date of Sterilization

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 recipient 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 recipient 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 recipient 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 recipient'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 recipient'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 recipient's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

Premature delivery

Recipient's expected date of delivery: \_\_\_\_\_

Emergency abdominal surgery (describe circumstances in an attachment)

X Physician's Signature X Date

Type/Print Name \_\_\_\_\_

NPI Number \_\_\_\_\_

## E.8 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: \_\_\_\_\_

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

**E.9 Prior Authorization Request Form****NOTE:**

Prior Authorization Form 369 may be downloaded from the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) .

## E.10 Prior Authorization Change Request Form Alabama Medicaid Agency Prior Authorization (PA) Change Request

<b>Supplier Information</b>	
Contact Name:	
NPI:	
Phone Number:	

<b>Recipient Information</b>	
Recipient Name:	
Medicaid ID:	

<b>Prior Authorization Number</b>	
-----------------------------------	--

<p><b>Reason for Change</b>  <i>Please use this section to denote what field(s) on the PA request require a change. Complete all applicable fields below.</i>  <b>Examples: Add/Change Modifier: Add "RR" to "E1088"</b>  <b>Correct Date(s) of Service: Change requested effective date from 08/01/2010 to 10/01/2010</b></p>	
Add/Change Modifier:	
Correct Number of Service(s):	
Correct Place of Service:	
Correct Diagnosis Code(s):	
Correct Date(s) of Service:	
Correct NPI:	
Other: (Please Explain)	

<b>Comments</b>

**NOTE:** The Alabama Medicaid Agency cannot revise a PA for which a claim has already been paid. The paid claim must be voided before the PA can be changed. This form must be received within 90 days of the date of the approval on the PA decision letter. The form is to be used for PA requests in evaluation status or for simple changes to an approved PA, such as adding appropriate modifiers. The form is NOT to be used for reconsiderations of denied PAs; for procedure code changes, or for pharmacy PAs. Please fax completed form to the Alabama Medicaid Agency at (334) 353-9352 or (334) 353-4909. Allow at least 5 business days to process request.

**E.11 Early Refill DUR Override Request Form****NOTE:**

The Pharmacy Override Form 409 may be downloaded from the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

## E.12 Growth Hormone for AIDS Wasting

**NOTE:**

PA Form- Growth Hormone-AIDS Wasting, may be downloaded from the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

**E.13 Growth Hormone for Children Request Form****NOTE:**

PA Form – Growth Hormone- Child may be downloaded from the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

## **E.14      Adult Growth Hormone Request Form**

**NOTE:**

PA Form – Growth Hormone – Adult may be downloaded from the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) .

## E.15 Maximum Unit Override

**NOTE:**

The Pharmacy Override Form 409 may be downloaded from the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov) .

## **E.16      Miscellaneous Medicaid Pharmacy PA Request Form**

**NOTE:**

The PA Form for Miscellaneous Drugs may be downloaded from the Medicaid website at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

**E.17**

**EPSDT Child Health Medical Record (4 pages)**

**EPSDT CHILD HEALTH MEDICAL RECORD**

Name \_\_\_\_\_ Medicaid Number \_\_\_\_\_  
 Last First Middle

Sex \_\_\_\_\_ Race \_\_\_\_\_ Birth Date \_\_\_\_\_  
 M  White  Black  Am. Indian  
 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			Tonsillitis		
Epilepsy			Bronchitis		
Thyroid Dysfunction			Ear Infection		
Mental 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		

Hospitalizations (year & reason) \_\_\_\_\_

Updates (each screening) \_\_\_\_\_

Form 172  
 Revised 1/1/97

Alabama Medicaid Agency

**DEVELOPMENTAL ASSESSMENT**

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

**ANTICIPATORY GUIDANCE**

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

<p><b>2 Weeks to 3 Months</b> _____  <small>Dates completed</small></p> <p>____ Nutrition                      ____ Safety                      ____ Spitting up, hiccoughs, sneezing, etc.                      ____ Immunizations                      ____ Need for affection                      ____ Skin &amp; scalp care, bathing frequency                      ____ Teach how to use the thermometer and when to call the doctor</p>	<p><b>13 to 18 Months</b> _____  <small>Dates completed</small></p> <p>____ Nutrition                      ____ Safety                      ____ Dental hygiene                      ____ Temper tantrums                      ____ Obedience                      ____ Speech development                      ____ Lead poisoning                      ____ Toilet training counseling begins</p>	<p><b>6 to 13 Years</b> _____  <small>Dates completed</small></p> <p>____ Nutrition                      ____ Safety (auto passenger safety)                      ____ Dental care                      ____ School readiness                      ____ Onset of sexual awareness                      ____ Peer relationships (male &amp; female)                      ____ Parent-child relationships                      ____ Prepubertal body changes (menst.)                      ____ Alcohol, drugs and smoking                      ____ Contraceptive information if sexually active</p>
<p><b>4 to 6 Months</b> _____  <small>Dates Completed</small></p> <p>____ Nutrition                      ____ Safety                      ____ Teething &amp; drooling/dental hygiene                      ____ Fear of strangers                      ____ Lead poisoning</p>	<p><b>19 to 24 Months</b> _____  <small>Dates Completed</small></p> <p>____ Nutrition                      ____ Safety                      ____ Need for peer relationships                      ____ Sharing                      ____ Toilet training should be in progress                      ____ Dental hygiene                      ____ Need for affection and patience                      ____ Lead poisoning</p>	<p><b>14 to 21 Years</b> _____  <small>Dates completed</small></p> <p>____ 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</p>
<p><b>7 to 12 Months</b> _____  <small>Dates completed</small></p> <p>____ Nutrition                      ____ Safety                      ____ Dental hygiene                      ____ Night crying                      ____ Separation anxiety                      ____ Need for affection                      ____ Discipline                      ____ Lead poisoning</p>	<p><b>3 to 5 Years</b> _____  <small>Dates completed</small></p> <p>____ Nutrition                      ____ Safety                      ____ Dental hygiene                      ____ Assertion of independence                      ____ Need for attention                      ____ Manners                      ____ Lead poisoning                      ____ Alcohol &amp; drugs</p>	

**NUTRITIONAL ASSESSMENT**

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



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 <input type="checkbox"/>		WNL <input type="checkbox"/>		WNL <input type="checkbox"/>		WNL <input type="checkbox"/>	
	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 <input type="checkbox"/>		WNL <input type="checkbox"/>		WNL <input type="checkbox"/>		WNL <input type="checkbox"/>	
	Abnormal:								
Signature									

# E.18 Alabama Medicaid Agency Referral Form

## ALABAMA MEDICAID REFERRAL FORM PHI-CONFIDENTIAL

Today's Date \_\_\_\_\_

Date Referral Begins \_\_\_\_\_

**Important NPI Information**  
See Instructions

**MEDICAID RECIPIENT INFORMATION**

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

**PRIMARY PHYSICIAN (PMP)**

**SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)**

Name	Name
Address	Address
Telephone # with Area Code _____	Telephone # with Area Code _____
Fax # with Area Code _____	Fax # with Area Code _____
Email _____	Email _____
Provider NPI # _____	Provider NPI # _____
Signature _____	Signature _____

**TYPE OF REFERRAL**

<input type="checkbox"/> Patient 1 <sup>st</sup> <input type="checkbox"/> EPSDT Screening Date _____ <input type="checkbox"/> Case Management/Care Coordination	<input type="checkbox"/> Lock-in <input type="checkbox"/> Patient 1 <sup>st</sup> /EPSDT Screening Date _____ <input type="checkbox"/> Other
---	--

**LENGTH OF REFERRAL**

Referral Valid for \_\_\_\_\_ month(s) or \_\_\_\_\_ visit(s) from date referral begins.

**REFERRAL VALID FOR**

<input type="checkbox"/> Evaluation Only <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> Referral by consultant to other provider for identified condition (cascading referral) <input type="checkbox"/> Referral by consultant to other provider for additional conditions diagnosed by consultant (cascading referral)	<input type="checkbox"/> Treatment Only <input type="checkbox"/> Hospital Care (Outpatient) <input type="checkbox"/> Performance of Interperiodic Screening (if necessary)
--	--

Reason for Referral By Primary Physician (PMP)	Other Conditions/Diagnoses Identified by Primary Physician (PMP)
---	---

**CONSULTANT INFORMATION**

Consultant Name	Consultant Telephone # with Area Code
Address	

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to Primary Physician (PMP).

Findings should be submitted to primary physician (PMP) by

<input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> In addition, please telephone
--

## Instructions for Completing The Alabama Medicaid Agency Referral Form (Form 362)

- TODAY'S DATE:** Date form completed
- REFERRAL DATE:** Date referral becomes effective
- RECIPIENT INFORMATION:** Patient's name, Medicaid number, date of birth, address, telephone number and parent's/guardian's name
- PRIMARY PHYSICIAN:\*** Provide all PMP information. **Must be signed by Primary Physician (PMP) or designee**
- SCREENING PROVIDER:\*** Screening provider (if different from Primary Physician) must complete and sign if the referral is the result of an EPSDT screening
- \*NPI INFORMATION:** Referrals effective February 23, 2008 or later MUST indicate the NPI number..

**TYPE OF REFERRAL:**

- ◆ *Patient 1st* - Referral to consultant for Patient 1st recipient only (See \*Chapter 39 for Claim Filing Instructions).
- ◆ *EPSDT* - Referral resulting from an EPSDT screening of a child **not in** the Patient 1st program – indicate screening date (See \*Appendix A for Claim Filing Instructions).
- ◆ *Case Management/Care Coordination* - Referral for case management services through Patient 1st Care Coordinators (See \*Chapter 39 for Claim Filing Instructions).
- ◆ *Lock-In* - Referral for recipients on lock-in status who are locked in to one doctor and/or one pharmacy (See \*Chapter 3 -3.3.2 for Claim Filing Instructions).
- ◆ *Patient 1st/EPSDT* - Referral is a result of an EPSDT screening of a child that **is in** the Patient 1st program – indicate screening date (See \*Appendix A for Claim Filing Instructions).
- ◆ *Other* - For recipients who are not in Patient 1st program.

\*\*The Alabama Medicaid Provider Manual<sup>®</sup> is available on the Alabama Medicaid website

**LENGTH OF REFERRAL:** Indicate the number of visits/length of time for which the referral is valid.

**Note: Must be completed for the referral to be valid.**

**REFERRAL VALID FOR:**

- ◆ *Evaluation Only* - Consultant will evaluate and provide findings to Primary Physician (PMP).
- ◆ *Evaluation and Treatment* - Consultant can evaluate and treat for diagnosis listed on the referral.
- ◆ *Referral By Consultant to Other Provider For Identified Condition (Cascading Referral)* – After evaluation, consultant may, using Primary Physician's (PMP) provider number, refer recipient to another specialist as indicated for the condition identified on the referral form.
- ◆ *Referral By Consultant To Other Provider For Additional Conditions Diagnosed By Consultant (Cascading Referral)* – Consultant may refer recipient to another specialist for other diagnosed conditions without having to get an additional referral from the Primary Physician (PMP).
- ◆ *Treatment Only* - Consultant will treat for diagnosis listed on referral.
- ◆ *Hospital Care (Outpatient)* - Consultant may provide care in an outpatient setting.
- ◆ *Performance of Interperiodic Screening (if necessary)* - Consultant may perform an interperiodic screening if a condition was diagnosed that will require continued care or future follow-up visits.

**REASON FOR REFERRAL BY PRIMARY PHYSICIAN (PMP):** Indicate the reason/condition the recipient is being referred.

**OTHER CONDITIONS/DIAGNOSIS IDENTIFIED BY PRIMARY PHYSICIAN:** Indicate any condition present at the time of initial exam by PMP.

**CONSULTANT INFORMATION:** Consultant's name, address and telephone number.

**PLEASE SUBMIT FINDINGS TO PRIMARY PHYSICIAN BY:** The Primary Physician (PMP) should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.

## E.19 Residential Treatment Facility Model Attestation Letter (The facility director must sign this attestation)

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

Medicaid Provider Number	
Number of Beds in Facility	
Number of individuals currently served in the PRTF who are receiving Alabama Medicaid covered <i>Psych Under 21</i> (PRTF) benefits	
Number of individuals, if any, whose PRTF services are being paid for by a state Medicaid agency other than Alabama Medicaid	

Dear (ALABAMA MEDICAID COMMISSIONER):

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. I hereby attest that I have read all of the requirements set out in the regulations as codified at 42 CFR 483.350-483.376. 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 the 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.

(NAME OF FACILITY) will submit a new attestation of compliance by July 21<sup>st</sup> of each year (or by the next business day if July 21<sup>st</sup> falls on a weekend or holiday).

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 \_\_\_\_\_ Title \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

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

Revised 09/29/2014

This form can be downloaded from the Alabama Medicaid Agency website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

## E.20 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](http://www.medicaid.alabama.gov)*

E-28

October 2016

## 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 NPI 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 web site: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

## E.22 Patient 1<sup>st</sup> Recipient Dismissal Form

### Patient 1<sup>st</sup> Recipient Dismissal Form

Recipient Information	Recipient Name _____		DOB _____	
	Medicaid Number _____		Gender	Male _____ Female _____
	Address _____		Telephone # _____	
	City: _____	State: _____	Zip: _____	
PMP	PMP Name _____		PMP NPI _____	

#### Reason for Dismissal

Recipient Behavior     Non Compliance w/treatment     Other: \_\_\_\_\_

To assist you and the recipient in the dismissal process, please list the name and telephone number of any referral for this recipient within the last 30 days or send copy of the referral.

Referred To	Diagnosis	Date	Length of Referral

After care management, would you accept this recipient back in your practice? Yes  NO

#### For Medicaid Office Use Only:

Refer to Care Coordinator:     Refer to Lock-in Program:

*A Primary Medical Provider may request removal of a recipient from his panel due to good cause. \* All requests for patients to be removed from a PMP's panel should be submitted on this form and provide the enrollee 30 days written notice. The request should contain documentation as to why the PMP does not wish to serve as the recipient's PMP.*

**\*IAW: ALABAMA MEDICAID BILLING MANUAL CHAPTER 39**

Fax number: (334) 353-3856  
FORM 450  
Revised 10/13/2011

[www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

## E.23 Patient 1<sup>st</sup> Medical Exemption Request Form

### Patient 1<sup>st</sup> Medical Exemption Request

The Patient 1<sup>st</sup> 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 Name

\_\_\_\_\_  
Recipient 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 1<sup>st</sup>. (**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.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print Physician's Name

\_\_\_\_\_  
NPI Number

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Return Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

If you have questions about this form, contact Patient 1<sup>st</sup> at (334) 353-5907. If you would like to apply to become a Patient 1<sup>st</sup> provider, call 1-800-688-7989. Send this completed and signed form via Fax to (334)353-3856 or mail to:

**Alabama Medicaid Agency  
Patient 1<sup>st</sup> Program  
501 Dexter Avenue  
Montgomery, AL 36103**

Form 392  
Revised 6/15/09

Alabama Medicaid Agency  
[www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

October 2016

E-31



## PATIENT 1<sup>ST</sup> COMPLAINT/GRIEVANCE FORM

Patient 1<sup>st</sup> 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. If you want us to use your name when investigating your complaint, sign your name in Section 1. If you do NOT want us to use your name when investigating your complaint, sign your name in Section 2. **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 1<sup>st</sup> 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 1<sup>st</sup> 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 about the use of this form or the Patient 1<sup>st</sup> complaint process, please contact the Quality Improvement Initiative Unit at 334-353-5435. *Thank you for giving us this opportunity to serve you better.*

### Please Do Not Write Below This Line

Patient 1<sup>st</sup> PMP Name: \_\_\_\_\_ NPI # \_\_\_\_\_

Patient 1<sup>st</sup> Practice Name: \_\_\_\_\_

County Where Patient 1<sup>st</sup> Practice is Located: \_\_\_\_\_

Comments: \_\_\_\_\_

## E.25 PATIENT 1<sup>ST</sup> Override Request Form

### PATIENT 1<sup>ST</sup> Override Request Form

Complete this form to request a Patient 1<sup>st</sup> 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 Patient 1st Program within 90 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 Patient 1st at the address below. Patient 1st will process your request within 60 days of receipt. If your request is approved, the corrected claim will be sent to HP and will be processed. If your request is denied, Patient 1st will notify you by mail of the denial. This form is available in Appendix E of the Alabama Medicaid Provider Manual and at [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov).

**Mail To:**  
**Alabama Medicaid Agency**  
**Patient 1<sup>st</sup> Program**  
**501 Dexter Avenue**  
**Montgomery, AL 36103**

Recipient's name: \_\_\_\_\_ Medicaid number: \_\_\_\_\_

Recipient's telephone number: (\_\_\_\_) \_\_\_\_\_ Date(s) of service: \_\_\_\_\_

Name of PMP: \_\_\_\_\_ PMP's telephone number: (\_\_\_\_) \_\_\_\_\_

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: \_\_\_\_\_

NPI # \_\_\_\_\_

Form completed by: \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Form 391  
Revised 2-10-10

Alabama Medicaid Agency  
[www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

## E.26 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 from the date of service.

#### Section A

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

I do not agree with the determination made on my EOB dated: \_\_/\_\_/\_\_\_\_

#### Section B

Please explain in detail your reasoning that the denial should be over turned and the claim paid:

---



---



---



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---

#### Section C

<b><u>Provider or representative's signature:</u></b>
<b><u>Provider or representative's signature:</u></b>
<b><u>Provider or representative's name:</u></b>
<b><u>Address(Street, City, State and Zip):</u></b>
<b><u>Date:</u></b>

Form 404 Rev. 02/26/2016

This form may be downloaded from the Medicaid website at: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

### **7.2.1 Administrative Review and Fair Hearings**

The Alabama Medicaid Agency is responsible for mandating and enforcing the Title XIX Medical Assistance State Plan. The Alabama Medicaid Agency contracts with a fiscal agent to process and pay all claims by providers of medical care, services, and equipment authorized under the provisions of the Alabama Title XIX State Plan. The present fiscal agent contract is with Hewlett-Packard Enterprise (HPE), PO Box 244032, Montgomery, AL 36124-4032. Their toll free telephone is 800-688-7989.

HPE provides current detailed claims processing procedures in a manual format for all claim types covered by Medicaid services. HPE prepares and distributes the **Alabama Medicaid Agency Provider Manual** to providers of Medicaid services electronically via the Alabama Medicaid Agency website. This manual is for guidance of providers in filing and preparing claims.

Providers with questions about claims should contact HPE. Only unsolved problems or provider dissatisfaction with the response from HPE should be directed to the Alabama Medicaid Agency, 501 Dexter Avenue, Montgomery, Alabama 36104 or by calling 334-242-5000.



**Section III: Respiratory Equipment -- Complete All Applicable Responses**  
**\* Indicates EPSDT Only**

13. Apnea Monitor \*  
 Apnea       SIDS Sibling Biological (Brother or Sister)       High Risk for Apparent Life Threatening Event (ALTE)  
 Infant less than 2 years of age with Trach       Preterm infant with period of pathologic apnea

14. Overnight Pulse Oximetry \*  
 Evaluation for serious respiratory diagnosis and requires short term oximetry to rule out hypoxemia or determine the need for supplemental oxygen

15. Pulse Oximetry \* - Patient on supplemental oxygen approved by Medicaid and patient has one of the following conditions  
 Trach       Ventilator dependant       Unstable saturations with weaning in progress

16. Percussor \*  
**Patient has one of following diagnoses**  
 Cystic Fibrosis       Bronchiectasis, and  
**Failed chest physiotherapy (Attach clinical documentation)**  
 Hand Percussion       Postural drainage      Date used \_\_\_\_\_ through \_\_\_\_\_, and  
**Caregiver ability to perform chest physiotherapy**  
 Caregiver not available to perform physiotherapy       Caregiver not capable of performing physiotherapy

17. Air Vest\*  
a. Acute Pulmonary exacerbation during last 12 months documented by  
 Hospitalization  $\geq 2$ , and       Episode of home IV antibiotic therapy, and  
 FEV1 in one second  $< 80\%$  of predicted value, or       FVC is  $< 50\%$  of predicted value, and  
c.  Need for chest physiotherapy  $\geq 2$  times daily, and  
d. Documented failure of other forms of chest physiotherapy  
**(Attach clinical documentation)**  
 Hand percussion       Mechanical percussion       Positive Expiratory Pressure

18. Ventilator (check one) \*       Laptop       Volume Ventilator
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a. Dependent on vent 6 hours or more per day, and   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Dependent on vent for at least 30 consecutive days, and<br>(Medical documentation from the recipient's primary physician indicates long term dependency on ventilator support) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Would need care in hospital, NF, ICF, MR and eligible inpatient care under state plan, and   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Patient has social supports to remain in home, and   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Physician has determined that home vent care is safe, and  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Patient has at least one or more of the following  |                              |                             |
| <input type="checkbox"/> Chronic respiratory failure  |                              |                             |
| <input type="checkbox"/> Spinal cord injury   |                              |                             |
| <input type="checkbox"/> Chronic pulmonary disorders  |                              |                             |
| <input type="checkbox"/> Neuromuscular disorders  |                              |                             |
| <input type="checkbox"/> Other neurological disorders and thoracic restrictive diseases   |                              |                             |

19. CPAP/BIPAP \*  
a. Physician       Pulmonologist       Neurologist       Board certified sleep specialist  
b. Patient diagnosis of  Obstructive sleep apnea       Upper airway resistance syndrome       Mixed sleep apnea  
c. Sleep study recorded for  $\geq 360$  minutes/6 hours       Yes       No  
OR  
For patients  $< 6$  months old -- sleep study recorded for  $\geq 240$  minutes/4 hours       Yes       No  
d. Sleep study documents  
 RDI or AHI  $\geq 5$  per hour       At least 30 apneas/hypopneas found in sleep study  
 CPAP reduces sleep events by  $\geq 50\%$   
For BIPAP only       Unsuccessful trial of CPAP      or       Patient is  $\leq 5$  years

20. Suction Pump -- Patient unable to clear airway of secretions by cough due to one of the following conditions:  
 Cancer/surgery of throat       Paralysis of swallowing muscles       Other \_\_\_\_\_  
 Tracheostomy       Comatose or semi-comatose condition      (specify)

**SECTION IV: MEDICAL APPLIANCES AND SUPPLIES**

**21. Disposable Diapers \***

(Patient meets all of following)

- ≥ 3 years old, and
- Patient non-ambulatory or minimally ambulatory (cannot walk 10 feet or more without assistance)

**Patient at risk for skin breakdown and has at least two of the following:**

- Unable to control bowel or bladder functions
- Unable to use regular toilet facilities due to medical condition
- Unable to physically turn or reposition self
- Unable to transfer self from bed to chair or wheelchair without assistance

**22. Augmentative Communication Device**

- Patient is mentally, physically and emotionally capable of operating ACD device
- Medical evaluation completed within 90 days of request for device and patient has a medical condition which impairs the ability to communicate and ACD device is needed to communicate
- Patient has evaluation by interdisciplinary team which includes a physician, speech pathologist or PT, OT or social worker.
- Request is for modification or replacement, and one of the following conditions exist
  - Include supporting documentation.
    - Patient had medical change
    - ACD no longer under warranty, device does not operate to capacity or repair is no longer cost effective
    - New technology is significantly meets medical need of client that is not meet with current equipment

**23. Home Phototherapy**

- Infant is term (≥ 37 weeks of gestation) ≥48 hours of age and otherwise healthy, and
- Serum bilirubin levels >12, and
- Elevated bilirubin levels are not due to a primary liver disorder, and
- Diagnostic evaluation is negative (see instructions), and
- Infants' age and bilirubin concentration is one of the following
  - Infant 25-48 hours of age with serum bilirubin ≥ 12 (170)
  - Infant 49-72 hours of age with serum bilirubin ≥ 15 (260)
  - Infant great than 72 hours of age with serum bilirubin ≥ 17 (290)

**24. Alternating Pressure Pad with Pump or Gel or Gel like Pressure Pad for Mattress**

- Patient is bed confined 75 to 100% of the time, and
  - Patient is unable to physically turn or reposition alone, or
  - Patient is medically at risk for skin break down and meets one of the following criteria
    - Impaired nutritional status defined as BMI ≤ 18.5
    - Fecal or urinary incontinence
    - Presence of any stage pressure ulcer on the trunk or pelvis
    - Compromised circulatory status

**AND**

  - Documentation of all of the following:
    - Recipient/caregiver educated on prevention/management of pressure ulcers
    - Assessment at least every 30 days by a nurse, doctor or other licensed healthcare professional
    - Recipient/caregiver can perform appropriate positioning and wound care
    - Recipient/caregiver understands management of moisture/incontinence
    - Recipient receives nutritional assessment documenting weight, height, BMI and nutritional intake
    - Compromised circulatory status
- Patient is unable to physically turn or reposition alone

## E.28 Request for National Correct Coding Initiative (NCCI) Administrative Review

### Alabama Medicaid Agency

#### Request For National Correct Coding Initiative (NCCI) Administrative Review

This form is to be completed only when the Redetermination Request results in a denial by the Fiscal Agent.

#### 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 Redetermination denial by the Fiscal Agent Dated: \_\_\_\_\_

#### Section B

My reasons are:

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#### 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

This form may be downloaded from the Alabama Medicaid Agency website: [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov)

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## ***NCCI 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 the 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 redetermination request results in a denial by the Fiscal Agent, the provider may request an *NCCI administrative review* of the claim. A request for an NCCI administrative review must be received by the Medicaid Agency within 60 days of the date of the redetermination denial from the Fiscal Agent. In addition to a clean claim, the provider must send a copy of the redetermination denial, all relevant Remittance Advices (RAs) and previous correspondence with the Fiscal Agent or the Agency in order to demonstrate a good faith effort at submitting a claim and supporting documentation. This information will be reviewed and a written reply will be sent to the provider.

Send requests for NCCI Administrative Reviews to the following address:

NCCI Administrative Review  
Alabama Medicaid Agency  
Attn: System Support Unit  
501 Dexter Ave.  
P.O. Box 5624  
Montgomery, AL 36103-5624

**NOTE:**

If all NCCI 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 NCCI Administrative Review does not result in a favorable decision, the provider may request a fair hearing.

## E.29 Request for NCCI Redetermination Review Form



**Hewlett Packard  
Enterprise**

**Request for NCCI Redetermination Review  
Hewlett Packard Enterprise  
PO Box 244032  
Montgomery AL 36124-4032**

**Complete ALL Fields Below - Print or Type**

<b>ICN #</b>	<b>Date of Service</b>
<b>Recipient Name</b>	<b>Recipient Medicaid Number</b>
<b>Provider Name</b>	<b>Provider NPI Number</b>
<b>NCCI Denial Code(s)</b>	
1. <input type="text"/>	2. <input type="text"/> 3. <input type="text"/>
<b>Date of Denial</b>	

**Required Attachments (check box to indicate which attachment is being submitted with request):**  
*Corrected paper claim submitted with procedure code(s) that denied along with specific reports (see below):*

- Anesthesia report for denied procedure codes in the range: 00100 – 01999
- Operative report for denied procedure codes in the range: 10000 – 69999
- Radiology report for denied procedure codes in the range: 70000 – 79999
- Pathology or Laboratory report for denied procedure codes in the range: 80000 – 89999
- Medical report for denied procedure codes in the range: 90000 – 99605

Comments:

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

<b>Date</b>
<b>Address</b>
<b>City, State and Zip code</b>
<b>Telephone Number, including area code</b>
<b>Signature</b>



# E.31 Medical Medicaid/Medicare Related Claim Form

## MEDICAL MEDICAID/MEDICARE RELATED CLAIM

Do not write in this space. Do not use red ink to complete this form.

### 1. RECIPIENT INFORMATION

a. Medicaid ID	
b. First Name	
c. Last Name	
d. Med. Rec. #	
e. Patient Acct. # (Optional)	

### 2. OTHER INSURANCE INFORMATION

a. Covered by other insurance (Except Medicare)? Enter Y if yes or N if no	
b. If other insurance rejected, attach rejection to completed claim and mail to HP and enter date TPL was denied here (MM/DD/YY).	
c. If other insurance paid, attach the completed Medicaid Other Insurance Attachment form (ALTPL01) and mail to HP.	

### 3. DIAGNOSIS CODES

A. \_\_\_\_\_ B. \_\_\_\_\_ C. \_\_\_\_\_ D. \_\_\_\_\_ E. \_\_\_\_\_ F. \_\_\_\_\_  
G. \_\_\_\_\_ H. \_\_\_\_\_ I. \_\_\_\_\_ J. \_\_\_\_\_ K. \_\_\_\_\_ L. \_\_\_\_\_

4. VERSION: 9=ICD-9, 0=ICD-10

### 5. DETAIL OF SERVICES PROVIDED

	a. DATES OF SERVICE		b. POS	c. NDC d. PROCEDURE CODE	e. UNIT	f. MOD	g. DIAG PTR	h. CHARGES	MEDICARE				
	FROM	THRU							i. ALLOWED	j. COINS.	k. DEDUCTIBLE	l. PAID	
1													
2													
3													
4													
5													
6													
7													
8													
9													
6. TOTALS									a.	b.	c.	d.	e.

It is not necessary to attach Medicare EOMB to this claim unless claim dates of service are over one year old AND Medicare payment is less than 120 days old.

7. Billing Provider Name	a.			
7. Billing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID
8. Performing Provider Name	a.			
8. Performing Provider ID	b. NPI	c. Taxonomy	d. Qu	e. Secondary ID

Submit completed claim to:

HP  
Post Office Box 244032  
Montgomery, AL 36124-4032

9. Billing Provider mailing address required in block below:

Form 340 Revised 10/12

## E.32 Request for Medical Utilization Redetermination (First Level of Appeal)

### Alabama Medicaid Agency Request for Medical Utilization Redetermination First Level of Appeal

This form is to be completed only when a claim has been denied for medical utilization. This form is not to be used if a denial of a claim has occurred for being outdated or for NCCI edits. This form is to be sent to the Fiscal Agent. Please print or type information in all areas.

#### Section A

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

I do not agree with the determination made on my EOB dated: \_\_/\_\_/\_\_\_\_

#### Section B

Please explain in detail your reasoning that the denial should be over turned and the claim paid:

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#### Section C

<b><u>Provider or representative's signature:</u></b>
<b><u>Provider or representative's signature:</u></b>
<b><u>Provider or representative's name:</u></b>
<b><u>Address(Street, City, State and Zip):</u></b>
<b><u>Date:</u></b>

Form 401 Rev 02/28/2016

## E.33 Request for Medical Utilization Redetermination (Second Level of Appeal)

### Alabama Medicaid Agency Request for Medical Utilization Redetermination Second Level of Appeal

This form is to be completed only when a claim has been denied for medical utilization. This form is not to be used if a denial of a claim has occurred for being outdated or for NCCI edits. This form is to be sent to the Director of Medical Services at the Alabama Medicaid Agency. Please print or type information in all areas.

**Section A**

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

I do not agree with the determination made on my EOB dated: \_\_/\_\_/\_\_\_\_

**Section B**

Please explain in detail your reasoning that the denial should be over turned and the claim paid:

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**Section C**

<b>Provider or representative's signature:</b>
<b>Provider or representative's signature:</b>
<b>Provider or representative's name:</b>
<b>Address(Street, City, State and Zip):</b>
<b>Date:</b>

Form 402 Rev 02/26/2016