



## 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:**

<i>Form Name</i>	<i>Contact</i>	<i>Phone</i>
Certification and Documentation of Abortion	Communications	(334) 353-5203
Check Refund Form	HP Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	HP Provider Assistance Center	(800) 688-7989
Hysterectomy Consent Form	Communications	(334) 353-5203
Patient Status Notification (Form 199)	HP Provider Assistance Center	(800) 688-7989
Prior Authorization Form	HP 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Request for Administrative Review of Outdated Medicaid Claim	System Support Unit	(334) 242-5562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 Review	System Support Unit	(334) 353-1747
Request for NCCI Redetermination Review	HP Provider Assistance Center	(800) 688-7989
Medicaid Other Insurance Attachment Form	HP Provider Assistance Center	(800) 688-7989
Medical Medicaid/Medicare Related Claim Form	HP Provider Assistance Center	(800) 688-7989

**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.

<i>Name of Patient</i>		<i>Patient's Medicaid Number</i>	
<i>Patient's Street Address</i>		<i>City</i>	<i>State</i>
		<i>Zip</i>	
<i>Printed Name of Physician</i>		<i>Physician's NPI #</i>	
<i>Signature of Physician</i>		<i>Date Physician Signed</i>	
<i>Date of Surgery</i>			

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

HP  
 P.O. Box 244034  
 Montgomery, AL 36124-4034

PHY-96-2 (Revised 2/10/2010)

Alabama Medicaid Agency

Formerly MSA-PP-81-1

## E.2 Check Refund Form

### Check Refund Form (REF-02)

Mail To: HP  
 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 \_\_\_\_\_

2-11-08

## E.3 Alabama Prior Review and Authorization Dental Request

### ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

<p><b>Section I – Must be completed by a Medicaid provider.</b></p> <p>Requesting NPI or License # _____</p> <p>Phone (     ) _____</p> <p>Name _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Medicaid Provider NPI # _____</p>	<p><b>Section II</b></p> <p>Medicaid Recipient Identification Number _____ (13-digit RID number is required)</p> <p>Name as shown in Medicaid system _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Telephone Number (     ) _____</p>
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Section III DATES OF SERVICE	REQUIRED PROCEDURE CODE	QUANTITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
START CCYYMMDD			
STOP CCYYMMDD			
<b>PLACE OF SERVICE (Circle one)</b>			
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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: HP, P.O. Box 244032, Montgomery, Alabama 36124-4032

## E.4 Hysterectomy Consent Form

ATTACHMENT I  
 ALABAMA MEDICAID AGENCY HYSTERECTOMY CONSENT FORM  
 See the back of this form for completion instructions

**PART I. PHYSICIAN**  
**Certification by Physician Regarding Hysterectomy**

I hereby certify that I have advised \_\_\_\_\_ Medicaid Number \_\_\_\_\_ to  
Typed or Printed Name of Patient  
 undergo a hysterectomy because of the diagnosis of \_\_\_\_\_,  
diagnosis code  
 Further, I have explained orally and in writing to this patient and/or her representative ( \_\_\_\_\_ ) 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.

\_\_\_\_\_  
Typed or Printed Name of Physician NPI # \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician Date of Signature \_\_\_\_\_

**PART II. PATIENT**  
**Acknowledgment by Patient (and/or Representative) of Receipt of Above Hysterectomy Information**

I, \_\_\_\_\_ and/or \_\_\_\_\_ 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.

\_\_\_\_\_  
Signature of Patient Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Representative, if any Date \_\_\_\_\_

**PART III. PHYSICIAN**

Date of Surgery \_\_\_\_\_

**PART IV. UNUSUAL CIRCUMSTANCES**

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. STATE REVIEW DECISION**

Signature of Reviewer: \_\_\_\_\_ Date of Review: \_\_\_\_\_  Pay  Deny

Reason for denial: \_\_\_\_\_

**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 NPI 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. HP will send a copy of the consent form containing the State payment decision to the surgeon following State review.

# 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) \_\_\_\_\_  
 \_\_\_\_\_ 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 Nursing Home \_\_\_\_\_

<b>For Medicaid Use Only:</b> Over 60-days late _____ Medicare Denial: _____
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Reference Information: \_\_\_\_\_  
 Name of Sponsor

Address of Sponsor \_\_\_\_\_

- Mental Illness  Developmentally Disabled
  - Convalescent Care  Post Extended Care Days  Swing Bed
  - Dual Diagnosis  Mental Retardation
- 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





# E.7 Sterilization Consent Form

## 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 \_\_\_\_\_ Black (not of  
\_\_\_\_\_ Alaska Native \_\_\_\_\_ Hispanic origin)  
\_\_\_\_\_ Hispanic \_\_\_\_\_ White (not of  
\_\_\_\_\_ Asian or Pacific \_\_\_\_\_ Hispanic origin)  
\_\_\_\_\_ Islander

### 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 - HP  
Copy 3 - Patient's Permanent Record

### 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) \_\_\_\_\_

(NPI Number) \_\_\_\_\_

Alabama Medicaid Agency

## 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: \_\_\_\_\_

## 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>	
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<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) \_\_\_\_\_

**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)

<b>Date of Exam</b>									
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**

<b>Date of Exam</b>									
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 _____	
Address _____	Consultant Telephone # with Area Code _____

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**

Mail     
  E-mail     
  Fax     
  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" 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.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)





### 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 \_\_\_\_\_

## 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 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:

---



---



---



---



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---



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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)

Form # 402  
Rev. 2-10-2010

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

ma 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 HP 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.



**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                       Yes                       No
- b. Dependent on vent for at least 30 consecutive days, and                       Yes                       No  
(Medical documentation from the recipient's primary physician indicates long term dependency on ventilator support)
- c. Would need care in hospital, NF, ICF, MR and eligible inpatient care under state plan, and                       Yes                       No
- d. Patient has social supports to remain in home, and                       Yes                       No
- e. Physician has determined that home vent care is safe, and                       Yes                       No
- f. Patient has at least one or more of the following
- Chronic respiratory failure
- Spinal cord injury
- Chronic pulmonary disorders
- Neuromuscular disorders
- 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)

## ***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



Request for NCCI Redetermination Review  
 HP Enterprise Services  
 PO Box 244032  
 Montgomery AL 36124-4032

Complete ALL Fields Below - Print or Type

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

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

Date
Address
City, State and Zip code
Telephone Number, including area code
Signature



## 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	
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**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													
<b>6. TOTALS</b>								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:

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