# E Medicaid Forms

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

**The following forms may be obtained by contacting the following:**

| ***Form Name*** | ***Contact*** | ***Phone*** |
|---|---|---|
| Certification and Documentation of Abortion | 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 | Pharmacy Management | (334) 242-5050 |
| Early Refill DUR Override | Pharmacy Management | (334) 242-5050 |
| Growth Hormone For AIDS Wasting | Pharmacy Management | (334) 242-5050 |
| Growth Hormone For Children | Pharmacy Management | (334) 242-5050 |
| Adult Growth Hormone | Pharmacy Management | (334) 242-5050 |
| Maximum Unit Override | Pharmacy Management | (334) 242-5050 |
| Miscellaneous Medicaid Pharmacy PA Request Form | Pharmacy Management | (334) 242-5050 |
| EPSDT Child Health Medical Record | Communications | (334) 353-5203 |
| Alabama Medicaid Agency Referral Form | Communications | (334) 353-5203 |
| Residential Treatment Facility Model Attestation Letter | Institutional Services Unit | (334) 353-4945 |
| Certification of Need for Services: Emergency Admission to a Residential Treatment Facility | Institutional Services Unit | (334) 353-4945 |
| Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility | Institutional Services Unit | (334) 353-4945 |
| Patient 1st Recipient Dismissal Form | Patient 1st Program | (334) 353-5907 |
| Patient 1st Medical Exemption Request Form | Patient 1st Program | (334) 353-5907 |
| Patient 1st Complaint/Grievance Form | Patient 1st Program | (334) 353-5907 |
| Patient 1st Override Request Form | Patient 1st Program | (334) 353-5907 |
| Request for Administrative Review of Outdated Medicaid Claim | System Support Unit | (334) 242-5562 |
| 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 |

## E.1 Certification and Documentation of Abortion

# ALABAMA MEDICAID AGENCY

## Certification and Documentation

## For Abortion

I,_____, certify that the woman,

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

| | | | |
|---|---|---|---|
| | | | |
| *Name of Patient* | *Patient's Medicaid Number* | | |
| *Patient's Street Address* | *City* | *State* | *Zip* |
| *Printed Name of Physician* | *Physician's NPI #* | | |
| *Signature of Physician* | *Date Physician Signed* | | |
| *Date of Surgery* | | | |

**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

**Section I** – Must be completed by a Medicaid provider.

Requesting NPI or License #_____

Phone (  ) _____

Name _____

Address _____

City/State/Zip _____

Medicaid Provider NPI # _____

**Section II**

Medicaid Recipient Identification Number _____
(13-digit RID number is required)

Name as shown in Medicaid system _____

Address _____

City/State/Zip _____

Telephone Number (  ) _____

**Section III**

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

**Section IV**

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

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

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

_____

_____

_____

_____

**3. Brief Dental/Medical History**:_____

_____

_____

_____

_____

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

Form 343
Revised 2/10/10

Alabama Medicaid Agency
www.medicaid.alabama.gov

# 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: _____

*PHY-81243* *(Revised 2-10-2010)* *Alabama Medicaid Agency*

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 paym ent 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: _____

| For Medicaid Use Only: |
|---|
| Over 60–days late _____ |
| Medicare Denial: _____ |

☐ New Admission ☐ Hospital ☐ Mental Institutuion

☐ Re–Admission From: ☐ Home

☐ Transferred Admission ☐ Other Nursing Home _____

Reference Information: _____
Name of Sponsor

_____
Address of Sponsor

☐ Mental Illness ☐ Developmentally Disabled

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

☐ Dual Diagnosis ☐ Mental Retardation Date Approved: _____

### PATIENT DISCHARGE STATUS

Discharged to: _____ Date _____

Death (Date) _____

Signed _____

Title _____

Distribution:
White: Alabama Medicaid Agency
Canary: Office of Determination for Medicaid Eligibility - check one: ☐ SSI ☐ D.O.
Pink: Nursing Home File Copy

_____
District Office

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

**THIS FORM MUST BE SUBMITTED TO MEDICAID WITHIN 60 DAYS OF MEDICAID ADMISSION DATE**

**Physician's current orders:**
**(a copy of orders may be attached)**

**PLEASE EXPLAIN REASON FOR HOSPITAL STAY OR POST EXTENDED CARE. (must be signed by an RN)**

**RN Signature**

**FOR POST EXTENDED HOSPITAL CARE ONLY:**
**(Please list nursing homes and dates they were contacted for placement. This form must be documented every 15 days.)**

| Nursing Home | Date Contacted |
|---|---|
| | |

**I CERTIFY THAT THIS RECIPIENT NEEDS NURSING HOME CARE**
**(Physician must sign and date)**

**Physician's Signature** **Date**

# E.6 Alabama Prior Review and Authorization Request Form

## ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ☐

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: _____ New _____ Used

First Diagnosis _____.____ Second Diagnosis _____.____

Assignment/Service Code ____ Patient Condition ____ Prognosis Code ____

| | | | | | |
|---|---|---|---|---|---|
| (01) | Medical Care | (44) | Home Health Visits | (AD) | Occupational Therapy |
| (02) | Surgical | (54) | LTC Waiver | (AE) | Physical Therapy |
| (12) | DME-Purchase | (56) | Medically-Related Transportation | | |
| (18) | DME-Rental | (69) | Maternity | (A4) | Psychiatric* |
| (35) | Dental Care | (72) | Inhalation Therapy | (AF) | Speech Therapy |
| (40) | Oral Surgery | (74) | Private Duty Nursing | (AL) | Vision-Optometry |
| (42) | Home Health Care | (75) | Prosthetic Device | (CQ) | Case Management |

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

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

Form 342
Revised 12-2011

Alabama Medicaid Agency
www.medicaid.alabama.gov

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

### INTERPRETER'S STATEMENT

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

(Interpreter) _____ (Date) _____

Original – Patient
Copy 2 – 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

Form 193 (Revised 2-30-2010)

# 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: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
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Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

Signature: _____
Date: _____

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

## E.9 Prior Authorization Request Form

**NOTE:**

Prior Authorization Form 369 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

## E.10 Early Refill DUR Override Request Form

**NOTE:**

The Pharmacy Override Form 409 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

# E.11 Growth Hormone for AIDS Wasting

**NOTE:**

PA Form- Growth Hormone-AIDS Wasting, may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

# E.12 Growth Hormone for Children Request Form

**NOTE:**

PA Form – Growth Hormone- Child may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

## E.13 Adult Growth Hormone Request Form

**NOTE:**

PA Form – Growth Hormone – Adult may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

## E.14 Maximum Unit Override

**NOTE:**

The Pharmacy Override Override Form 409 may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

## E.15 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.

# E.16 EPSDT Child Health Medical Record (4 pages)

## EPSDT CHILD HEALTH MEDICAL RECORD

Name_____ Medicaid Number _____
Last First Middle

Sex Race
__M ___White ____Black ____Am. Indian Birth Date _____
__F ___Latino ____Asian ____Other

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

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

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

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

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

### MEDICAL HISTORY

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

Hospitilizations (year & reason)_____

Updates (each screening)_____

Form 172
Revised 1/1/97

Alabama Medicaid Agency

Page 2

## DEVELOPMENTAL ASSESSMENT

| DATE | NORMAL | ABNORMAL (detail) | DATE | NORMAL | ABNORMAL (detail) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## ANTICIPATORY GUIDANCE

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

**2 Weeks to 3 Months**_____
Dates completed

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

**4 to 6 Months**_____
Dates Completed

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

**7 to 12 Months**_____
Dates completed

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

**13 to 18 Months**_____
Dates completed

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

**19 to 24 Months**_____
Dates Completed

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

**3 to 5 Years**_____
Dates completed

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

**6 to 13 Years**_____
Dates completed

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

**14 to 21 Years**_____
Dates completed

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

## NUTRITIONAL ASSESSMENT

| DATE | ADEQUATE | INADEQUATE (detail) | DATE | ADEQUATE | INADEQUATE (detail) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Form 172 Revised 1/1/97
Page 2 of 4

Alabama Medicaid Agency

Page 3

## LABORATORY TESTING

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

| Date | PROGRESS NOTES | SIGNATURE |
|---|---|---|
| | | |
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Form 172 Revised 1/1/97
Page 3 of 4

Alabama Medicaid Agency

Page 4

## PHYSICAL ASSESSMENT

(UC=Under the care)

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

## PHYSICAL ASSESSMENT

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

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

**Alabama Medicaid Agency**

# E.17 Alabama Medicaid Agency Referral Form

## ALABAMA MEDICAID REFERRAL FORM

Today's Date _____

**PHI-CONFIDENTIAL**

Date Referral Begins _____

**Important NPI Information**
**See Instructions**

**MEDICAID RECIPIENT INFORMATION**

| Recipient Name | Recipient # | Recipient DOB |
|---|---|---|
| Address | Telephone # with Area Code _____<br>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**

| | |
|---|---|
| ❑ Patient 1st<br>❑ EPSDT Screening Date _____<br>❑ Case Management/Care Coordination | ❑ Lock-in<br>❑ Patient 1st/EPSDT Screening Date _____<br>❑ Other |

**LENGTH OF REFERRAL**

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

**REFERRAL VALID FOR**

| | |
|---|---|
| ❑ Evaluation Only<br>❑ Evaluation and Treatment<br>❑ Referral by consultant to other provider for identified condition (cascading referral)<br>❑ Referral by consultant to other provider for additional conditions diagnosed by consultant (cascading referral) | ❑ Treatment Only<br>❑ Hospital Care (Outpatient)<br>❑ 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

Form 362
Rev. 1-30-08

Alabama Medicaid Agency
www.medicaid.alabama.gov

## 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.

Form 362
Rev.1-30-08

Alabama Medicaid Agency
www.medicaid.alabama.gov

# E.18 Residential Treatment Facility Model Attestation Letter

## Residential Treatment Facility Model Attestation Letter

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

Dear (ALABAMA MEDICAID COMMISSIONER):

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

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

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

Signature,

Printed Name
Title
Date

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

*Revised 2/11/08*
*This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov*

# E.19 Certification of Need for Services: Emergency Admission to a Residential Treatment Facility

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

**Recipient Name** **Recipient Medicaid Number**

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

**Facility Name and Address** **Admission Date**

## INTERDISCIPLINARY TEAM CERTIFICATION:

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

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

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

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

***Form 371*** ***Revised 10/01/01***

***This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov***

# E.20 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.*

## E.21 Patient 1st Recipient Dismissal Form

### Patient 1st 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**

# E.22 Patient 1st Medical Exemption Request Form

## Patient 1st Medical Exemption Request

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

| Recipient 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 1st. (**Note:** This statement is not a determination of the patient's legal mental competence.

☐ Currently undergoing **Chemotherapy** or **Radiation treatments.** (**Note:** Exemption for this is temporary and will end with the completion of the therapy).

☐ **Diagnosis/Other information**: (Specify reasons why this recipient would not benefit from having a medical home with a local PMP who would coordinate his/her care.)

_____

_____

_____

| 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 1st at (334)242-5048. If you would like to apply to become a Patient 1st provider, call (334) 242-5907. Send this completed and signed form via Fax to (334)353-3856 or mail to:

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

Form 392
Revised 2/15/08

Alabama Medicaid Agency
www.medicaid.alabama.gov

# E.23 PATIENT 1st Complaint/Grievance Form

## PATIENT 1st COMPLAINT/GRIEVANCE FORM

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

Mail the completed, ***signed*** form to: Alabama Medicaid Agency
Quality Improvement Initiatives Unit
501 Dexter Avenue
Montgomery, AL 36103

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

Date Form Completed: _____ Relationship to Recipient: _____

Recipient Name: _____ DOB: _____

Recipient Medicaid Number: _____ County of Residence: _____

Address: _____

Telephone Number:_____

Name of Doctor: _____ Practice: _____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

***Over (See Consent Statement and Signature)***

Form 393
Revised 2/15/08

Page 1 of 2

Alabama Medicaid Agency
www.medicaid.alabama.gov

# PATIENT 1ST COMPLAINT/GRIEVANCE FORM

Patient 1st staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place to address them. It is not necessary to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. 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 1st staff permission to use my name when sharing my complaint with the Primary Medical Provider (PMP) named in my complaint. The PMP has my permission to respond to the Patient 1st staff concerning my complaint and release medical records regarding the patient when necessary.

_____ _____
Signature of Complainant Date

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

## OR

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

_____ _____
Signature of Complainant Date

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

If you have any questions about the use of this form or the Patient 1st 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 1st PMP Name: _____ NPI # _____

Patient 1st Practice Name: _____

County Where Patient 1st Practice is Located: _____

Comments: _____

_____

Form 393
Revised 2/15/08

Page 2 of 2

Alabama Medicaid Agency
www.medicaid.alabama.gov

# E.24 PATIENT 1ST Override Request Form

## PATIENT 1ST Override Request Form

Complete this form to request a Patient 1st override when you have received a denial for referral services or the Primary Medical Provider (PMP) has refused to authorize treatment for past date(s) of service. The request must be submitted to Medicaid's 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.

**Mail To:**
**Alabama Medicaid Agency**
**Patient 1st 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

# E.25 Request for Administrative Review of Outdated Medicaid Claim

## Alabama Medicaid Agency

### REQUEST FOR ADMINISTRATIVE REVIEW OF OUTDATED MEDICAID CLAIM

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

**Section A**

**Print or Type**

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

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

**Section B**

My reasons are:

**Section C**

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

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

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

Form # 402
Rev. 2-10-2010

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

ı 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.

# E.26 Prior Authorization Request Form for Durable Medical Equipment

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

ALABAMA MEDICAID AGENCY
DURABLE MEDICAL EQUIPMENT

☐ Certification ☐ Recertification

**Section I: Patient Information -- Complete All Items Pertaining to the Patient's Condition and Equipment**

| 1. Patient's Name | 2. Medicaid Number | 3. Date of Last EPSDT Screening |
|---|---|---|
| 4. Indicate all relevant diagnoses | | 5. Prognosis ☐ Good ☐ Fair ☐ Poor |
| 6. Estimated number of months equipment needed (Do not put "Indefinite." Be specific.) _____ | 7. Date Prescribed _____ | 8. Requested HCPC code(s) _____ |

9. Rental Period this certification applies to
(Certification length CANNOT exceed 12 months)
From _____ To _____

Short Term (6 months or less ) _____
(MM-DD-YYYY)

Continuous Rental _____
(MM-DD-YYYY)

10. Supplier's Name _____
Street Address _____
City, State, Zip _____
Telephone # _____
Supplier's Provider Number _____

11. What is The Patient's Condition Concerning Mobility?

a. Bed Confined? ☐ No ☐ Yes - If Yes, complete below
☐ <50% of the time ☐ 50% of the time ☐ 75% of the time ☐ 100% of the time

b. Room Confined? ☐ No ☐ Yes

c. Wheelchair Confined? ☐ No ☐ Yes

d. Ambulatory ☐ No ☐ Yes - If Yes, complete below
☐ Assistance not required ☐ Assisted by a walker or cane ☐ Assisted by a person

e. Is Patient Disoriented? ☐ No ☐ Yes

f. Can patient position self? ☐ No ☐ Yes

g. Does patient have severe contractions? ☐ No ☐ Yes If yes, where? _____

h. Is the patient comatose? ☐ No ☐ Yes

i. Is the patient semi comatose? ☐ No ☐ Yes

j. Is the patient highly susceptible to decubitis ulcers? ☐ No ☐ Yes If yes, explain _____

k. Does patient have decubitis ulcers? ☐ No ☐ Yes If yes, what stage? _____

**Section II: General Equipment -- Complete All Applicable Responses**

12. General equipment selected for patient (complete all applicable items above in 11)
☐ New Equipment ☐ Replacement Equipment (Attach documentation)

a. Wheelchair
☐ Standard (11a-11k must be completed)
☐ Electric (Form 384 must be completed)
☐ Custom (Form 384 must be completed)

Accessories _____
(Type of Accessory / Weight of Patient / Depth)
_____
_____
_____

b. Hospital Bed ☐ variable ☐ fixed
☐ Semi electric
☐ Other (please specify) _____

Accessories _____
(Type of Accessory / Weight)
_____
_____

c. Hospital Bed Accessories:
Patient has physical and mental capacity to use equipment ☐ Yes ☐ No

| | | | | |
|---|---|---|---|---|
| Hydraulic lift with: | ☐ Seat | or | ☐ Sling | |
| Trapeze bar | ☐ Standard | or | ☐ Heavy Duty | Patient's weight _____ |
| Bed Rail | ☐ Yes | | ☐ No | Height _____ |

d. Ambulatory Devices
☐ Walker ☐ Crutches ☐ Quad Cane ☐ Three pronged cane

Form 342-A
4/2/08

Alabama Medicaid Agency
www.medicaid.alabama.gov

**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 ≥ 2, and ☐ Episode of home IV antibiotic therapy, and
b. ☐ FEV1 in one second < 80% of predicted value, or ☐ FVC is < 50% of predicted value, and
c. ☐ Need for chest physiotherapy ≥ 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 ≥ 360 minutes/6 hours ☐ Yes ☐ No
OR
For patients < 6 months old -- sleep study recorded for ≥ 240 minutes/4 hours ☐ Yes ☐ No
d. Sleep study documents
☐ RDI or AHI ≥ 5 per hour ☐ At least 30 apneas/hypopneas found in sleep study
☐ CPAP reduces sleep events by ≥ 50%
For BIPAP only ☐ Unsuccessful trial of CPAP or ☐ Patient is ≤ 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

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**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

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**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 <u>one</u> 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)

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**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.27 Request for National Correct Coding Initiative (NCCI) Administrative Review

**NOTE:**

The Request for National Correct Coding Initiative (NCCI) Administrative Review Form may be downloaded from the Medicaid website at www.medicaid.alabama.gov.

# E.28 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)**<br>**1.** ☐ **2.** ☐ **3.** ☐ | |
| **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:

_____

_____

_____

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

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

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