E Forms

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

The following forms may be obtained by contacting the following:

Form Name	*Contact*	*Phone*
Certification and Documentation of Abortion	Communications	(334) 353-5203
Check Refund Form	Gainwell Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	Gainwell Provider Assistance Center	(800) 688-7989
Hysterectomy Consent Form	Communications	(334) 353-5203
Patient Status Notification (Form 199)	Gainwell Provider Assistance Center	(800) 688-7989
Prior Authorization Form	Gainwell 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
PCP Override Request Form	Managed Care Network Provider Assistance Unit	(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Request for Administrative Review of Outdated Medicaid Claim	System Support Unit	(334) 242-5562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	Gainwell Provider Assistance Center	(800) 688-7989

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

E.1 Certification and Documentation of Abortion

ALABAMA MEDICAID AGENCY

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*
By entering my name above I agree to the contents of this document.	
Date of Surgery	

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

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

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

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

PHY-96-2 (Revised 09/29/16) Alabama Medicaid Agency

E.2 Check Refund Form

Check Refund Form (REF-02)

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

Provider Name _____ NPI Number_____

Check Number_____ Check Date _____ Check Amount _____

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

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

_____

_____

Signature _____ Date _____ Telephone_____

Revised 01/06/16

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	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: _____

_____

_____

_____

_____

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 5/28/13

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.4 Hysterectomy Consent Form

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 *Medicaid Number*
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. I further certify that the procedure is being performed for the treatment of disease and not for the prevention of disease or prophylaxis.

_____ _____
Typed or Printed Name of Physician *Medicaid Provider Number*

_____ _____
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 with legal authority. Attach legal documents. *Date*

PART III. **DATE OF SURGERY**

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-51243 *(Revised 06/16/2026)* *Alabama Medicaid Agency*

Hysterectomy Form Instructions

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

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

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

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

Part III.
This section is required for all hysterectomies.

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

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.

- Enter name of the patient.
- Enter the recipient's 13-digit Medicaid Number.
- Enter the name of the physician who performed the surgery.
- Check the appropriate box to indicate the specific unusual circumstance.
- Check the appropriate box regarding whether the patient was informed she would be permanently incapable of reproducing as a result of the operation.
- Physician must sign their name and enter the date of signature.

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

SUBMISSION INSTRUCTIONS:
Effective October 26, 2016, the physician must submit this form via Provider Web Portal upload or fax with supporting medical records (Medical History, Operative Records, Discharge Summary and a Hospital Consent Form for Hysterectomy) and claim to Gainwell.

Refer to Chapter 5 (Filing Claims) for instructions on the digital submission of the Hysterectomy Consent Form and supporting documentation.

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

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

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

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

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ( )

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 ____

( ) Medical Care	( ) Home Health Visits	( ) Occupational Therapy
( ) Surgical	( ) LTC Waiver	( ) Physical Therapy
( ) DME-Purchase	( ) Medically-Related Transportation	
( ) DME-Rental	( ) Maternity	( ) Psychiatric*
( ) Dental Care	( ) Inhalation Therapy	( ) Speech Therapy
( ) Oral Surgery	( ) Private Duty Nursing	( ) Vision-Optometry
( ) Home Health Care	( ) Prosthetic Device	( ) Case Management

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

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

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

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

Signature of Requesting Provider _____ Date _____

FORWARD TO: Gainwell Technologies, P.O. Box 244036 Montgomery, Alabama 36124-4032

Form 342
Revised 4-2016

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.7 Sterilization Consent Form

ALABAMA MEDICAID AGENCY STERILIZATION CONSENT FORM

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

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____
Physician or 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 Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

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

I understand that I will be sterilized by an operation known as a

_____
Specify Type of Operation

The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

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

I am at least 21 years of age and was born on _____.
Month/Day/Year

I, _____
Name of the Recipient

hereby consent of my own free will to be sterilized by

_____
Physician or Clinic

by the method called _____.
Specify Type of Operation

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about this operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

X _____ X _____
Recipient's Signature Date

_____
Type/Print Recipient's Name

_____
Recipient's Medicaid Number

INTERPRETER'S STATEMENT

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

_____ _____
Interpreter's Signature Date

Form 193 (Rev. 9-26-2016)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____.
Name of the Recipient

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

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

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

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

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

X _____ X _____
Signature of Person Obtaining Consent Date

_____
Type or Print Name

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ on X _____
Name of the Recipient Date of Sterilization

I explained to him/her the nature of the sterilization operation _____.
Specify Type of Operation

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

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

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

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

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

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

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

☐ Premature delivery
Recipient's expected date of delivery: _____

☐ Emergency abdominal surgery **(describe circumstances in an attachment)**

X _____ X _____
Physician's Signature Date

Type/Print Name _____

NPI Number _____

E.8 Family Planning Services Consent Form

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

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

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ Date: __________________________________

Signature: ______________________________ Signature: ______________________________
Date: __________________________________ 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 Prior Authorization Change Request Form

Alabama Medicaid Agency
Prior Authorization (PA) Change Request

Supplier Information	
Contact Name:	
NPI:	
Phone Number:	

Recipient Information	
Recipient Name:	
Medicaid ID:	

Prior Authorization Number	

Reason for Change *Please use this section to denote what field(s) on the PA request require a change. Complete all applicable fields below.* *Examples: Add/Change Modifier: Add "RR" to "E1088"* *Correct Date(s) of Service: Change requested effective date from 08/01/2010 to 10/01/2010*	
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)	

Comments

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.

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.

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.

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 .

E.15 Maximum Unit Override

NOTE:

The Pharmacy Override Form 409 may be downloaded from the Medicaid website at 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.

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

EPSDT CHILD HEALTH MEDICAL RECORD

Name_____ Medicaid Number _____
Last First Middle

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

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

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

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

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

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

MEDICAL HISTORY

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

Hospitilizations (year & reason)_____

Updates (each screening)_____

Form 172
Revised 1/1/97 Alabama Medicaid Agency

DEVELOPMENTAL ASSESSMENT

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

ANTICIPATORY GUIDANCE

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

2 Weeks to 3 Months_____
Dates completed

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

4 to 6 Months_____
Dates Completed

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

7 to 12 Months_____
Dates completed

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

13 to 18 Months_____
Dates completed

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

19 to 24 Months_____
Dates Completed

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

3 to 5 Years_____
Dates completed

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

6 to 13 Years_____
Dates completed

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

14 to 21 Years_____
Dates completed

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

NUTRITIONAL ASSESSMENT

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

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

Page 3

LABORATORY TESTING

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

Date	PROGRESS NOTES	SIGNATURE

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 **Alabama Medicaid Agency**
Page 4 of 4

E.18 Alabama Medicaid Agency Referral Form

ALABAMA MEDICAID REFERRAL FORM
PHI-CONFIDENTIAL

Today's Date _____

Date Referral Begins _____
(if different from above)

Important NPI Information
See Instructions

Medicaid Recipient Information

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

Primary Care Provider /Alabama Coordinated Health Care Network Information

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

Screening Provider (if different from PCP)

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

Type of Referral

- ☐ PCP/ACHN
- ☐ EPSDT Screening Date _____
  Select one of the following types of EPSDT Screenings:
  - ☐ Periodic
  - ☐ Interperiodic
- ☐ Case Management / Care Coordination
- ☐ Lock-in
- ☐ Other (please describe) _____

Length of Referral

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

Referral Valid For

- ☐ Evaluation Only
- ☐ Evaluation and Treatment
- ☐ Referral by consultant to other provider for identified condition (cascading referral)
- ☐ Referral by consultant to another provider for additional conditions diagnosed by consultant (cascading referral for EPSDT only)
- ☐ Treatment Only
- ☐ Hospital Care (Outpatient)
- ☐ Performance of Interperiodic Screening (if necessary)
- ☐ For Billing Purposes Only
- ☐ Other (please describe) _____

Reason for referral by PCP/ACHN	Other conditions/diagnoses identified by PCP

Consultant Information (Consultant can be an individual provider or a provider group)

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 PCP

Findings should be submitted to Primary Care Physician (PCP) by

☐ Mail ☐ E-mail ☐ Fax ☐ In addition, please telephone

Form 362
Revised 10/2019

Alabama Medicaid Agency
www.medicaid.alabama.gov

10/2019

Instructions for Completing
The Alabama Medicaid 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 CARE PROVIDER (PCP)- Provide all Provider information. For hard copy referrals, the printed, typed, or stamped name of the PCP with an original signature of the physician or designee is required. Stamped or copied signatures will not be accepted. For electronic referrals provider certification is made via standardized electronic signature protocol.

SCREENING PROVIDER- Screening provider (if different from primary provider) must complete and sign if the referral is the result of an EPSDT screening.

NPI INFORMATION- Provide the NPI number of the referring PCP. For billing purposes, indicate Medicaid Provider number, if available.

TYPE OF REFERRAL:

- **PCP/ACHN**- Referral to specialist/consultant. (See *Chapter 40 for Claim Filing Instructions).
- **EPSDT** - Referral resulting from an EPSDT screening. – indicate screening date (See *Appendix A for Claim Filing Instructions)
  Select one of the following types of EPSDT Screenings:
  - **Periodic**- Well-child checkups that are based on a periodicity schedule
  - **Interperiodic**- Problem-focused and abnormal screenings that are medically necessary for undiagnosed conditions outside the periodicity schedule
- **Case Management/Care Coordination** - Referral for case management services through Network Care Coordinators (See *Chapter 40 for ACHN contact information).
- **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).
- **Other** – All other referral types. (Describe referral type)

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 PCP.
- **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 PCP's NPI, refer recipient to another specialist as indicated for the condition identified on the referral form without having to get an additional referral from the PCP.
- **Referral by consultant to another 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 PCP. **(EPSDT ONLY)**
- **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.
- **For Billing Purposes Only**—For ACHN Referrals to specialists/consultants when a PCP is not attributed.
- **Other** – All other referral validation types (i.e. DME). (Describe referral validation type)

REASON FOR REFERRAL BY PCP/ACHN- Indicate the reason/condition the recipient is being referred.

OTHER CONDITIONS/DIAGNOSIS IDENTIFIED BY PCP- Indicate any condition present at the time of initial exam by PCP.

CONSULTANT INFORMATION- Consultant's name, address and telephone number. The consultant can be an individual provider or provider group.

PLEASE SUBMIT FINDINGS TO PCP- The PCP should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.

*The Alabama Medicaid Provider Manual is available on the Alabama Medicaid website at http://www.medicaid.alabama.gov

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

(PRTF LETTERHEAD)
NAME OF THE PRTF
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 *Psych Under 21* (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 21st of each year (or by the next business day if July 21st 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 02/04/2021
This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

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

This form is required for Medicaid recipients under age 21 who are admitted to an Alabama psychiatric residential treatment facility (PRTF) on an emergency basis or for individuals who become eligible for Medicaid after admission to the PRTF. 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 02/04/2021***

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

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

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

Recipient Name **Recipient Medicaid Number**

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

Facility Name and Address **Planned Admission Date**

PHYSICIAN CERTIFICATION:

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

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

Physician Address **License Number**

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

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

Form 370 *Revised 02/04/2021*
This form can be downloaded from the Alabama Medicaid Agency web site: www.medicaid.state.al.us.

E.22 PCP Override Request Form

PCP Override Request Form

Please fill out this form **completely** to request a PCP override when you have received a denial for referral services **or** the Primary Care Provider (PCP) has not authorized treatment for **past** date(s) of service. You may also use this form to request an override for a BMI that cannot be obtained. The request must be submitted to Medicaid's Network Provider Assistance Unit within 90 days of the date of service. Attach a **"clean claim"** with any supporting documentation to this form and mail to the Network Provider Assistance Unit at the address below. The Network Provider Assistance Unit will process your request within 60 days of receipt. If your request is approved, the corrected claim will be sent to DXC and will be processed. If your request is denied, Managed Care Operations 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
Network Provider Assistance Unit
501 Dexter Avenue
Montgomery, AL 36103

Recipient's name:_____Medicaid number: _____

Recipient's telephone number: (_____)_____Date(s) of service: _____

Name of PCP:_____PCP's telephone number: (_____)_____

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

Reason PCP stated he would not authorize treatment: _____

_____

I am requesting an override due to: **(Please check applicable)**

☐ Recipient not attributed to a PCP
☐ Unable to contact or identify the PCP **Please explain**: _____

_____

☐ Unable to obtain BMI (must submit documentation to support reasoning) **Please explain**: _____

_____

☐ Other **Please explain**: _____

_____

Provider name: _____

NPI #_____

Form completed by: _____

Telephone_____Fax _____

Form 391
Revised 12/2019

Alabama Medicaid Agency
www.medicaid.alabama.gov

E.23 Request for Administrative Review of Outdated Medicaid Claim

Alabama Medicaid Agency

Request for Administrative Review of Outdated Medicaid Claim

This form is to be completed only if the claim is more than one year old from the date of service.

Section A

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

I do not agree with the determination made on my EOB dated: __/__/____

Section B

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

_____

_____

_____

_____

_____

_____

Section C

Provider or representative's signature:
Provider or representative's signature;
Provider or representative's name:
Address(Street, City, State and Zip):
Date:

Form 404 Rev. 02/26/2016

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

7.2.1 Administrative Review and Fair Hearings

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

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

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

E.24 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

---

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.25 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:

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 403
Created 3-21-2011

Alabama Medicaid Agency

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.26 Request for NCCI Redetermination Review Form

gainwell

Request for NCCI Redetermination Review
Gainwell Technologies
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. ☐ 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

E.27 Medicaid Other Insurance Attachment Form

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

OTHER INSURANCE ATTACHMENT

1. Billing Provider ID	a. NPI	**Name**	b.
2. Medicaid ID	a.	**Name**	b.

3. List other payors in order of responsibility. Sequence 1=Primary, 2=Secondary, 3=Tertiary

SEQ	a. HEALTH PLAN ID	b. PAYOR NAME AND ADDRESS	c. POLICY NUMBER	d. DATE PAID
1.				
2.				
3.				

4. Indicate TPL payment amounts per claim detail. (Note: For header amount on Institutional claims use detail number 0.)

a. DTL	b. PAYOR SEQ	c. COPAY	d. COINSURANCE	e. DEDUCTIBLE	f. TPL PAID

Submit completed claim to:

Gainwell
Post Office Box 244032
Montgomery, AL 36124-4032

Form ALTPL-01 10/12

E.28 Medical Medicaid/Medicare Related Claim Form

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

MEDICAL MEDICAID/MEDICARE RELATED CLAIM

1. RECIPIENT INFORMATION

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

2. OTHER INSURANCE INFORMATION

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

3. DIAGNOSIS CODES

A_____ B._____ C._____ D._____ E._____ F._____

G._____ H._____ I._____ J._____ K._____ L._____

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

5. DETAIL OF SERVICES PROVIDED

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

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

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

Submit completed claim to:

Gainwell Technologies
Post Office Box 244032
Montgomery, AL 36124-4032

9. Billing Provider mailing address required in block below:

Form 340 Revised 10/12

E.29 Request for Medical Utilization Redetermination (First Level of Appeal)

Alabama Medicaid Agency

Request for Medical Utilization Redetermination

First Level of Appeal

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

Section A

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

I do not agree with the determination made on my EOB dated: __/__/____

Section B

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

_____

_____

_____

_____

Section C

Provider or representative's signature:
Provider or representative's signature;
Provider or representative's name:
Address(Street, City, State and Zip):
Date:

Form 401 Rev 02/26/2016

E.30 Request for Medical Utilization Redetermination (Second Level of Appeal)

Alabama Medicaid Agency

Request for Medical Utilization Redetermination

Second Level of Appeal

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

Section A

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

I do not agree with the determination made on my EOB dated: __/__/____

Section B

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

_____

_____

_____

_____

Section C

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

Form 402 Rev 02/26/2016

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