



**ALABAMA MEDICAID AGENCY
EPSDT REFERRAL FOR SERVICES**

Date of screening

TO BE COMPLETED BY REFERRAL PROVIDER

Name and address of CONSULTANT		Name of Screening provider USA Family Practice 1504 Springhill Ave. Mobile, AL 36604	
Provider phone number 4343475		Screening provider no. and signature	
Appointment date & time		Medical record number	
Name of patient	Date of Birth	Medicaid number 000	
Patient address		Phone number	
Reason for referral		Additional health problems	
This referral is valid for <u>12</u> months from date of screening. (maximum of 12 months)			
Printed Name and title of PMP	Referral/PMP Provider No. 000810619	Signature of PMP	
PMP Address USA Family Practice 1504 Springhill Ave. Mobile, AL 36604	PMP Phone number 434 3475	PMP Fax number 434 5047	
TO THE REFERRING PROVIDER: FORWARD WHITE AND YELLOW COPIES TO CONSULTANT RETAIN PINK COPY FOR YOUR FOLLOW-UP			

Date of Examination or service _____ Diagnosis/es _____

CONSULTANT'S REPORT - Please write below or attach report to assure payment: Include summary of treatment rendered, treatment plan and duration, and estimated number of visits.

Printed Name and title of consultant _____ Signature of consultant _____

TO THE CONSULTANT: RETURN WHITE COPY TO THE SCREENING PROVIDER - RETAIN YELLOW COPY FOR YOUR FILE. SEE ADDITIONAL INSTRUCTIONS ON THE BACK OF THIS FORM. THIS WILL BECOME A PART OF THE PATIENT'S MEDICAL RECORDS.