Alabama CommunityCare

Care Management Referral Form

Cullman, Limestone, Madison and Morgan Counties

Form must be completely filled out in order to be processed

Patient Name: _____Date: _____

DOB: _____ Sex ○ M ◉ F Phone _____

Medicaid #: _____ Primary Language: _____

Home Address: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact: _____Phone: _____

Referring Physician / Facility: _____

Facility Contact: _____ Phone: _____

Facility Email: _____ Fax: _____

Qualifying Chronic Condition:

- ☐ Asthma
- ☐ BMI greater than 25
- ☐ Bio-Monitoring (ADPH will contact)
- ☐ Cancer
- ☐ COPD
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Dietitian Services (Additional info required)
- ☐ Hepatitis C
- ☐ HIV
- ☐ Medication Management Assistance
- ☐ Mental Illness
- ☐ Organ Transplant
- ☐ Sickle Cell
- ☐ Substance Disorder

Reason for Referral / Reason for Dietitian Services:

_____

Special Instructions: _____

Send Referral form to Diane McCrary or Ross Hudson Fax: (888) 965-0510
Email (secure only): Referrals@alabamacommunitycare.org

Mailing: P.O. Box 18926
Huntsville, AL 35804

Phone: 256-382-2590
FAX: 888-965-0510
www.alabamacommunitycare.org

Toll Free: 1-855-640-8827
TTY #: 1855-219-6599