

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 11-018	2. STATE: Alabama
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE: October 1, 2011	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)


6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 441.30	7. FEDERAL BUDGET IMPACT: a. FFY 11 Cost to Agency \$.00 b. FFY 12 Cost to Agency \$.00
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: State Plan Amendment 3.1A page 2.5, Attachment 3.1-A page 2.5a, Attachment 3.1-A page 3, Attachment 3.1-A page 3.6, Attachment 4.19-B page 2a, Preprint page 27	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): State Plan Amendment 3.1A page 2.5, Attachment 3.1- A page 2.5a, Attachment 3.1-A page 3, Attachment 3.1-A page 3.6, Attachment 4.19-B page 2a, Preprint page 27

10. SUBJECT OF AMENDMENT:

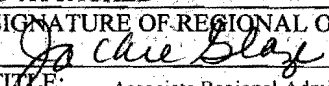
This amendment will define services an optometrist is legally authorized to perform as physicians' services under this plan and are reimbursed whether furnished by a physician or an optometrist.

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Governor's designee on file
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL via letter with CMS

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: R. Bob Mullins, Jr., MD Commissioner Alabama Medicaid Agency 501 Dexter Avenue Post Office Box 5624 Montgomery, Alabama 36103-5624
13. TYPED NAME: R. Bob Mullins, Jr., MD	
14. TITLE: Commissioner	
15. DATE SUBMITTED: 9-16-11	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/15/11	18. DATE APPROVED: 12/07/11
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/11	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Jackie Glaze	22. TITLE: Associate Regional Administrator Division of Medicaid & Children Health Opns
23. REMARKS:	