Division of Medical Services
Arkansas Medicaid Primary Care Physician Managed Care Program
Referral Form

Member Information:

First Name_____ Last Name _____ Middle Initial _____

Medicaid ID#_____ Social Security #_____

Birth Date (mm/dd/yyyy) _____

Mailing Address_____ City _____ State _____ Zip _____

Home Phone_____ Cell Phone _____

Email address _____

Medicaid Providers Receiving Referral:

Per Medicaid policy (Section 171.400, B.) two or more providers of the same type or specialty must be listed in the receiving referral section to ensure member free choice.

1. _____ _____ _____
   Physician first and last name | Medicaid Provider ID# | Date of referral

2. _____ _____ _____
   Physician first and last name | Medicaid Provider ID# | Date of referral

I have performed a clinical assessment of the patient named above whom I am referring for the service listed below:

_____
_____
_____

Please advise me as appropriate, of your medical findings and diagnosis, treatment plan and/or services you provide as a result of this referral. Please note that services beyond the scope of this referral require a new referral. **Referrals for ongoing services require renewal at least every 6 months**.

____Yes ____No Referral is for a diagnostic or corrective treatment identified during an initial or periodic EPSDT screening service.
(Please check one)

Primary Care Physician (PCP) Name _____

(Please print, stamp, or type physician's name)

Medicaid Provider Number/Taxonomy Code _____

PCP Signature_____

PCP Phone Number_____

Date (mm/dd/yyyy)_____