

**Division of Medical Services  
Arkansas Medicaid Primary Care Case Management Program  
Referral Form**

**Member Information:**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Medicaid ID# \_\_\_\_\_ Social Security # \_\_\_\_\_  
Birth Date \_\_\_\_\_  
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. \_\_\_\_\_  
Provider first and last name                      Medicaid Provider ID#                      Date of referral
2. \_\_\_\_\_  
Provider 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 Provider (PCP) Name \_\_\_\_\_  
(Please print, stamp, or type provider's name)

Medicaid Provider Number/Taxonomy Code \_\_\_\_\_

PCP Signature \_\_\_\_\_

PCP Phone Number \_\_\_\_\_

Date \_\_\_\_\_