

**Arkansas Division of Medical Services (DMS)  
Applied Behavior Analysis (ABA) Therapy Services  
for Medicaid Eligible Beneficiaries under Age 21  
TREATMENT PRESCRIPTION (DMS-641 TP)**

The patient's Arkansas Medicaid assigned primary care provider (PCP) or substitute/affiliated physician must use this form to prescribe applied behavior analysis (ABA) therapy services. Providers are responsible for renewing treatment prescriptions in accordance with Section 212.400 of the Applied Behavior Analysis Therapy Medicaid manual.

Patient Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Date Patient Last Seen In Office: \_\_\_\_\_

\_\_\_\_\_  
PCP or Substitute/Affiliated Physician Name (Please Print)

\_\_\_\_\_  
PCP or Substitute/Affiliated Physician Medicaid ID #

Is the prescribing practitioner the patient's Arkansas Medicaid assigned PCP?  Yes (**one must be checked**)  No

If "No," include the assigned PCPs name/Medicaid # and reason unavailable: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Primary Diagnosis: Autism Spectrum Disorder ICD 10 Code: F84.0

Secondary Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_  
(if applicable)

\_\_\_\_\_ ICD 10 Code: \_\_\_\_\_  
(if applicable)

<b>Applied Behavior Analysis (ABA) Therapy Treatment</b>	
_____	Average Minutes per week
_____	Duration (months)

Is the patient currently receiving/prescribed day habilitative, occupational therapy, physical therapy, or speech-language pathology services?

Yes  No  
**(one must be checked)**

If "Yes," please indicate each service the patient is currently receiving/prescribed, and in which setting(s) each service is provided (i.e. EIDT, school, private clinic/outpatient, rehabilitation clinic, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***I hereby certify that I have carefully reviewed the comprehensive evaluation and recommended individualized treatment plan (ITP) and believe the prescribed frequency, intensity, and duration of ABA therapy treatment services are medically necessary. If this is a continuing plan, I have reviewed the patient's progress and adjusted the prescription for their meeting or failing to meet their ITP goals and objectives.***

\_\_\_\_\_  
PCP or Substitute/Affiliated Physician Signature

\_\_\_\_\_  
Date

**Instructions for Completing  
Form DMS-641TP - Applied Behavior Analysis (ABA) Therapy Services  
TREATMENT PRESCRIPTION (TP)**

**Primary Care Provider (PCP) office must complete the following:**

- Patient Name – Enter the patient’s full name.
- Medicaid ID # – Enter the patient’s Medicaid ID number.
- Patient Date of Birth – Enter the patient’s date of birth.
- Date Patient Was Last Seen In Office – Enter the date of patient’s last office visit. This could have been for a complete physical examination, routine check-up, or office visit for other reasons.
- PCP or Substitute/Affiliated Physician Name and Medicaid ID Number – Print the name of the prescribing PCP or substitute/affiliated physician and their Medicaid ID number.
- Is Prescribing Practitioner the Patient’s Arkansas Medicaid Assigned PCP – Check the box indicating whether the prescribing practitioner signing this DMS-641 TP is the patient’s Arkansas Medicaid assigned PCP.
  - The patient’s Arkansas Medicaid assigned PCP must sign a patient’s *initial* DMS-641TP prescription for ABA therapy services. The use of a substitute or affiliated physician is not allowed.
  - If a substitute physician is issuing a patient’s renewal prescription, then the name and Medicaid # of the patient’s Arkansas Medicaid assigned PCP must be provided along with the reason the assigned PCP is unavailable. See Sections 171.600 and 212.400 of the Applied Behavior Analysis Therapy Service Medicaid manual regarding permitted substitutes for an assigned PCP.
- Diagnosis/ICD 10 Code – The patient’s primary diagnosis must be autism spectrum disorder to be eligible for applied behavior analysis services, and the PCP or substitute/affiliated physician should enter any secondary (if applicable) diagnoses and corresponding international classification of diseases (ICD) – 10th revision code(s) applicable to the diagnosis.
- Applied Behavior Analysis (ABA) Therapy Treatment – Enter the prescribed average number of minutes per week and the duration (in months) of the ABA therapy treatment services.
- Day habilitative, occupational, physical, and speech therapy services – Check the box indicating whether the patient is already prescribed/receiving day habilitative, occupational therapy, physical therapy, or speech-language pathology services. If the patient is already prescribed one of those services, indicate the setting(s) in which each service is currently provided to the patient.
- PCP or Substitute/Affiliated Physician Signature and Date – The prescribing PCP or substitute/affiliated physician must sign and date the DMS-641 TP in their original signature unless electronic signature is used. Medicaid’s criteria for electronic signatures as stated in Ark. Code Ann. § 25-31-103 must be met. Providers will be compliant if a scanned copy of the original document is kept in a format that can be retrieved for a specific beneficiary.