DIVISION OF MEDICAL SERVICES
ARKANSAS MEDICAID PRIMARY CARE PHYSICIAN MANAGED CARE PROGRAM

REFERRAL FORM

Medicaid Provider Receiving Referral

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

Please advise me, as appropriate, of your medical findings and diagnosis, treatment plan and/or services you provide subsequent to 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.

Medicaid Beneficiary Name

Medicaid I.D. Number

Primary Care Physician (PCP) Name
(Please print, stamp or type physician's name)

PCP Provider ID Number/Taxonomy Code

PCP Signature

PCP Phone Number

Date

DMS-2610 (Rev. 4/07)