

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

REFERRAL FORM

Methodist Behavioral Hospital/Methodist Children's Home

Medicaid Provider Receiving Referral:

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

Long-Term Psychiatric Residential Treatment where he/she can receive 24-hour therapeutic services.

NOTES: Mental Health Services: Including, but not limited to evaluation, treatment, individual, group, family, and on/off site therapy services. Hospital consultation for medical care and medication management as needed and transportation (if applicable). Occupational therapy evaluation, speech therapy evaluation and physical therapy evaluation as needed.

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 Recipient Name

Medicaid Recipient I.D. Number

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

PCP Medicaid Provider Number

PCP Social Security Number , EIN
or Federal ID Number

PCP Signature

PCP Phone Number

Date