Arkansas Division of Medical Services

Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21
PRESCRIPTION/REFERRAL

The **Primary Care Physician** (PCP) or attending physician must use this form to make a referral for evaluation or prescribe medically necessary Medicaid therapy services. The PCP or attending physician must check the appropriate box or boxes indicating the modality. Providers of therapy services are responsible for obtaining renewed PCP referrals every 6 months in compliance with Section I 171.400 and Section II 214.00 of the Arkansas Medicaid Therapy services provider manual. **REFERRAL LOCATION:** _____

Referral (check all that apply) ▢ OT ▢ PT ▢ ST ▢ DT ▢ Treatment

EVALUATE/TREAT IS NOT A VALID PRESCRIPTION

Patient Name: _____ Medicaid ID #: _____DOB:_____

Date Child Was Last Seen In Office: _____

Diagnosis as Related to Prescribed Therapy: _____

Complete this block if this form is a prescription			
Occupational Therapy (OT)	**Physical Therapy (PT)**	**Speech Therapy (ST)**	**Developmental Therapy (DT)**
_____ Minutes per week	_____ Minutes per week	_____ Minutes per week	_____ Minutes per week
_____ Duration (months)	_____ Duration (months)	_____ Duration (months)	_____ Duration (months)
☐ *Therapy Not Medically Necessary*	☐ *Therapy Not Medically Necessary*	☐ *Therapy Not Medically Necessary*	☐ *Therapy Not Medically Necessary*

Other Information: _____

Note:

	OT	***PT***	***ST***
Expenditures for SFY15	****$46,259,404***	****$35,025,080***	****$70,442,268***
Average Units Per Beneficiary	***94***	***94***	***97***
Average Cost Per Beneficiary	***$1,930***	***$1,892***	***$1,945***
Total Beneficiaries Served	***23,957***	***18,505***	***36,217***

_____ _____
Primary Care Physician (PCP) Name *(Please Print)* Provider ID Number/Taxonomy Code

_____ _____
Attending Physician Name *(Please Print)* Provider ID Number/Taxonomy Code

By signing as the PCP or Attending Physician, I hereby certify that I have carefully reviewed each element of the therapy treatment plan, that the goals are reasonable and appropriate for this patient, and in the event that this prescription is for a continuing plan I have reviewed the patient's progress and adjusted the plan for his or her meeting or failure to meet the plan goals.

_____ _____
Physician Signature *(PCP or attending Physician)* Date

Return To (name of provider): *Creative Kids Therapy fax: 870-558-5637*

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