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

REFERRAL FORM

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Medicaid Provider Receiving Referral

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

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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
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PCP Signature	PCP Phone Number

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Date

DMS-2610 (REV.4/07)