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

REFERRAL FORM

Behavioral Health Services of Arkansas

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Youth Home, Inc.
10 Corporate Hill Drive, Suite 330
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Ph.# (501) 954-7470 ▪ Fax# (501) 954-7420

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

Mental Health Services to include Evaluation & Treatment

Referral Dates: _____

Please advise me, as appropriate, of your medical findings and diagnosis, treatment plan and/or service 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 six **(6) months**.

_____ _____
Medicaid Recipient Name & Date of Birth **Medicaid Recipient I.D. Number**

_____**M.D.** _____
Primary Care Physician (PCP) Name **PCP Medicaid Provider Number**

_____
PCP NPI Number

_____ _____
PCP Telephone Number **PCP Fax Number**

_____ _____
PCP Signature **Date PCP Signed Referral**