

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
Little Rock, Arkansas 72205
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

Primary Care Physician (PCP) Name M.D.

PCP Medicaid Provider Number

PCP NPI Number

PCP Telephone Number

PCP Fax Number

PCP Signature

Date PCP Signed Referral

If this request has been faxed, this facsimile may contain PROTECTED HEALTH INFORMATION of a sensitive and confidential nature. It has been faxed to you with the authorization of the patient or under circumstances where authorization is not required. This information is intended for the use of the person or entity to which it is addressed and may contain information that is confidential or privileged, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is strictly prohibited. If you have received this facsimile by error, please notify us immediately by replying to this fax and by destroying the original.