ABSOLUTE Pediatric THERAPY

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 (check all that apply) ☐ OT ☐ PT ☐ ST ☐ DT ☐ Treatment

EVALUATE/TREAT IS NOT A VALID PRESCRIPTION

Patient Name: _____ Medicaid ID #: _____

Date Child Was Last Seen In Office: _____

Diagnosis as Related to Prescribed Therapy: **Suspected Developmental Delays**

Complete this block if this form is a prescription		
Occupational Therapy (OT)	**Physical Therapy (PT)**	**Speech Therapy (ST)**
_____Minutes per week	_____Minutes per week	_____Minutes per week
_____Duration (months)	_____Duration (months)	_____Duration (months)
☐ 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 patients 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): Absolute Pediatrics Fax Number: 479-553-7954

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