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

REFERRAL FORM

Pinnacle Pointe Hospital
Medicaid Provider Receiving Referral

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

Mental Health evaluate and treat

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 Recipient Name

Medicaid Recipient I.D. Number

Primary Care Physician (PCP) Name
(Please print, stamp or type physician name)

PCP Medicaid Provider Number

PCP Signature

PCP Phone Number

Date

DMS-2610 (R 4/96)