

Arkansas Division of Medical Services

**Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries
Under Age 21
PRESCRIPTION/REFERRAL**

The PCP or attending physician must use this form to prescribe medically necessary Medicaid therapy services or must use this form to make a referral for therapy services. The provider must check the appropriate box or boxes.

Referral

Treatment

EVALUATE/TREAT IS NOT A VALID PRESCRIPTION

Patient Name: _____ Medicaid ID #: _____

Date Child Was Last Seen In Office: _____

Primary Diagnosis or ICD-9 code: _____

Diagnosis as Related to Prescribed Treatment: _____

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 SFY08	*\$30,209,065	*\$17,389,858	*\$32,842,746
Average Units Per Beneficiary	155	45	67
Average Cost Per Beneficiary	\$1,577	\$726	\$1,112
Total Beneficiaries Served	15,465	20,886	24,708

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

Instructions for Completion

Form DMS-640 – Occupational, Physical and Speech Therapy for Medicaid Eligible Beneficiaries Under Age 21 PRESCRIPTION/REFERRAL

- If DMS-640 is used to make an initial referral for evaluation, check the referral box only. After receiving the evaluation results and determining that therapy is necessary, you must use a separate DMS-640 form to prescribe the therapy. Check the treatment box for prescription and complete the form following the instructions below. If the referral and prescription are for previously prescribed services, you may check both boxes.
- Patient Name – Enter the patient’s full name.
- Medicaid ID # - Enter the patient’s Medicaid ID number.

Physician/Physician’s office staff must complete the following:

- Date Child Was Last Seen In Office – Enter the date of the last time you saw this child. (This could be either for a complete physical examination, a routine check-up or an office visit for other reasons requiring your personal attention.)
- Primary Diagnosis – Enter the primary medical diagnosis description or ICD-9 diagnosis code.
- Diagnosis as Related to Prescribed Treatment – Enter the diagnosis that indicates or establishes medical necessity for prescribed therapy.
- Prescription block – If the form is used for a prescription, enter the prescribed number of minutes per week and the prescribed duration (in months) of therapy.
- If therapy is not medically necessary at this time, check the box.
- Other Information – Any other information pertinent to the child’s medical condition, plan of treatment, etc., may be entered.
- Primary Care Physician (PCP) Name and Provider ID Number/Taxonomy Code – Print the name of the prescribing PCP and his or her provider identification number and taxonomy code.
- Attending Physician Name and Provider ID Number/Taxonomy Code – If the Medicaid-eligible child is exempt from PCP requirements, print the name of the prescribing attending physician and his or her provider identification number and taxonomy code.
- Physician Signature and Date – The prescribing physician must sign and date the prescription for therapy in his or her original signature.

***These therapy amounts include therapy provided in a Developmental Day Treatment Center (DDTCS)**

The original of the completed form DMS-640 must be maintained in the child’s medical records by the prescribing physician. A copy of the completed form DMS-640 must be retained by the therapy provider.