**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

DMS-640 (Rev. 09/09)

## 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.