Arkansas Division of Medical Services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
PRESCRIPTION/REFERRAL
For Medically Necessary Services/Items not Specifically included in the Medicaid State Plan

The primary care physician (PCP) must use this form to prescribe medically necessary services resulting from an EPSDT screen when the services are not specifically included in the Arkansas Medicaid State Plan. Please refer to Section I of your Arkansas Medicaid Child Health Services (EPSDT) manual for a list of covered services. Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) is defined as follows: a benefit provided for screening, vision, hearing and dental services at intervals which meet reasonable standards of medical and dental practice established after consultation with recognized medical and dental organizations involved in child health care. EPSDT covers any medically necessary service that will lead to the maximum reduction of medical and physical disabilities and restore the child to his or her best possible functional level. Services that are necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be considered for EPSDT beneficiaries under age 21 regardless of whether the service is otherwise included in the Arkansas Medicaid State Plan.

The PCP must check the appropriate box or boxes and complete and sign the form. A copy of the EPSDT screen results (form CMS-1500) may be attached.

☐ Prescription/Treatment ☐ Referral

Patient Name: _____ Medicaid ID #: _____

Date of Last Physical Examination: _____

Medical Diagnosis: _____

Developmental Diagnosis: _____

Other Diagnosis: _____

Prescribed Treatment___ _____

_____

Primary Care Physician Name (Please Print) Provider Identification Number/Taxonomy Code

By signing as the primary care physician (PCP), I hereby certify that I have carefully reviewed the EPSDT screen result, and that the goals are reasonable and appropriate for this patient. If this prescription is for a continuing plan, I have reviewed the patient's progress and adjusted the plan based on his or her meeting, or failing to meet, the plan goals.

_____ _____

Primary Care Physician (PCP) Signature Date

Mail to: Division of Medical Services
Utilization Review
P.O. Box 1437, Slot S413
Little Rock, AR 72203-1437

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