Arkansas Children's
Referred Patient Requisition / Order / Referral
Ancillary Services

NOTE: ORDERS WILL NOT BE PROCESSED WITHOUT THE APPROPRIATE INFORMATION COMPLETED AND THE PHYSICIAN'S SIGNATURE AFFIXED.

Patient Name:	Insurance Company:
Patient Address:	Insurance Policy Number:
	Insurance Referral #:
Patient's Birthdate: Phone #:	Medicaid Policy Number:
Mother's First Name:	Pre Authorization#:
ACH Medical Record #:	**Medicaid Referral#: (NPI)**
Referring / Ordering MD:	**NOTE: Non-PCP providers must have a PCP referral on file for Medicaid patients**
Street:	Pre Authorization Time Frame
City: State: Zip:	Requested Date of Service___________________________

WRITE THE TEST / PROCEDURE / SUPPLY, LOCATION, AND THE APPROPRIATE DIAGNOSIS CODE IN THE SPACES BELOW.

All orders for tests /procedures /supplies must include the diagnosis /medical reason for the test. This must be an ICD 10 Diagnosis Code. All orders for supplies must also include the quantity.

Procedure / Supply	Location / Department	Please indicate the specific diagnosis code requiring the ordered test/procedure/supply. Do not use "rule out" diagnoses and avoid using "V" codes	
		ICD-10 Diagnosis	Diagnosis
Example: Sweat Test	**Pulmonary Lab**	**J45.909**	**Asthma Unspecified**
1.			
2.			
3.			
4.			
5.			
6.			

❏ Audiology Evaluation & Management
❏ Speech/Language/Feeding Evaluation & Management
❏ Patient will be seen in ACH clinic/or ASC same day as radiology testing

ORDERING PHYSICIAN/APN Printed ____

❏ Pregnancy Test if required for imaging study/procedure

Duration of Order _______________ Frequency of test/supply_____________

Source Document Name: ____ Date of Document__________________

Transcribed for ____________________________________by___________________________Title_____Date_________Time_______

Physician / APRN Signature: ____________________________________Printed Name: ________________Date:_________ Time:_______
The above signed Physician / APN certifies that the ordered tests/ procedures are medically necessary for the diagnosis and treatment of the patient. I am responsible for the care of the patient.

Contact Person: **Fax Results #:** **Phone Results#:**

Please fax this form to: 501-978-6440

For ACH Pulmonary Lab: 501-364-1887