ARKANSAS CHILDREN'S NORTHWEST
Referred Patient Requisition Order / Referral
Ancillary Services

Scheduling Phone Number: 479−725−6995
Fax Number: 479−725−6582

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

Patient Name: Patient Address: Patient's Birthdate: Phone #: Mother's First Name: ACH Medical Record #: Referring / Ordering MD: Street: City: State: Zip:	Insurance Company: Insurance Policy Number: Insurance Referral #: Medicaid Policy Number: Pre Authorization#: Medicaid Referral#: (NPI) **Note: Non−PCP providers must have a PCP referral on file for Medicaid patients** Pre Authorization Time Frame 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 Code	Diagnosis
Example: Sweat Test	**Pulmonary Lab**		**Asthma NOS**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Source Document Name: _____ Date of Document)_____

Scribed/Transcribed for _____by_____Title_____Date_____Time_____

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 directly to the specified service: 479−725−6582

Arkansas Children's Northwest
Address:
2601 Gene George Blvd.
Springdale, AR 72762

Nov 26, 2018