EPSDT SPECIALIZED SERVICES
TREATMENT REFERRAL INFORMATION FORM

Virginia Department of Medical Assistance Services
Early and Periodic Screening Diagnosis and Treatment Services

This form must be completed by a physician or nurse practitioner based on health conditions observed during the most recent EPSDT screening.

Patient Name	
Patient Medicaid ID	
Attending Physician NPI	
Attending Physician telephone number	

Fax completed form to: DMAS/Maternal and Child Health Division /Fax – 804.225.3961
For questions about EPSDT email epsdt@dmas.virginia.gov

Service Requested:	**CPT/HCPCS/Rev Code(s):**

Describe Medical Necessity/Selection Criteria specific to the affected health condition:

_____
_____
_____
_____
_____

Describe recent treatment related to this health condition:

_____
_____
_____
_____

Recommended Treatment Services, Amount Frequency and Discharge Criteria:

_____
_____
_____
_____
_____
_____
_____
_____

Attending Physician:_____Signature:_____Date:___/__/___

DMAS-355
9/10/2008