Dental Health Services

Specialty Referral Form - CA

Authorization Number: _____

Patient Signature

I have reviewed the following treatment plan. I authorize release of any information relating to this referral. I understand that I am responsible for deductible charges, copayments and all costs for services not covered by my Dental Health Services plan.

_____

Signed (patient or legal guardian of minor) Date

For General Provider Use:

_____

Patient Name Date of Birth Patient Phone Number Relationship to Subscriber

_____

Employee Name Employee Social Security Number

_____

Referring Dentist Provider # Address City, State, Zip

Treatment Requested (please include x-rays):

_____ **Endo** _____ **O.S.** *reason for extraction(s)* _____ **Pedo** *lifetime maximum of $500 is payable*

_____ **Perio** *Please include FMX; case description and number of each tooth that requires surgery; pre and post Scaling/curettage pocket depth comparison; documentation of Phase 1 Therapy; evidence of good oral hygiene for at least three months prior to referral*

Tooth Number	ADA Code	Reason for Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I request authorization for the treatment described on this form, which in my professional judgment is necessary. This request is made in accordance with current Dental Health Services requirements and guidelines.

_____

Signature of Referring Dentist License Number

For Dental Health Services Claims Department Use Only:

_____

Specialist Name Specialist Number

Treatment Authorized:

Tooth Number	ADA Code	Patient's Copayment	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*Pending any unprocessed claims there is $_____ remaining for pedo benefits

*Please send patient's radiographs to the specialist office.

_____

Signature Approval of Dental Health Services Representative Date

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