

Specialty Referral Request Form
 Pre-Authorization Direct Self Emergency

Referring Provider Name	Phone Number	Employee Name	ID #
Street Address		Street Address	
City, State, and ZIP Code		City, State, and ZIP Code	Home Phone
Employee Name	Group Number	Patient's Name	Birth Date Relationship

SPECIALIST <small>(check one)</small>	ATTESTATION <small>(Must be completed for the speciality type, or request will be returned)</small>	OTHER REASONS/NARRATIVE
<input type="checkbox"/> ENDODONTICS	<input type="checkbox"/> Yes <input type="checkbox"/> No All teeth to be treated by endodontist are restorable? <input type="checkbox"/> Emergency Palliative Date <input type="checkbox"/> Yes <input type="checkbox"/> No Teeth to be treated have a good periodontal prognosis? <input type="checkbox"/> Tooth/Teeth #s <input type="checkbox"/> Yes <input type="checkbox"/> No Hemisection or root amputation planned? <input type="checkbox"/> Yes <input type="checkbox"/> No Crown lengthening will be needed? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment needed is beyond the scope of a general dentist? If "Yes" check why below	
	X-rays needed <input type="checkbox"/> Canal(s) cannot be located <input type="checkbox"/> Severely curved canal(s)/root <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Canal(s) calcified/blocked <input type="checkbox"/> Retreatment <input type="checkbox"/> Other – provide narrative in area at right	
<input type="checkbox"/> ORAL SURGERY	<input type="checkbox"/> Yes <input type="checkbox"/> No Referral is due to medical condition or physical limitation? <input type="checkbox"/> Yes <input type="checkbox"/> No All teeth requested currently symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No Service(s) for orthodontic purpose(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No Removal of supernumerary tooth/teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment needed is beyond the scope of a general dentist? If "Yes" check why below	
	<input type="checkbox"/> Treatment of tumor and/or neoplasm <input type="checkbox"/> Treatment of nondentigerous cyst <input type="checkbox"/> Treatment fractured jaw <input type="checkbox"/> Treatment of dislocation or subluxation <input type="checkbox"/> Treatment TMJ/myofascial pain <input type="checkbox"/> Specialized test or equipment needed <input type="checkbox"/> Patient wants general anesthesia when local would normally suffice <input type="checkbox"/> Consultation needed to aid in treatment planning or to evaluate a lesion <input type="checkbox"/> Other – provide narrative in area at right including tooth numbers and pathology <input type="checkbox"/> Surgery too complex for general dentist	
<input type="checkbox"/> ORTHODONTICS	<input type="checkbox"/> Yes <input type="checkbox"/> No Patient's oral hygiene/home care is adequate? <input type="checkbox"/> Yes <input type="checkbox"/> No All diagnosed preventive and restorative treatment completed? Orthodontic treatment is needed because of: <input type="checkbox"/> Treatment TMJ/myofascial pain <input type="checkbox"/> Retreatment <input type="checkbox"/> Relapse after orthodontics <input type="checkbox"/> Jaw positioning <input type="checkbox"/> Myofunctional therapy <input type="checkbox"/> Malocclusion or crowding <input type="checkbox"/> Micrognathia, macroglossia or other congenital/developmental condition? <input type="checkbox"/> Orthodontic treatment is in progress	
	X-rays needed for most requests	
<input type="checkbox"/> PEDIATRIC DENTISTRY	<input type="checkbox"/> Yes <input type="checkbox"/> No If patient is over 3 years, treatment was attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment needed is beyond the scope of a general dentist? If "Yes" check why below	
	<input type="checkbox"/> Complexity of case, not related to medical condition or limitations <input type="checkbox"/> Inability to cooperate, not related to medical condition or limitations <input type="checkbox"/> Medical condition/physical limitations <input type="checkbox"/> Other – provide narrative in area at right	
<input type="checkbox"/> PERIODONTICS	<input type="checkbox"/> Yes <input type="checkbox"/> No Patient's oral hygiene/home care is adequate? <input type="checkbox"/> Dates of SRP's <input type="checkbox"/> Yes <input type="checkbox"/> No Prophylaxis and scaling/root planing completed? UR _____ <input type="checkbox"/> Re-Eval Date _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Pocket charting done before & after scaling/root planing? LR _____ <input type="checkbox"/> Case Type IV <input type="checkbox"/> Yes <input type="checkbox"/> No Bone graft/bone replacement? UL _____ <input type="checkbox"/> Perio Prognosis # _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Crown lengthening? LL _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Treatment needed is beyond the scope of a general dentist? If "Yes" check why below	
	<input type="checkbox"/> Osseous mucogingival surgery is needed to reduce pockets <input type="checkbox"/> Gingival grafting is needed to treat recession in absence of pockets <input type="checkbox"/> Patient has not responded to treatment by general practice provider <input type="checkbox"/> To aid in treatment planning <input type="checkbox"/> Other – provide narrative in area at right	

SERVICES REQUESTED FOR REFERRAL		
Procedure Code	Tooth/Quad/Arch	Description of Procedure

NOTE: For additional services, a standard claim form may be appended to this form.

As the referring dentist, I affirm that all information above is true and accurate.

Referring Dentist's Signature: _____ Signature Date: _____

Mail Completed Form to:
Specialty Referral Request, P.O. Box 30552, Salt Lake City, UT 84130.

Specialist Information:

Specialist Name	Street Address	City, State, and ZIP Code
		Phone Number

Specialty Referral Process

To prevent any delay in processing, Specialty Referral Request Forms must be completed in full per requirements of the specific referral type request (pre-authorization/direct/self/emergency). Include all of the following information necessary to review the referral:

- Specific ADA Procedure Codes
- Tooth numbers or Quadrants
- X-Rays, Photographs
- Narrative
- Periodontal Probing

In cases of direct referral, the General Dentist must complete the referral form and provide the original copy and all clinical documentation to the patient for transmittal to the participating specialty care dentist.

For those referrals requiring or requesting pre-authorization, all pertinent supporting attachments must be included and forwarded to:

Specialty Referral Requests
P.O. Box 30552
Salt Lake City, UT 84130-0552

For pre-auth specialty referrals, the Referral will be reviewed and if found to meet the Referral Criteria, approval and notification will be sent to the General Dentist, the authorized Specialty Care Provider and Member/Patient. The referring dentist may be financially liable for treatment not pre-authorized. Emergency treatment should be limited to the services necessary to treat pain, swelling, infection and/or stabilization of the emergency conditions. Definitive care should be deferred until a proper pre-authorization can be performed with x-rays, narrative and other necessary documentation.

In cases where EMERGENCY SERVICES are referred to a specialist, a Specialty Referral Form should be completed and accompany the patient to the specialist, whenever possible. Otherwise the General Dentist or Member may contact Member Services for an authorization number to give to the specialist for approval of the consultation and/or specialty treatment necessary for the stabilization of emergency conditions.

Commonly Referred Specialty Procedure Codes

Oral Surgery

- 9310 Consultation
- 7140 Extraction, erupted tooth or exposed root
- 7210 Surgical removal of erupted tooth
- 7220 Removal of impacted tooth - soft tissue
- 7230 Removal of impacted tooth - partially bony
- 7240 Removal of impacted tooth - completely bony
- 7250 Surgical removal of residual tooth roots (cutting procedure)
- 7285 – 7288 Biopsy (various types, subject to coverage)
- 7310 – 7321 Alveoloplasty (various types)
- 7510 Incision and drainage of abscess

Periodontics

- 9310 Consultation
- 4210 – 4211 Gingivectomy
- 4260 Osseous surgery 4+ contiguous teeth or bounded teeth spaces per quadrant
- 4361 Osseous surgery 1-3 teeth or bounded teeth spaces per quadrant
- 4910 Periodontal Maintenance
- 4263 – 4267 Bone grafting
- 4270 – 4276 Soft tissue grafting

Pediatric Dentistry

- 9310 Consultation
- 2140 – 2161 Amalgam restorations
- 2330 – 2335 Composite restorations
- 2930 – 2932 Prefabricated crowns (various)
- 3220 Therapeutic pulpotomy
- 3230 – 3240 Pulpal therapy on Primary Teeth
- 7111 Extraction, coronal remnants, deciduous tooth

Endodontics

- 9310 Consultation
- 3310 Anterior root canal (excluding final restoration)
- 3320 Bicuspid root canal (excluding final restoration)
- 3330 Molar root canal (excluding final restoration)
- 3346 Re-treatment of previous root canal therapy-anterior
- 3347 Re-treatment of previous root canal therapy-bicuspid
- 3348 Re-treatment of previous root canal therapy-molar
- 3351 – 3353 Apexification
- 3410 – 3430 Apicectomy/Retrograde filling

Orthodontics

- 9310 Consultation

PROVIDER HOTLINE:

1.877.732.4337 - UnitedHealthcare
- Pacific Union Dental Direct Compensation
- AARP Medicare Complete (Secure Horizons)
- PacifiCare

1.888.877.7828 - Lincoln Financial Group

1.866.249.4435 - Health Net of CA