Specialty Request Referral Form
Nevada Pacific Dental

UnitedHealthcare®

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

SPECIALIST (Check One)	ATTESTATION	(Must be completed for the specialty type, or request will be returned)			OTHER REASONS
Endodontist	Yes No	All teeth to be treated by endodontist are restorable?	Emergency Palliative Date		
	Yes No	Teeth to be treated have a good periodontal prognosis?	Tooth/Teeth #s_____		
	Yes No	Hemisection or root amputation planned?			
	Yes No	Treatment needed is beyond the scope of a general dentist? If "Yes" check why below			
		Canal(s) cannot be located	Severely curved canal(s)/root	Surgical Procedure	
		Canal(s) calcified/blocked	Retreatment	☐ Other–Provide narrative in area at right	
Oral Surgeon	Yes No	Referral is due to medical condition or physical limitation?			
	Yes No	Service(s) for orthodontic purposes(s)?			
	Yes No	Removal of supernumerary tooth/teeth?			
	Yes No	Treatment needed is beyond the scope of a general dentist? If "Yes" check why below			
		Treatment of tumor and/or neoplasm	Treatment of nondentigerous cyst		
		Treatment fractured jaw	Treatment of dislocation or subluxation		
		Treatment TMJ/myofascial pain	Specialized test or equipment needed		
		Patient wants general anesthesia when local would normally suffice			
		Consultation needed to aid in treatment planning or to evaluate a lesion			
		Surgery too complex for general dentist	☐ Other–Provide narrative in area at right		
☐ Orthodontist	☐Yes ☐No	Patient's oral hygiene/home care is adequate?			
	☐Yes ☐No	All diagnosed preventive and resotrative treatment completed?			
		Orthodontic treatment is needed because of:	Retreatment		
		Treatment TMJ/myofascial pain	Jaw repositioning		
		Relapse after orthodontics	Malocclusion or crowding		
		Myofunctional therapy	Orthodontic treatment is in progress		
		Micrognathia, macroglossia or other congenital/developmental condition?			
☐ Pedodontist	☐Yes ☐No	If patient is over 3 years, treatment was attempted?			
	☐Yes ☐No	Treatment needed is beyond the scope of a general dentist? If "Yes" check why below			
		Complexity of case, not related to medical condition or limitations			
		Inability to cooperate, not related to medical condition or limitations			
		Medical condition/physical limitations	☐ Other–Provide narrative in area at right		
☐ Periodontist	☐Yes ☐No	Patient's oral hygiene/home care is adequate?	Dates of SRP's		
	☐Yes ☐No	Prophylaxis and scaling/root planing completed?	UR_____	Re-Eval Date_____	
	☐Yes ☐No	Pocket charting done before & after scaling/root planing?	LR_____	Case Type IV	
	☐Yes ☐No	Bone graft/bone replacement?	UL_____	PerioPrognosis#_____	
	☐Yes ☐No	Crown lengthening?	LL_____		
	☐Yes ☐No	Treatment needed is beyond the scope of a general dentist? If "Yes" check why below			
		Osseous mucogingival surgery is needed to reduce pockets			
		Gingival grafting is needed to treat recession in absence of pockets			
		Patient has not responded to treatment by general practice provider			
		To aid in treatment planning	☐ Other–Provide narrative in area at right		

SERVICES REQUESTED FOR REFERRAL & SPECIALIST CLAIM FOR SERVICES RENDERED

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: _____

As the specialist, I affirm services were needed and done on the date(s) above.

Specialist's Signature _____

Signature Date: _____ TAX ID #: _____

EMERGENCY REFERRALS

FOR EMERGENCY SERVICES, PLEASE CONTACT OUR PROVIDER SERVICES AT 800-926-0925 FOR AUTHORIZATION.

Mail Completed Form to:

Nevada Pacific Dental c/o UnitedHealthcare Dental, P.O. Box 30552, Salt Lake City, UT 84130

Specialist Information

Specialist Name	Street Address	City, State, and Zip Code
		Phone Number:

For Emergency Referrals - Member delivers a copy to the specialist. General Dentist retains a copy for their records.

Request for Specialty Referral

Evaluation of the recommended specialty care treatment will be made and if found to meet the criteria for referral, the treatment will be approved and notification will be made to the General Dentist, the authorized Specialty Care Provider and member/patient. To achieve authorization, it is imperative that the General Dentist provide all recommended treatment information. Please mail, non-emergency, specialty referral request forms to:

Nevada Pacific Dental
c/o UnitedHealthcare Dental
P.O. Box 30552
Salt Lake City, UT 84130

Payment for unauthorized referral claims will be denied, except in the case of emergencies. Emergency treatment should be limited to the services necessary for the relief of 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 documentation.

In cases where EMERGENCY SERVICES are referred to a specialist, a specialty referral request form must be completed and accompany the patient to the specialist. For emergency referrals, please contact our Provider Services at 800-926-0925.

To prevent any delay in processing, the Specialty Referral Request Forms must be completed in full, including the procedure code(s) for the service(s) you are requesting. To aide in this process, the following list was complied of the most commonly referred specialty procedure codes.

Quick Reference Guide

Most Commonly Referred Specialty Procedure Codes

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

Oral Surgery

- 9310 Consultation
- 7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap removal of bone and/or section of tooth
- 7220 Removal of Impacted tooth – soft tissue
- 7230 Removal of Impacted tooth – partially bony
- 7240 Removal of Impacted tooth – completely bony

Orthodontics

- 9310 Consultation

Pedodontics

- 9310 Consultation

Periodontics

- 9310 Consultation
- 4260 Osseous surgery 4+ contiguous teeth or bounded teeth spaces per quadrant
- 4361 Osseous surgery 1-3 teeth or hounded teeth spaces per quadrant