



1971 E. 4th Street, Suite 184
 Santa Ana, CA 92705-3917
 (877) 4-DENTAL (433-6825)
 Fax (714) 479-0779

Specialty Referral Form

Prepaid Plan # _____
 Member # _____
 Authorization # _____

Provider Name _____ Facility # _____	Patient Name _____ SS# _____
Address _____ Phone _____	Address _____ Birthdate _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Subscriber Name _____ SS# _____ Employer _____	
Phone _____	

Please submit with all documentation and radiographs required for each specialty category requested.

Periodontics: GP is responsible for all Phase I therapy and perio emergencies. Patient must have completed Phase I therapy within past year and have been seen regularly for perio maintenance. Submit full mouth radiographs, periodontal charting. Panoramic &/or bitewings are not acceptable.
 Case type (circle) I II III IV
 Full mouth periodontal pocket charting enclosed
 Full mouth radiographs enclosed (panoramic or bite-wings not acceptable)
 Other (please describe below)

Dates of root planing (max 2 quads/visit)
 UR _____ UL _____
 LR _____ LL _____

If root planing over 6 months ago, dates of all subsequent perio maintenance/hygiene _____

Patient motivation (circle) Good Fair Poor _____

Endodontics: GP is responsible for diagnosis and treatment of all anterior, bicuspid, & routine molar endodontics and for providing palliative treatment (pulpotomy, pulpectomy, incise & drain, antibiotics &/or analgesics) even if tooth must be referred out for definitive treatment. Patients referred for diagnostic purposes will be referred back to GP for treatment once endodontist has confirmed diagnosis. Submit pre-treatment periapical radiographs.
 Tooth #(s) _____ Check reason(s) for referral below

Calcified/inaccessible canals: If calcification not conclusively shown on radiograph, must submit with files & rubber dam in place showing inability to reach apex.
 Mid-treatment complications (broken file, perforation, etc.) Describe below & submit with pre-op & mid treatment periapical radiographs.
 Tooth with existing, sound crown or bridge that will not be replaced & GP feels excessive risk of perforation. (If C&B to be replaced: GP to remove & attempt tx.)
 Retreatment, apico/retrofill. Date of initial therapy _____ Was initial therapy performed by referring office? (circle) Y N
 Missing teeth in arch other than 3rd molars? (circle) Y N Missing tooth #'s _____
 Does patient have an existing sound prosthesis to replace these teeth? (circle) Y N
 Does tooth in question oppose a natural tooth or present/planned prosthesis? (circle) Y N
 Other (please describe below)

Pedodontics: For unmanageable patients under age six. Medically compromised or developmentally disabled patients age six and over will be subject to plan review. Please attach a physician's statement of condition & describe below.
 Child's age _____ 1 date attempted treatment for child under 3 _____
 2 dates attempted treatment for child 3 & over (1) _____ (2) _____
 Describe _____

Orthodontics: No need to submit radiographs.
 Patient age _____
 Classification of malocclusion _____
 Retreatment? (circle) Y N

Oral Surgery: GP is responsible for routine, simple surgical & soft tissue impaction extractions. There is no coverage for preventive extraction of asymptomatic nonpathologic erupted or impacted teeth, or extractions for orthodontic purposes. Treatment of cysts, tumors & neoplasms is not covered. Refer to patient's medical insurance. Oral surgery referral is considered for individual symptomatic or pathologically involved partial or full bony impactions, and difficult surgical or soft tissue extractions of pathologic/symptomatic teeth. List tooth numbers requested & describe symptoms/pathology for each tooth requested and reason GP cannot perform tx.

Tooth Number	Eruption Status FB,PB,ST,SG,RT	Symptoms/Pathology Necessitating Extraction <u>At This Time</u>	Why GP Cannot Perform Extraction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FB = Full bony, PB = Part bony, ST = Soft tissue, SG = Surgical erupted, RT = Surgical root tip removal

Medically compromised patient requiring specialist treatment, please submit physician note documenting condition (referrals for health or behavioral reasons are not covered, but patient may be eligible for discounted service upon review).
 Other (please describe below)

Other – Please describe _____

Signature of referring Dr. _____ Date _____

Submit with periapical or panoramic films that clearly show each tooth in its entirety. Radiographs are not a covered benefit at the specialist's office. Please submit with all indicated radiographs/documentation. Failure to provide required documentation may result in delay or denial of authorization. Emergency referrals should be called or faxed to Plan, then mail in all supporting documentation and radiographs. All emergency referrals are subject to retrospective review by the Dental Director. Referring office will be responsible for all specialist costs for procedures found on retrospective review to have been inappropriately referred.