Specialty Request Referral Form

☐ Pre-Authorization ☐ Direct ☐ Self ☐ Emergency

Dental Benefit Providers of California

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 / Narrative
☑ **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	Crown lengthening will be needed?			
	☐ Yes ☐ No	Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below**			
X-rays needed		☐ 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	All teeth requested currently symptomatic?			
	☐ 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			
X-rays needed for most requests		☐ Consultation needed to aid in treatment planning or to evaluate a lesion	☐ Other - provide narrative in area at right including tooth numbers and pathology		
		☐ Surgery too complex for general dentist			
☐ **Orthodontist**	☐ Yes ☐ No	Patient's oral hygiene/home care is adequate?			
	☐ Yes ☐ No	All diagnosed preventive and restorative 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?			
☐ **Pediatric Dentistry**	☐ 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			
X-rays needed for most requests		☐ 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	LR	
	☐ Yes ☐ No	Pocket charting done before & after scaling/root planing?	UL	LL	
	☐ Yes ☐ No	Bone graft/bone replacement?	☐ Re-eval date		
	☐ Yes ☐ No	Crown lengthening?	☐ Case type IV		
	☐ Yes ☐ No	Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below**	☐ Perio prognosis#		
X-rays & Perio Chart needed for most requests		☐ 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		
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	**Fax Completed Form to: 248-733-6372**

Specialist information	
Specialist name	Phone number:
Street address	City, State, and ZIP Code

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 Apicioectomy/Retrograde filling

Orthodontics

- 9310 Consultation

Provider Hotline:

1-877-732-4337	UnitedHealthcare Dental Pacific Union Dental Direct Compensation UnitedHealthcare Dental (PacifiCare Dental)
1-888-877-7828	Lincoln Financial Group
1-866-249-2382	Health Net of CA