California DENTAL NETWORK, INC
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Specialty Referral Form

Prepaid Plan #_____.
Member #_____.
Authorization #_____.

Provider Name_____Facility #_____.
Address_____Phone_____.
City_____State_____Zip_____.

Patient Name_____SS#_____.
Address_____Birthdate_____.
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 (root planing or perio maintenance) within past 6 months . 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_____.
Patient motivation (circle) Good Fair Poor

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

☐ **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 assymptomatic 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 At This Time	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.

WHITE – PLAN COPY YELLOW – PATIENT COPY PINK - SPECIALIST COPY GOLD – DENTAL OFFICE COPY