Specialty Referral Request Form

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Blue Shield of California
An Independent Member of the Blue Shield Association

☐ 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 (check one)	ATTESTATION (Must be completed for the specialty type, or request will be returned)	OTHER REASONS/NARRATIVE
ENDODONTICS X-rays needed	Yes No All teeth to be treated by endodontist are restorable? Yes No Teeth to be treated have a good periodontal prognosis? 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:** 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 SURGERY X-rays needed for most requests	Yes No Referral is due to medical condition or physical limitation? Yes No All teeth requested currently symptomatic? Yes No Service(s) for orthodontic purpose(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 of fractured jaw; Treatment of disclocation 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 including tooth numbers and pathology*	
ORTHODONTICS	☐ Yes ☐ No Patient's oral hygiene/home care adequate? ☐ Yes ☐ No All diagnosed preventive and restorative treatment completed? Orthodontic treatment is needed because of: Treatment TMJ/myofascial pain; Retreatment Relapse after orthodontics; Jaw positioning Myofunctional therapy; Malocclusion or crowding Micrognathia, macroglossia or other congenital/developmental condition?; Orthodontic treatment is in progress	
PEDIATRIC DENTISTRY X-rays needed for most requests	☐ 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*	
PERIODONTICS X-rays & Perio Chart needed for most requests	☐ Yes ☐ No Patient's oral hygiene/home care is adequate? ☐ Yes ☐ No Prophylaxis and scaling/root planing completed? ☐ Yes ☐ No Pocket charting done before & after scaling/root planing? ☐ Yes ☐ No Bone graft/bone replacement? ☐ Yes ☐ No Crown lengthening? ☐ Yes ☐ No Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below:** Dates of SRPs UR_____ Re-Eval Date_____ LR_____ Case Type IV_____ UL_____ Perio Prognosis#_____ LL_____ 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

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 Pre-fabricated 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
1.888.271.4929