Specialty Referral Request Form

UnitedHealthcare

Referring Provider Name	Phone Number	Employee Name	ID #
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	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 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 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 othodontics ☐ Malocclusion or crowding	
		☐ Myofunctional therapy ☐ Othodontic 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**	
X-rays preferred when possible		☐ 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 _____ ☐ Perio Prognosis # _____	
	☐ Yes ☐ No	Crown lengthening? LL _____	
	☐ Yes ☐ No	Treatment needed is beyond the scope of a general dentist? **If "Yes" check why below**	
X-rays and 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 & SPECIALIST CLAIM FOR SERVICES RENDERED

Proc. Code	Tooth/ Quad/arch	Description of Procedure	Date of Service	Charge

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:** _____

SPECIALTY REFERAL REQUEST INSTRUCTIONS:

MEMBER – Call Customer Service at 1-800-232-0990 and request an authorization.
SPECIALIST – Attach a copy of this referral when you submit your pre-determination and mail to P.O. Box 30552, Salt Lake City, UT 84130

SPECIALTY CARE REFERRAL GUIDELINES

THE GENERAL DENTIST CANNOT REFER DIRECTLY TO A SPECIALIST, THE GENERAL DENTIST MUST COMPLETE THE SPECIALIST REFERRAL FORM AND GIVE IT TO THE MEMBER WITH ALL SUPPORTIVE DOCUMENTATION REQUIRED TO COORDINATE THE REFERRRAL. THE MEMBER WILL CONTACT CUSTOMER SERVICE TO PROCESS THE REFERRAL TO THE SPECIALIST.

The Customer Service Department WILL NOT process a referral to a Specialist if the member does not have a referral form and appropriate x-rays/documentation in hand to take to the Specialist.

General Dentist Instructions: To prevent any delay in processing, it is critical that the General Dentist **complete the entire NPD Specialty Care Referral Form** in full per requirements of the specific referral type request (preauthorization/emergency). Include all of the following information necessary to review the referral request:

- Specific ADA Procedure Codes
- Tooth numbers or Quadrants
- X-Rays, Photographs
- Other Reasons (Notes -if you feel there is additional information that needs to be relayed)
- Periodontal Probing

Member Instructions:
The Member will contact Customer Service at **800-232-0990** to request processing of the referral and authorization to a participating Specialist.

Specialist Instructions for Non-Emergency Treatment:
After determining the diagnosis and treatment required, the Specialty Care Provider will submit an itemized treatment plan (ADA Universal Claim Form) attached to the Specialty Referral Request Form including all pertinent supporting documentation listed above. The pre-determination request is sent to:

NPD Specialty Referral Requests
P O Box 30552
Salt Lake City, UT 84130-0552

EMERGENCY SPECIALTY REFERRAL GUIDELINES

There may be circumstances when it will be necessary to refer a member to a specialist to receive emergency treatment. However, the Plan, expects the general dentist to provide proper stabilization of any situations or conditions to allow the Plan to conduct its review of requests for Specialist Care. In many cases it may be appropriate for the general dentist to treat the emergency himself.

A dental emergency is considered to be:
Acute pain, fever, swelling, infection and/or, any condition, which a reasonable person under the circumstances believes, if left untreated may result in disability, death, or the delay of treatment would be medically inadvisable.

For such situations, treatment should be limited to services necessary for:
Relief of pain, control of bleeding, treatment of swelling, treatment of infection, and/or stabilization of trauma and related emergency conditions.

General Dentist and Member Instructions:
Follow the same instructions as listed above.

Specialist Instructions for Emergency Referral Requests:
If a Member has been referred to your office for an Emergency Referral, after determining the diagnosis and treatment required, call Customer Service at **800-232-0990** to coordinate and for authorization for the treatment required to relieve the patient of pain.

After treatment has been completed; please send the claim for payment with supporting documentation:

National Pacific Dental
c/o UnitedHealthcare Dental
Attn: Claims
PO BOX 30567
Salt Lake City, UT 84130-0567

Please refer to your Provider Manual for complete Specialist Referral Guideline Instruction