Specialty Communication Tool

UnitedHealthcare Dental does not require a provider to submit a formal referral form to the plan when referring a member to another provider or specialist for treatment.
This communication form is simply a tool for a provider to utilize to send communication to another provider or specialist concerning the care of a member, if the provider chooses to utilize this tool (not required, and not to be submitted to UnitedHealthcare Dental).
The referring dentist should verify that the provider or specialist that the member is being referred to is within the member's network.

Member Information

Member Name (Last Name, First Name)

Date of Birth (MM/DD/YYYY)

Member ID Number

Phone Number

Referring Dentist Information

Dentist Name (Last Name, First Name)

Provider NPI Number

Provider ID Number

Phone Number

Today's Date (MM/DD/YYYY)

Referral Overview

Select requested specialty:

D General Dentistry
D Pediatric Dentistry
D Orthodontics *
D Oral/Maxillofacial Surgery
D Periodontics
D Prosthodontics
D Endodontics
D Other: _____

Specialist Name (Last Name, First Name)

Provider ID Number

Telephone Number

Area or Tooth Number(s)

Tooth Surface(s)

Is this an urgent request? ☐ Yes ☐ No

** Note : Orthodontic services are limited to those circumstances where the child's condition creates a disability and impairs physical development, not for cosmetic reasons.*

Please list reason for referral

Does the member have a medical condition or medication that may influence scheduling or treatment? *(If yes, please list below.)* ☐ Yes ☐ No

Does the member have any special needs or developmental disabilities? *(II yes. please list below.)* ☐ Yes ☐ No

Any additional information that you would like to communicate to the provider or specialist:

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