



# SPECIALIST REFERRAL FORM

Mail to: Access Dental Plan – Referral Department  
PO Box 659005 – Sacramento, CA 95865-9005  
Telephone: 800-270-6743 x6012 Fax: 877-648-7741

**PLEASE CHECK APPROPRIATE BOXES:**

- Routine Referral       Emergency Referral  
 GMC       DMO-Commercial Managed Care       HFP       LAPHP

PATIENT INFORMATION		PRIMARY CARE DENTIST INFORMATION	
Patient Name:		Provider Name:	
Parent's Name (if minor):		Provider Office Number:	
CIN Number:		Provider Phone Number:	
Phone:	DOB:	Provider Fax Number:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Social Security Number (optional):		License Number:	

**REQUEST FOR REFERRAL:**       Endodontist       Pedodontist       Periodontist  
     Oral surgeon       Orthodontist       Other

**ATTACHMENTS:**       X-rays included:  Yes  No      If yes, how many? \_\_\_\_\_ (PLEASE ATTACH FILMS TO THIS FORM)

**PLEASE REFER TO THE ACCESS DENTAL SPECIALTY CARE GUIDELINES ON THE BACK OF THIS FORM FOR DETAILS REGARDING THE DOCUMENTATION REQUIRED TO PROCESS YOUR SPECIALTY REFERRAL.**

### DESCRIBE THE PROCEDURE AND REASON FOR SPECIALTY REFERRAL

	<b>PATIENT MUST BE ELIGIBLE FOR COVERAGE AT TIME OF SERVICE</b>  <b>SPECIALIST: PLEASE RETURN X-RAYS WHEN TREATMENT IS COMPLETED</b>

**IN MY PROFESSIONAL JUDGMENT THE TREATMENT LISTED REQUIRES A SPECIALIST:  YES  NO**

**REFERRING DENTIST SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF APPROVAL.**

#### FOR ACCESS DENTAL PLAN USE ONLY

Eligibility:  Yes  No      Date: \_\_\_\_\_      Initial: \_\_\_\_\_

#### PLEASE SEE ATTACHED RESPONSE TO SPECIALTY REFERRAL REQUEST FOR THE FOLLOWING

<input type="checkbox"/> Approved	Date: _____	Initial: _____
<input type="checkbox"/> Modified	Date: _____	Initial: _____
<input type="checkbox"/> Insufficient Information	Date: _____	Initial: _____
<input type="checkbox"/> Denied	Date: _____	Initial: _____