- Click here for: SPECIALIST REFERRAL FORM

- Click here for DIRECT REFERRAL FORM
  - All States (except California)

- Click here for DIRECT REFERRAL FORM
  - California ONLY

Metropolitan Life Insurance Company
MetLife Health Plans, Inc.
SafeGuard Health Plans, Inc.

SPECIALIST REFERRAL FORM

For multiple family members or multiple specialist requests, use a separate form for each specialty referral.

USE THIS FORM FOR:

☐ **Pediatric Dentistry***	☐ **Orthodontics**
***EXCEPT FOR CUSTOM PLANS**: Please complete this form for members 8 years old and above. (7 years old and under, please use Direct Referral Form) ***FOR CUSTOM PLANS:** Please refer to the member's Schedule of Benefits	This form required for California members only. (In FL, NJ, NY & TX, please use the Direct Referral Form.)

USE DIRECT REFERRAL FORM FOR: Endodontics, Periodontics, Oral Surgery, and Pediatric Dentistry as described above.

Section 1: Member's Information

Patient Name	Date of Birth	Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child		Date of Initial Visit
Subscriber Name	Date of Birth	Social Security Number	Group ID	Plan

Address	City	State	Zip	Telephone	Home: ( ) Work: ( )

Section 2: Referring Facility's Information

Name	Facility #	Provider #

Address	City	State	Zip	Telephone ( )

Section 3: Referred Contracted Specialist's Information

Name	Facility # *(if available)*	Provider # *(if available)*

Address	City	State	Zip	Telephone ( )

Section 4: Pediatric Dentistry

Instructions:
1) ***If referral is due to any of the following Qualifying Medical Conditions (i.e. Down Syndrome, Deafness, Autism, Multiple Sclerosis, Cerebral Palsy, Mentally/Physically disadvantaged, or Baby Bottle Syndrome), please indicate the Qualifying Medical Condition(s) in the section below. No further documentation will be required.***
2) ***If referral is due to any other medical condition(s), please indicate the medical condition(s) in the section below and submit chart notes and a completed medical history form with parent/guardian signatures.***
3) ***If referral is due to any other reason(s), please indicate the reason(s) in the section below and submit chart notes. For uncooperative cases, one (1) documented attempt at treatment will be required.***
4) ***All required documentation should be submitted with this request in order to complete the review process and avoid any delays.***

Please check the applicable box below and provide the requested information

☐ **Uncooperative – Attempt Date:** ______________________	☐ **Other reasons for referral, please describe:** ____________
☐ **Qualifying Medical Condition(s):** ______________________	______________________________________
☐ **Diagnosis (as per Referring Dentist):** ______________________	______________________________________

Section 5: Orthodontics (*please check box below for Orthodontic Referral)*

☐ As the Member's Selected General Dentist, I am requesting that this Member be referred to a SafeGuard contracted **Orthodontist**. Treatment should be provided according to the Member's SafeGuard dental plan.

Signature of Referring Dentist: ______________________________ Date: ______________________________

FOR STATE OF NEW JERSEY PLAN MEMBERS ONLY:
MAIL THIS FORM, CHART NOTES and ANY ATTACHMENTS TO:
MetLife Dental
PO Box 14749
Lexington, KY 40512

FOR ALL OTHERS PLAN MEMBERS:
MAIL THIS FORM, CHART NOTES and ANY ATTACHMENTS TO:
SafeGuard DHMO Claims
P.O. Box 981987
El Paso, TX 79998

For emergencies, call the Customer Service Center at (800) 880-1800

Managed Dental Care plans are available in California, Florida and Texas provided by a domestic company in the applicable state named SafeGuard Health Plans, Inc. The SafeGuard companies are part of the MetLife family of companies. Managed Dental Care plans are available in Illinois through SafeGuard Health Plans, Inc., a Texas corporation. Managed Dental Care plans in New Jersey are provided by MetLife Health Plans, Inc. and Metropolitan Life Insurance Company. Managed Dental Care plans in New York are provided by Metropolitan Life Insurance Company. "Managed Dental Care" is used to refer to products that may differ by state of residence of the enrollee, including but not limited to: "Specialized Health Care Service Plans" in California; "Prepaid Limited Health Service Organizations" as described in Chapter 636 of the Florida statutes in Florida; "Single Service Health Maintenance Organization" in Texas, "Limited Health Service Organizations" in Illinois, "Dental Plan Organizations" in New Jersey, and "Dental Managed Care Plan" in New York.

Direct Referral Form

Referring Dentist – In order to ensure proper communication, ALL information must be filled out accurately and completely. Appropriate radiographs should be placed in an envelope and forwarded to the specialists.

Referring Dentist Information

Facility Number: ______________________________

Name: ______________________ Phone: ______________________

Specialist Information

Facility Number: ______________________________

Name: ______________________ Phone: ______________________

Address: ______________________________

City: ____________________ State: __________ Zip: ______________

Patient Information

Family ID Number: ______________________________

Patient Name: ______________________ DOB: ______________________

Subscriber Name: ______________________ Plan: ______________________

Clinical Information

Referral Type:

[ ] Oral Surgery [ ] Endodontics [ ] Pedodontics [ ] Periodontics

[ ] Orthodontics

Tooth Number / Area in Question: ______________________________

Reason for Referral: ______________________________

____

____

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______________________________ ______________________________

Referring Dentist Signature Date

California

Direct Referral Form

Referring Dentist – In order to ensure proper communication, ALL information must be filled out accurately and completely. Appropriate radiographs should be placed in an envelope and forwarded to the specialists.

Referring Dentist Information

Facility Number: ______________________________

Name: ______________________ Phone: ______________________

Specialist Information

Facility Number: ______________________________

Name: ______________________ Phone: ______________________

Address: ______________________________

City: ______________________ State: __________ Zip: ____________

Patient Information

Family ID Number: ______________________________

Patient Name: ______________________ DOB: ______________________

Subscriber Name: ______________________ Plan: ______________________

Clinical Information

Referral Type:

[ ] Oral Surgery [ ] Endodontics [ ] Pedodontics [ ] Periodontics

Tooth Number / Area in Question: ______________________________

Reason for Referral: ______________________________

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______________________________ Referring Dentist Signature

______________________________ Date