

# Specialty Referral Request Form

UnitedHealthcare Dental®



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
<input type="checkbox"/> Endodontist	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	All teeth to be treated by endodontist are restorable? <input type="checkbox"/> Emergency Palliative Date _____ Teeth to be treated have a good periodontal prognosis? <input type="checkbox"/> Tooth/Teeth #s _____ Hemisection or root amputation planned? Crown lengthening will be needed? Treatment needed is beyond the scope of a general dentist? <b>If "Yes" check why below</b> <input type="checkbox"/> Canal(s) cannot be located <input type="checkbox"/> Severely curved canal(s)/root <input type="checkbox"/> Surgical Procedure <input type="checkbox"/> Canal(s) calcified/blocked <input type="checkbox"/> Retreatment <input checked="" type="checkbox"/> Other - provide narrative in area at right	
X-rays needed			
<input type="checkbox"/> Oral Surgeon	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral is due to medical condition or physical limitation? All teeth requested currently symptomatic? Service(s) for orthodontic purpose(s)? Removal of supernumerary tooth/teeth? Treatment needed is beyond the scope of a general dentist? <b>If "Yes" check why below</b> <input type="checkbox"/> Treatment of tumor and/or neoplasm <input type="checkbox"/> Treatment of nondentigerous cyst <input type="checkbox"/> Treatment fractured jaw <input type="checkbox"/> Treatment of dislocation or subluxation <input type="checkbox"/> Treatment TMJ/myofascial pain <input type="checkbox"/> Specialized test or equipment needed <input type="checkbox"/> Patient wants general anesthesia when local would normally suffice <input type="checkbox"/> Consultation needed to aid in treatment planning or to evaluate a lesion <input checked="" type="checkbox"/> Other - provide narrative in area at right including tooth numbers and pathology <input type="checkbox"/> Surgery too complex for general dentist	
X-rays needed for most requests			
<input type="checkbox"/> Orthodontist	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's oral hygiene/home care is adequate? All diagnosed preventive and restorative treatment completed? Orthodontic treatment is needed because of: <input type="checkbox"/> Treatment TMJ/myofascial pain <input type="checkbox"/> Retreatment <input type="checkbox"/> Relapse after orthodontics <input type="checkbox"/> Jaw repositioning <input type="checkbox"/> Myofunctional therapy <input type="checkbox"/> Malocclusion or crowding <input type="checkbox"/> Micrognathia, macroglossia or other congenital/developmental condition? <input type="checkbox"/> Orthodontic treatment is in progress	
<input type="checkbox"/> Pedodontist	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	If patient is over 3 years, treatment was attempted? Treatment needed is beyond the scope of a general dentist? <b>If "Yes" check why below</b> <input type="checkbox"/> Complexity of case, not related to medical condition or limitations <input type="checkbox"/> Inability to cooperate, not related to medical condition or limitations <input type="checkbox"/> Medical condition/physical limitations <input checked="" type="checkbox"/> Other - provide narrative in area at right	
X-rays preferred when possible			
<input type="checkbox"/> Periodontist	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient's oral hygiene/home care is adequate? <input type="checkbox"/> Dates of SRP's Prophylaxis and scaling/root planing completed? UR _____ <input type="checkbox"/> Re-Eval Date _____ Pocket charting done before & after scaling/root planing? LR _____ <input type="checkbox"/> Case Type IV Bone graft/bone replacement? UL _____ <input type="checkbox"/> Perio Prognosis # _____ Crown lengthening? LL _____ Treatment needed is beyond the scope of a general dentist? <b>If "Yes" check why below</b> <input type="checkbox"/> Osseous mucogingival surgery is needed to reduce pockets <input type="checkbox"/> Gingival grafting is needed to treat recession in absence of pockets <input type="checkbox"/> Patient has not responded to treatment by general practice provider <input type="checkbox"/> To aid in treatment planning <input checked="" type="checkbox"/> Other - provide narrative in area at right	
X-rays and Perio Chart needed for most requests			

**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 REFERRAL 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 REFERRAL. 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**

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