

Maryland Uniform Dental Consultation Referral Form

Date of Referral:		Carrier Information: Name: Address: Phone Number: () Facsimile/Data #: ()
Patient Information:		
Name: (Last, First, MI)		
Date of Birth (MM/DD/YY):	Phone:	
Member #:		
Site #:		

Primary or Requesting Dentist

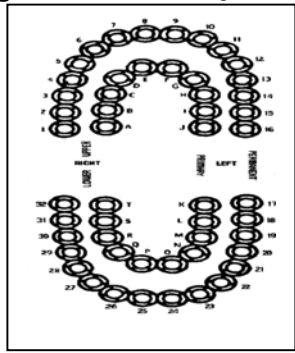
Name (Last, First, MI):		Specialty:	
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)	
Address: (Street #, City, State, Zip)			
Phone Number: ()		Facsimile/Data #: ()	

Specialist Dentist

Name: (Last, First, MI)		Specialty:	
Dental Office Name:	Dental Office Code:	Provider ID/License #:	
Address: (Street #, City, State, Zip)			
Phone Number: ()		Facsimile/Data #: ()	

Referral Information

Reason for Referral:
Brief History, Diagnosis, and Test Results:

<p>Services Desired: Provide Care as Indicated:</p> <p><input type="checkbox"/> Initial Consultation Only</p> <p><input type="checkbox"/> Consultation with Specific Procedures (Specify)</p> <p><input type="checkbox"/> Other: (Explain)</p> <hr/> <p>Place of Service:</p> <p><input type="checkbox"/> Office</p> <p><input type="checkbox"/> Hospital</p> <p><input type="checkbox"/> Other: (Explain)</p>	<p>Teeth Diagram: Indicate Missing Teeth with an "X".</p> <div style="text-align: center;">  </div>
Authorization # (If Required):	Referral is Valid Until: (Date) (See Carrier Instructions)
Signature: (Individual Completing This Form)	Authorizing Signature: (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Reverse and Carrier/Plan Manual for Specific Instructions

There are no special instructions in completing this form.