Maryland Uniform Dental Consultation Referral Form

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

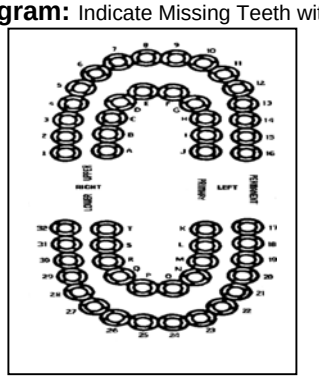
Primary or Requesting Dentist

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:	
Services Desired: Provide Care as Indicated: ☐ Initial Consultation Only ☐ Consultation with Specific Procedures (Specify) ☐ Other: (Explain) **Place of Service:** ☐ Office ☐ Hospital ☐ Other: (Explain)	**Teeth Diagram:** Indicate Missing Teeth with an "X". 
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.