

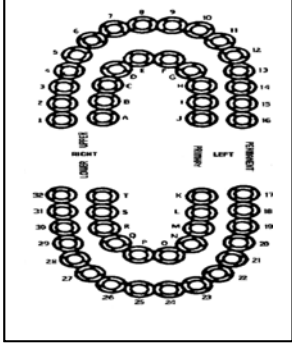
Maryland Uniform Dental Consultation Referral Form

| | | |
|-----------------------------|---------|-----------------------------|
| Date of Referral: | | Carrier Information: |
| 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>  |
| 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.