DELTA DENTAL

DELTACARE SPECIALTY REFERRAL FORM

DeltaCare Member: This form must be completed by your current DeltaCare Primary Care Dentist prior to seeking treatment from a specialist. Referrals issued after the service date will not be honored and the member will be responsible for the cost of all services. This form does not guarantee payment of services. Non-covered services are your responsibility as well as any services that are subject to the exclusions and limitations of your plan. Treatment must be started within 3 months and fully completed within 6 months days of the referral date*. If you transfer to another primary care dentist before the treatment is completed, you must obtain a new referral from your new Primary Care Dentist or you will be responsible for the cost of the specialty treatment. Your signature is required below.

*Periodontal maintenance following root planing and scaling or osseous surgery allowed up to 12 months following the final procedure.

Primary Care Dentist: This form must be completed in its entirety and signed by the referring dentist. Incomplete forms will be returned and will delay processing of the claim. Do not make any modifications to this form after it has been given to the patient or the Specialty Dentist. Keep a copy for your records and forward the original along with recent, appropriate diagnostic quality radiographs to the DeltaCare Specialty Dentist. Please refer to the DeltaCare Specialty Referral guidelines to ensure the referral is valid. Failure to adhere to the guidelines may result in your office being charged for the specialty services rendered. If you have any questions, please contact DeltaCare Customer Service at 800-870-9988.

Specialty Dentist: If this form is not completed in its entirety, return it the DeltaCare Primary Care Dentist for completion prior to beginning treatment. Attach a completed ADA approved claim form and include any appropriate radiographs and periodontal charting. If procedures other than those requested on this referral are needed, you must contact the referring Primary Care Dentist for written authorization. Do not modify this form. Failure to adhere to these conditions may result in disallowance of the procedures. **Submit the claim to DeltaCare, P.O. Box 30383, Lansing, MI 48909-7883. To verify eligibility and benefit coverage, please contact DeltaCare Customer Service at 800-870-9988.**

DELTACARE MEMBER INFORMATION

REFERRAL DATE	PATIENT NAME	
SUBSCRIBER NAME:	PATIENT DATE OF BIRTH	
SUBSCRIBER SSN OR ALT ID	GROUP NO.	PLAN ID
SUBSCRIBER TELEPHONE NO.	GROUP NAME	

DELTACARE PRIMARY CARE DENTIST

FC ID	FACILITY NAME
ADDRESS	
TELEPHONE	FAX

DELTACARE SPECIALTY DENTIST

SP FC ID	SPECIALTY DENTIST/FACILITY NAME
SPECIALIST ADDRESS	
TELEPHONE	FAX
☐ Endodontist ☐ Pedodontist ☐ Oral Surgeon ☐ Periodontist	If Pedo or Perio, indicate date of last D1110, D1120, D4355 or D4910

SERVICES REQUESTED BY PRIMARY CARE DENTIST

QUAD/ TOOTH	TYPE OF RADIOGRAPHS SENT TO SPECIALIST (indicate number of PAs sent)	DATE TAKEN	REASON FOR REFERRAL
	________☐ PA(s) ☐Panorex ☐ Complete Series		
	________☐ PA (s) ☐Panorex ☐ Complete Series		
	________☐ PA(s) ☐Panorex ☐ Complete Series		
	________☐ PA (s) ☐Panorex ☐ Complete Series		

ADDITIONAL INFO

I hereby refer the above name Member to the above named DeltaCare Specialty Dentist for the service(s) indicated. I have reviewed the DeltaCare Specialty Referral guidelines and understand that if this referral does not meet those guidelines, I may be responsible for the fees that DeltaCare pays to the specialty office for covered, but non-referable services. Only those services covered by the Member's DeltaCare Plan will be reimbursable to the DeltaCare Specialty Dentist. Non-covered services are the responsibility of the Member. All services are subject to the Exclusions and Limitations of the Member's plan. If the Member is not eligible on the date of service, the member is financially responsible for all services rendered.

PRIMARY CARE DENTIST'S SIGNATURE	DATE
MEMBER/PATIENT SIGNATURE	DATE