MHS
Managed Health Services

Periodontist Referral Request

Be sure to ask if the MHS/NHP member has other insurance.
The other insurance is primary, follow its guidelines.

SEDA Fax 414-389-9830 Date of Request _____ / _____ / _____

Member' Name:	DOB: Age:	
ID#:	Eligibility:	
Patient's CURRENT Address		
Patient's CURRENT Phone Number	Patient's Alternate Phone Number	
Patient's OTHER Insurance	ID #	Phone #

Provider's Name:	Provider's Address:
Office Contact Name: Fax: **( )**	Phone: **( )**
High Risk Factors:	
MHS Case Manager:	Phone:

SEDA Notes:

To ensure a timely turnaround on requested services, please complete this form and fax it to the number listed above, along with all other appropriate information/records pertaining to the services requested.

Thank you from the MHS Medical Services Department

This authorization is based on Medical Necessity. It is subject to the member's eligibility and contract limitations, and is not a guarantee of payment.