Print

Dental Hospital Referral

Clear Form

Caller Name	Date of call	CoverageVerified
Dentist Name	Phone	Fax
Address		
Client Name	ID#	Date of Birth
Parent/Guardian Name	Client Phone	
Address		
Medical Plan Name	Phone	Contact Name
PCP Name		PCP Phone
Hospital Facility Requested		Date(s) Requested
Patient special needs (i.e. interpreter, etc.)		

Clinical Information

Give a detailed description of the dental treatment needed (or a copy of the treatment plan can be attached if it details treatment needed)

Give a detailed explanation why a dental hospitalization is being requested. In the explanation state whether office oral sedation was used, and the results. Also, list other important information contributing to the need for hospitalization, such as the condition of the teeth/mouth, physical or mental disability, behavior issues, etc.

For use by Medical Plan Staff

Date services approved	Referral #
Dates referral valid	Approved by
Comments	