DeltaCare® USA

Specialty Care Direct Referral Form

INFORMATION FOR THE REFERRING DENTIST AND SPECIALIST:

- See the DeltaCare USA Dentist Handbook to verify enrollee benefits and that referral criteria have been met.
- For **Direct Referral** to a DeltaCare USA network specialist, complete the form and attach needed radiographs and charting. Send to the specialist either directly or by giving to the enrollee for the specialist. Note: This form is not required for referral to a DeltaCare USA contracted pediatric dentist.
- If unsure whether a DeltaCare USA network specialist is available, **phone our Customer Service department at 866-774-5595**. For emergency specialty care, Customer Service can issue an Emergency Authorization Number over the telephone.
- If there is no local DeltaCare USA network specialist, and the enrollee needs non-emergency specialty care, mail this form and required radiographs/charting to Delta Dental.

DeltaCare USA, Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

REFERRED PATIENT AND SUBSCRIBER/PRIMARY ENROLLEE (PE)

Patient Name (First)	(Middle)	(Last)	Patient Relationship to Primary Enrollee/Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient Date of Birth Month / Day / Year

Patient Covered by Any Other Dental Plan? ☐ Yes ☐ No	Name and Address of Other Dental Plan	Other Dental Plan Group #	Subscriber/PE ID #

Subscriber/PE Name (First)	(Middle)	(Last)	Subscriber/PE Daytime Telephone Number(s)	Amount Paid by Other Dental Plan

Subscriber/PE Street Mailing Address	Subscriber/PE Employer or Group Name
Subscriber/PE City, State Zip	Subscriber/PE Group/DeltaCare USA Plan Number

REFERRING CONTRACT GENERAL DENTIST OR PEDIATRIC DENTIST

DeltaCare USA Facility Number
Facility Name
Facility Street Address
Facility City, State ZIP
Facility Telephone

SPECIALIST RECEIVING REFERRAL

DeltaCare USA Facility Number (Or Enter “Non-Contracted”)
Specialist Name
Specialist Street Address
Specialist City, State ZIP
Specialist Telephone

NEEDED SPECIALTY SERVICES(S)

Needed Specialist Type (check one):
☐ Endodontist ☐ Oral Surgeon ☐ Orthodontist ☐ Periodontist

Specialist Plan Status (check one):
☐ DeltaCare USA Contracted ☐ Non-Contracted

Referral Type (check one):
☐ Direct Referral to a DeltaCare USA network specialist
☐ DeltaCare USA Preauthorized Referral for Routine Specialty Services(s)
☐ DeltaCare USA Preauthorized Referral for Emergency Specialty Services(s) with DeltaCare USA Emergency Authorization Number: ________________

Radiograph(s) Forwarded with This Form
☐ Radiographs How many? __________ ☐ to DeltaCare USA ☐ to Specialist
☐ Full-mouth periodontal charting ☐ to DeltaCare USA ☐ to Specialist
☐ Other: ____________________________ ☐ to DeltaCare USA ☐ to Specialist

Comments:

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TOOTH NO. QUADRANT ARCH	SURFACES	ENROLLEE'S COPAYMENT	[RESERVED FOR SPECIALIST]	
					Date of Service	Specialist Fee
					Total Fee	
					Patient Pays	

REFERRING DENTIST SIGNATURE
In my professional judgment all services I have listed above are needed and beyond the scope of a general or pediatric dentist. The information supplied herein is true and accurate.

Dentist Signature:____ Date:____________

PREAUTHORIZING SPECIALIST SIGNATURE
The treatment listed above is necessary in my professional judgment and I request a predetermination of cost and authorization.

Signature:____ Date:____________

SPECIALIST SIGNATURE FOR PAYMENT
The treatment listed above was completed on the date(s) of service listed. All information I have provided concerning this case is true and accurate.

Signature:____ Date:____________

Note, all dental services listed above may not be covered under all DeltaCare USA plans and referrals are subject to an enrollee's eligibility and plan-specific benefits, limitations and exclusions. For further information, enrollees can refer to their DeltaCare USA Evidence of Coverage.