aetna™ AETNA MANAGED DENTAL SPECIALTY REFERRAL FORM FOR DMO

☐ DIRECT REFERRAL (Eligible only to participating Specialty Dentists) ☐ SPECIALTY APPROVAL

IF SUBMITTING A UNIVERSAL CLAIM FORM FOR PAYMENT OR SPECIALTY APPROVAL, THIS REFERRAL FORM MUST BE INCLUDED.

COMPLETE MEMBER/PATIENT INFORMATION

PART I **EMPLOYEE INFORMATION**

EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) PLEASE PRINT | MEMBER IDENTIFICATION NUMBER | GROUP NUMBER OR CONTROL NUMBER | DATE OF BIRTH (MM/DD/YYYY)

HOME ADDRESS | WORK PHONE | HOME PHONE

CITY | STATE | ZIP CODE | OTHER INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, NAME OF PLAN

Is this member listed as a Late Entrant (LE) on your Monthly Roster? ☐ YES ☐ NO

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT PAYMENT WILL BE MADE DIRECTLY TO ATTENDING DENTIST.

PATIENT SIGNATURE (If minor, parent signature required) _____ DATE _____

PART II **COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT**

PATIENT'S NAME (LAST, FIRST, MI) If a Dependent | ☐ MALE ☐ FEMALE | DATE OF BIRTH (MM/DD/YYYY) | DEPENDENT STATUS ☐ SPOUSE ☐ CHILD ☐ OTHER | IF CHILD, IS HE/SHE WHOLLY DEPENDENT FOR SUPPORT & MAINTENANCE ☐ YES ☐ NO

PART III **REFERRING DENTIST**

REFERRING DR. _____ PHONE # _____ OFFICE CODE # _____

REFERRING TO DR. _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

☐ IN Network ☐ OUT of Network; if so, indicate reason _____

DMO Plan Code

ALL PROCEDURES BELOW, PRECEDED BY AN " * ", MUST BE APPROVED PRIOR TO REFERRAL

PLEASE INDICATE PRIMARY REASON FOR PATIENT REFERRAL:

ENDODONTICS *- Include Pre-OP and Post-OP Periapical X-rays*

- ☐ Consultation or problem focused examination (please explain below)
- ☐ Molar root canal therapy Tooth # _____
- ☐ Calcified/inaccessible canals (with conclusive radiograph evidence) Tooth # _____
- ☐ Root canal retreatments Tooth # _____
- ☐ Other procedure(s) eligible for direct referral (see list on opposite side of form) _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

PEDIATRICS *- Direct referral eligible only for consultation/evaluation for children under age 7. Detailed narrative required for children age 7 or over.*

- ☐ Medically compromised or developmentally disabled (please include a physician's statement of condition)
- ☐ Presents a documented behavioral management problem (please indicate below any attempts made to manage patient)
- ☐ Has rampant caries, or
- ☐ Requires emergency care that is beyond the scope or ability of the Primary Care Dentist
- ☐ Other * - **Any other service requires approval. Please explain below.**

ORAL SURGERY *- Include Pre-OP X-ray/Panoramic X-ray (Bitewings are NOT acceptable) and provide rationale for each tooth requested.*

- ☐ Consultation or problem focused examination (please explain below)
- ☐ Single symptomatic and/or pathologically involved partial or full bony impaction Tooth # _____ Symptoms: _____
- ☐ Five or more routine extractions to be performed in one visit (except for 3rd molars) Teeth #s _____ Symptoms: _____
- ☐ Alveoloplasty (in conjunction with three or more extractions in the same quadrant or in an edentulous area)
- ☐ Surgical removal of residual roots
- ☐ Other procedure(s) eligible for direct referral (see list on opposite side of form) _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

PERIODONTICS *- Include Periodontal charting, full mouth mounted intraoral X-rays (Panoramic X-ray is NOT acceptable)*

- ☐ Generalized moderate to severe periodontitis - consultation only
- ☐ Indicate date(s) and quadrants Scaling and Root Planing completed _____
- ☐ Other * - **Any other service requires approval. Please explain below.**

ORTHODONTICS *- Verify patient is eligible for Orthodontic benefits*

- ☐ Consultation or problem focused examination only

Clinical Indications / Rationale / Additional Comments: _____

SIGNATURE OF REFERRING DR. _____ DATE _____

PART IV **EXAMINATION, TREATMENT PLAN, and/or SERVICES RENDERED** **ATTENDING SPECIALIST**

Tooth # or Letter	Surface	Description of Services	Date Service Performed MM	DD	YYYY	Procedure Number (ADA Code)	Fee	Copay Collected

I hereby certify that the procedure(s) indicated by date have been completed and that the copay represents the actual copay collected.

Treating Dentist's Signature _____ TIN/SSN _____ NPI _____