SPECIALTY REFERRAL REQUEST FORM

**** THIS FORM IS TO BE COMPLETED BY THE PCD AND SIGNED BY THE MEMBER, PCD & SPECIALIST ****

Select one of the following: ☐ **Direct Referral** **or** ☐ **Pre-Authorization**

Authorization #: ______________________ **Date:** ______________________________

☐	**FCW IL/IN/MI/MO**	**(866) 494-4542**	**P.O. Box 981571**	**El Paso, TX 79998-1571**
☐	**MDC CA**	**(800) 273-3330**	**P.O. Box 981571**	**El Paso, TX 79998-1571**
☐	**MDG TX**	**(888) 618-2016**	**P.O. Box 981571**	**El Paso, TX 79998-1571**
☐	**MDG All Other States**	**(888) 618-2016**	**P.O. Box 981571**	**El Paso, TX 79998-1571**
☐	**Individual Plan Exchange**	**(844) 561-5600**	**P.O. Box 981587**	**El Paso, TX 79998-1587**
☐	**Individual Plan Direct**	**(866) 569-9900**	**P.O. Box 981587**	**El Paso, TX 79998-1587**

Office ID#: ______________________ **Referring PCD:** ____

Phone#:________________________ **PCD E-mail Address:**____

Patient Name: _____________________________________**Date of Birth:** _______________ **Plan #:** ___________________

Subscriber Name: _________________________________ **ID #:** _______________________ **Emergency:** ☐ **Yes** ☐ **No**

Subscriber Street Address:___________________________ **City/State:**__________________ **Zip:**__________________

Primary Care Dentist (PCD): Referral must be made to a network specialist. If there is no network specialist available, you must obtain prior authorization from the Plan. All referrals must be made in compliance with Plan Referral Guidelines. The PCD is responsible for the cost of covered services referred to non-participating specialists or for those services designated to be the responsibility of the PCD, unless prior authorization has been obtained from the Plan. Please have the member sign and date all Specialty Referral Request Forms. All necessary diagnostic x-rays must be attached and sent to the network specialist.

Network Specialist: Only the covered services referred by the PCD and listed on this form will be considered for payment. You may request authorization for any service not listed on this referral form by submitting a pre-authorization on an ADA approved claim form. Please attach this Specialty Referral Request Form and submit with a dated and signed claim form.

Specialty Care Benefits will only be considered for referable services listed on the applicable plan schedule and as explained in the Specialty Referral Guidelines Section of the Network Operations Manual.

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Some important Specialty Referral Guidelines are listed here for your convenience:

- **Endodontics:** Uncomplicated anterior (D3310) and bicuspid (D3320) root canals are the responsibility of the PCD.
- **Oral Surgery:** Routine (D7140) and uncomplicated surgical (D7210) extractions are the responsibility of the PCD. Referral of routine or uncomplicated surgical extractions for general anesthesia and extraction of asymptomatic or non-pathological 3rd molars are not covered.
- **Pediatric Dentistry:** Routine care for children is the responsibility of the PCD.
- **Periodontics:** A comprehensive treatment plan, preliminary therapy (including therapy to achieve control of local factors) and scaling and root planing (D4341), where appropriate, are the responsibility of the PCD.

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Specialty Requested: ☐ **Endodontics** ☐ **Oral Surgery** ☐ **Orthodontics** ☐ **Pediatric Dentistry** ☐ **Periodontics**

Refer To Network Specialist: ____ **Office ID:** ________________

Specialist E-mail Address: ____ **Phone:**____________________

Street Address: _______________________________________ **City/State :** ___________________________**Zip:** ___________

☐ **Consultation only** ☐ **Evaluation and Treatment** ☐ **Emergency**

Procedures Requested (attach additional form, if necessary):

Tooth # / Area	CDT Code	Tooth # / Area	CDT Code	Tooth # / Area	CDT Code

List circumstances requiring specialty referral for the requested services; please include all clinically relevant information:

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Patient Informed Consent for Referral: Your PCD has requested a referral for the specialty care services listed above. For covered services, the patient is responsible for the applicable plan schedule charges at the time of service. For non-covered services, the patient is responsible for the network specialist's usual fee. This referral is not a guarantee of coverage or benefit payment. The patient must be eligible at the time of service and the Plan's benefits, specialty referral guidelines, limitations and exclusions will determine coverage in all cases.

Patient (or Guardian) Signature: ____ Date: _______________

PCD Signature: ____ Date: _______________

Specialist Signature: ____ Date: _______________