

Specialty Care Referral Form

All pertinent specialty care information must be provided

Date _____

Patient name _____ Daytime phone # (_____) _____
FIRST MIDDLE LAST

Address _____
STREET CITY STATE ZIP CODE

Subscriber _____ Subscriber I.D. # _____
FIRST MIDDLE LAST

Plan # _____ Group # _____ Patient D.O.B. _____

Referring Dentist _____ Dentist I.D. # _____

Participating Specialist _____ Phone # (_____) _____

Address _____
STREET CITY STATE ZIP CODE

Periodontics Required Enclosed Items: Periocharting F.M. X-rays

Perio Case Type _____

Dates of Scaling & Root Planing _____, _____, _____, _____

Compliance with home care instruction: Good Fair Poor

Prognosis of Case: Good Fair Poor

Service Requested: Eval Surgery

Endodontics Required P.A. X-rays enclosed? Yes No ** 3310 Anterior - Tooth # _____

Calcified Canals ** 3320 Bicuspid - Tooth # _____

Retreatment ** 3330 Molar - Tooth # _____

Other Complications ** 3410 Apico - Tooth # _____

Oral Surgery Required Panoramic X-rays enclosed? Yes No

** 7210 Surgical Extraction - Tooth # _____ ** 7230 Partial Bony Impaction - Tooth # _____

** 7220 Soft Tissue Impaction - Tooth # _____ ** 7240 Full Bony Impaction - Tooth # _____

Pedodontics Required Bitewing and Periapical X-rays enclosed? Yes No

Age of Child: _____ years Patient compliance to treatment? Yes No

Orthodontics Age of Patient: _____ years

Comments _____

Please list complications prohibiting Family Dentist from performing the procedures requested:

		Services Requested
Tooth	ADA Code	Description
**		
**		
**		
**		

Approved Denied

UDC DENTAL CALIFORNIA, INC. USE ONLY

_____/_____/_____ ____/____/_____ _____ _____ ____/____/_____
 Date Received Date to Specialist UDC Signature UDC Dental Director Date

Contract Compliance Yes No Member Eligibility Yes No Emergency Yes No X-Ray Yes No Retro Review

UDC Comments _____

Send to: UDC Dental California, Inc. 6310 Greenwich Drive, Suite 210, San Diego, CA 92122 Toll Free Phone # 1.800.821.1294

THIS REFERRAL IS ONLY VALID FOR 60 DAYS FROM THE DATE SENT TO THE SPECIALIST INDICATED ABOVE