UDC Dental California, Inc.

* Required Field

Specialty Care Referral Form

All pertinent specialty care information must be provided

Clear Form

Date * _____

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

Address _____ (STREET CITY STATE ZIP CODE)

Subscriber * _____ (FIRST MIDDLE LAST) Subscriber I.D. # * _____

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 Plaining _____ , _____ , _____ , _____

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

☐ Calcified Canals

☐ Retreatment

☐ Other Complications

** 3310 Anterior - Tooth # _____

** 3320 Bicuspid - Tooth # _____

** 3330 Molar - Tooth # _____

** 3410 Apico - Tooth # _____

Oral Surgery Required Panoramic X-rays enclosed? ☐ Yes ☐ No

** 7210 Surgical Extraction - Tooth # _____

** 7220 Soft Tissue Impaction - Tooth # _____

** 7230 Partial Bony 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

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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