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		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 on you Monthly Compensation List? ☐ 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

REFERRING DENTIST

PART III

REFERRING DR. _____ PHONE # _____ OFFICE CODE # _____

REFERRING TO DR. _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

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

MEMBER'S PLAN _____

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

CLINICAL INDICATIONS / RATIONALE: **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 6. Detailed narrative required for children age 6 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 Case Type IV/V - 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

COMMENTS _____

_____

_____

SIGNATURE OF REFERRING DR. _____ DATE _____

ATTENDING SPECIALIST

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

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 _____

23.09.804.1D 2/07

Please see reverse side for additional information

R-WH

Note: Approval is ***not required*** if a member requires **emergency care** from a **pediatric dentist** because the needed care is beyond the scope or ability of the Primary Care Dentist.

ADDITIONAL PROCEDURES ELIGIBLE FOR DIRECT REFERRAL - Please indicate selected procedure in the appropriate area on the front of the form.

PLEASE NOTE: A Primary Care Dentist may Directly Refer only to a participating Specialty Dentist. Any procedure not specifically listed as eligible for Direct Referral or referrals to non-participating Specialty Dentists must be approved in advance by the appropriate Aetna Dental Service Center prior to referral. When submitting requests for approval or reimbursement consideration, please ensure supporting diagnostic material is included. **FAILURE TO COMPLY WITH THESE INSTRUCTIONS MAY AFFECT YOUR COMPENSATION.**

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

- Severely dilacerated and/or sclerosed roots (with conclusive radiographic evidence)
- Tortuous and/or convoluted roots (with conclusive radiographic evidence)
- Complications encountered during treatment (please explain on other side)
- Hemisection
- Root amputation
- Apexification/recalcification

ORAL SURGERY - Include Pre-OP X-ray/Panoramic X-ray
(Bitewings are not acceptable)

- Complications mid-treatment
- Treatment needs due to cellulitis
- Frenectomy
- Exostosis removal
- Removal of foreign body from bone
- Sequestrectomy
- Closure of oral fistula
- Transplantation of tooth or tooth bud
- Sialolithotomy
- Excision of hyperplastic tissue per arch (in conjunction with fabrication of prosthetic device)
- Biopsy

SPECIALTY DENTIST: Additional approval is required for treatment beyond the approved directly referred procedure(s). Approval must be obtained from the appropriate Aetna Dental Service Center for treatment to be eligible for benefit consideration. **FAILURE TO COMPLY WITH THESE INSTRUCTIONS MAY AFFECT YOUR COMPENSATION.**

The Specialty Dentist may report examination, treatment plan approval, or services rendered as follows:

Complete the appropriate section of the Specialty Referral Form, attach supporting diagnostic material and submit to the appropriate Aetna Dental Service Center.

OR

Submit a completed ADA type claim form along with a copy of the Specialty Referral Form indicating prescribed treatment and supporting diagnostic material to the appropriate Aetna Dental Service Center.

DID YOU REMEMBER TO . . . . . .

- ☐ OBTAIN APPROVAL AS REQUIRED?
- ☐ Complete each box applicable on the form?
- ☐ Provide copies of payment or rejection statements from another group?
- ☐ Provide all required diagnostic information?
- ☐ Sign the form and secure patient's signature?
- ☐ Mail completed forms to Aetna Dental, P.O. Box 14094, Lexington, KY 40512-4094

DISTRIBUTION OF COPIES: White - Specialist Yellow - Aetna Pink - Referring Primary Dentist

Return all copies to Aetna when requesting pretreatment estimates, specialty referrals, or special approvals.