FOR DNoA USE

CONTROL #

FORM #

DENTAL NETWORK OF AMERICA

DENTAL HMO PROGRAMS

SPECIALTY REFERRAL/TREATMENT FORM

PATIENT INFORMATION

1. Patient Name — First / M.I. / Last
2. Relationship to employee: ☐ self ☐ child ☐ spouse ☐ other________
3. Sex: M F
4. Patient birthdate: MM DD YYYY
5. Employee/subscriber name
6. Member I.D. Number
7. Employee/subscriber birthdate: MM DD YYYY
8. Employer name
9. Group number
10. Patient mailing address

COB SECTION

11. Is patient covered by another carrier? ☐ Yes (If "Yes", answer #'s 12-15) ☐ No

12a. Policyholder's name

12b. Policyholder's Member ID #

12c. Policyholder's birthdate: MM DD YYYY

13. Name and address of policyholder's employer
14. Carrier name & phone #
15. Relationship to patient: ☐ self ☐ parent ☐ spouse ☐ other ______________

REFERRING PRIMARY CARE DENTIST SECTION

16. Referral Date

16a. Reason for Referral

17. Referring Dentist Name
18. Referring Dentist Signature
19. Referring Office Center #

20. Benefit Plan #
21. Benefit Plan Maximum
22. **MAXIMUM REMAINING**
23. Pediatric Dentistry — Date of last visit with PCD___________
24. Endodontics Retreatment ☐ Yes ☐ No — Tooth #(s)_________________________________
25. Oral Surgery — Are teeth symptomatic? ☐ Yes ☐ No — Tooth #(s)_______________________________
26. Periodontics — Quadrants or Tooth#(s): ☐ UR ____________ ☐ UL ____________ ☐ LR ____________ ☐ LL ____________

☐ Type III Date S&RP ______________________ Date Re-evaluation______________________

☐ Type IV

I have received the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for co-payments on all covered benefits and for all costs of noncovered dental treatment.

➤ ________________________________ ________________

Signed (Patient, or parent, if minor) Date

I understand that payment will be made directly to the below named dentist.

➤ ________________________________ ________________

Signed (Insured person) Date

ATTENDING DENTIST

27. Dentist's Name
28. Dental Center No.
29. Mailing address
30. City, State, Zip
31. Dentist's S.S. or T.I.N. #
32. Dentist's License #
33. Dentist's phone # (including area code) (   )

	No	Yes	If yes, enter brief description and dates
34. Is treatment result of occupational illness or injury?			
35. Is treatment result of auto accident?			
36. Other accident?			
37. Are any services covered by another plan?			
38. Is treatment for orthodontics?			Class of malocclusion / Banding Date / Mos. treatment

PATIENT MUST BE ELIGIBLE AT TIME OF SERVICE FOR THE CLAIM TO BE CONSIDERED.

Tooth # or letter	Surface	Description of Service	Date Service performed Mo.	Day	Year	Procedure number (ADA code)	Fee For Service	Co-Pay	Amount of Benefit	**Administrative Use Only**
						TOTAL				

I hereby certify that the procedures indicated by date have been completed and that the fees submitted are the actual fees I have charged.

➤ ________________________________ ________________

Attending Dentist's Signature Date

FFS	
Co-Pay	
Not Cov.	
Over Max.	
Benefit Allowed	

Return all copies to DNoA when requesting Pretreatment Estimates, Specialty Referrals, or Special Authorizations

DISTRIBUTION OF COPIES: White - Return to DNoA Yellow - Specialist copy Green - Referring Dental Center Blue - DNoA use only

SPECIALTY REFERRAL FORM INSTRUCTIONS

ACCURATE COMPLETION OF ALL INFORMATION IS ESSENTIAL FOR PROMPT REIMBURSEMENT AND TREATMENT REPORTING.

- Only the primary care dentist can initiate a referral for treatment.
- The patient **MUST BE ELIGIBLE** at the time of service for the claim to be considered.

REFERRING PRIMARY CARE DENTIST (PCD) MUST:

☑ Refer your patient to a PARTICIPATING specialist.

☑ Complete the shaded section of the form. Be sure to provide the maximum remaining amount in box #22.

ATTENDING DENTIST PROVIDING SPECIALTY CARE MUST:

☑ Verify eligibility at the time of service by calling 800/462-8998.

☑ Complete the information in the Attending Dentist Section.

☑ Collect the following from the patient at the time of service:
- co-payments;
- charges for non-covered services;
- charges exceeding the benefit maximum.

☑ If another carrier is primary, submit an itemized explanation of benefits (EOB) attached to this claim.

☑ The suggested orthodontic financial arrangement for collecting the COPAYMENT is:

- 35% at the records appointment.
- 65% over the following 12 months.

PARTIAL COURSE OF TREATMENT

☑ A partial course of treatment is defined as a treatment of one arch; it does not refer to the number of months of treatment. The member's copayment will be prorated accordingly. Contact the Customer Service department for assistance.

SEND ALL FORMS TO: **Dental Network of America, LLC.**
P.O. Box 23089
Belleville, IL 62223-0089

FOR FURTHER INSTRUCTIONS, PLEASE REFER TO THE SPECIALTY REFERRAL PROCESS SECTION OF YOUR OFFICE MANAGER'S MANUAL.

If you have questions, call DNoA at: 1-888-DDS-1008