SPECIALTY REFERRAL REQUEST

Please submit all pertinent material to: First Commonwealth
P.O.Box 3319 Chicago, IL 60654 312/644-1800 ext. 8560

Center # _____ Referring Doctor _____ Phone # (____) _____
Address _____ City, State, Zip _____
Patient Name _____ Age _____ Plan # _____
Member Name _____ SS # ____-____-____ Emergency: ❑ Yes ❑ No

❑ **Periodontics** Referral should be preceeded by comprehensive treatment plan, preliminary therapy, including therapy to achieve control of plaque and scaling and root planing where appropriate.
Documentation Included: ❑ X-rays, Date Taken _____, ❑ Periodontal Charting
❑ Scaling and Root Planing Performed. Dates, _____,_____,_____

Referral For ❑ **Generalized Periodontitis;** ❑ **Gingival Grafting in** _____**Area;** ❑ **Other** _____

❑ **Endodontics** Uncomplicated anterior, bicuspid and molar root canals should be done by the primary care dentist. For all others please submit x-rays and reason for referral.
Documentation Included: ❑ Periapical X-rays , Date Taken_____, Area_____
Initial Treatment of Tooth/Teeth#_____, _____
Retreatment of Tooth/Teeth# _____, _____ Date of Original Treatment _____
Other Endodontic Service Tooth _____ , Description _____ADA Code_____
Unusual Circumstance Requiring Specialty Referral _____
_____

❑ **Oral Surgery** Routine extractions/surgical procedures are to be performed by the primary care dentist.
Teeth#_____, ADA Code_____ Teeth#_____, ADA Code_____
Teeth#_____, ADA Code_____ Teeth#_____, ADA Code_____
Teeth#_____, ADA Code_____ Teeth#_____, ADA Code_____
Unusual Circumstance Requiring Specialty Referral _____
_____

❑ **Pedodontics** Routine care for children is to be delivered by the primary care dentist.
Teeth#_____, ADA Code_____ Teeth#_____, ADA Code_____
Teeth#_____, ADA Code_____ Teeth#_____, ADA Code_____
❑ Referral is for behavior management reasons. ❑ X-rays Included, Date taken _____
Unusual Circumstance Requiring Specialty Referral _____
_____

❑ **Orthodontics** Angle Class_____,Overbite_____mm., Overjet_____mm.

❑ **Other Services**

Tooth #	Description	ADA Code

Patient consent: I understand that my primary care dentist has requested a referral for the dental specialty listed above. An approved referral is not a guarantee of covered services. The plan's benefits, rules, limitations, and exclusions will determine coverage in all cases.

X_____Patient (Parent or Guardian) Date_____

Specialist Patient is Being Referred To: _____
Street Address _____ City _____Telephone _____ / _____

FCW USE ONLY

Date Received_____ , Date Processed_____, Documentation Returned ❑, Processed by _____
❑ **Referral cannot be processed without** _____**documentation.**
❑ **Referral Approved** ❑ **Referral Denied** for the following reason:_____
_____
❑ **Referral Approved, but the following requested procedures will not be covered by the plan:** ☑ TMJ, ☑ Implants, ☑ General Anesthesia, ❑ Other
_____

Reviewer: _____ **Date:** _____ **Authorization #** _____

Specialist - White Copy *General Dentist - Yellow Copy* *First Commonwealth - Pink Copy* 177-012 11/99