Health Net Dental Specialist Referral Form

HEALTH NET DENTAL

3200 El Camino Real, Suite 290
Irvine, CA 92602

☐ **Specialty Referral**
(Mail to LDP with x-ray(s) & documents)

☐ **Emergency Referral**
(Call (800) 977-7307or Fax (800) 268-0154)

Provider		**Member**	
Prov License #	Phone	Member Name	ID#
Name		Patient Name	Phone
Address Address			DOB
City Cit		y	

CHECK ALL THAT APPLY IN EACH CATEGORY:

☐ **Endodontics** (must submit PA & BWX)

☐ **Prognosis** _____
☐ Pain
☐ Retreatment (date of original RCT ___)
☐ Calcification (circle one)
Canal involved M D B P
☐ Curved Canal (circle one)
Canal involved M D B P
☐ Internal/Ex ternal Resorption
☐ Apico ectomy/Retrofiling
☐ Other _____

☐ **Oral Surgery** (must submit PA or Pano)

☐ Pain
☐ Sw elling
☐ Periocornitis caused by exacerbated third molars
☐ Non-restorable – caries/internal resorption
☐ Resorption of roots of adjacent teeth
☐ Interference with prosthesis
of edentulous arches
☐ Other _____

- In absence of Pathology extractions of impacted teeth and roots are not a benefit

☐ **Periodontics** (must submit FMX & perio charting)

(circle one)
Case Type I, II, III, IV
Dates of Root Planing

UR _____ LL_____
LR _____ LR _____
☐Other _____

_____

☐ **Pedodontics**

☐ Unco operative
Date of treatment attempt _____
☐ Medical Reason _____
☐ See MD attached note
☐Other _____

_____

☐ **Orthodontics** Notes:

TREATMENT REQUEST

Tooth #	Surface	ADA Code	Description	Fee	Co-Pay

Dentist Signature _____ **Date** _____

In office use only
Date Received _____ Eligibility _____ Plan # _____
Date Processed _____
Approved ☐ Denied ☐ Modified ☐
X-rays reviewed _____ Tracking # _____
Comments_____