DeltaCare® USA

SPECIALTY CARE DIRECT REFERRAL FORM

INFORMATION FOR THE REFERRING GENERAL DENTIST AND SPECIALIST:

- See the DeltaCare USA Dentist Handbook to verify enrollee benefits and that referral criteria have been met.
- For **Direct Referral** to a DeltaCare USA Contracted Specialist, complete the form and attach needed radiographs and charting. Send to the specialist either directly or by giving to the enrollee for the specialist.
- If unsure whether a contract specialist is available, **phone our Customer Service department at 866-774-5595**. For emergency specialty care, Customer Service can issue an Emergency Authorization Number over the telephone.
- If there is no local contracted specialist, and the enrollee needs non-emergency specialty care, mail this form and required radiographs/charting to the Plan.

The Plan mailing address for referrals and claims is: **DeltaCare USA**, **Claims Department**, **P.O. Box 1810**, **Alpharetta, GA 30023.**

REFERRED PATIENT AND SUBSCRIBER/PRIMARY ENROLLEE (PE)

PATIENT NAME (FIRST) (MIDDLE) (LAST)	PATIENT RELATIONSHIP TO PRIMARY ENROLLEE/SUBSCRIBER ❑ Self ❑ Spouse ❑ Child ❑Other	PATIENT DATE OF BIRTH MONTH/DAY YEAR

PATIENT COVERED BY ANY OTHER DENTAL PLAN? ❑ Yes ❑ No	NAME AND ADDRESS OF OTHER DENTAL PLAN	OTHER DENTAL PLAN GROUP NUMBER	SUBSCRIBER/PE ID #

SUBSCRIBER/PE NAME (FIRST) (MIDDLE) (LAST)	SUBSCRIBER/PE DAYTIME TELEPHONE NUMBER(S)	AMOUNT PAID BY OTHER DENTAL PLAN

SUBSCRIBER/PE STREET MAILING ADDRESS	SUBSCRIBER/PE EMPLOYER OR GROUP NAME
SUBSCRIBER/PE CITY, STATE ZIP	SUBSCRIBER/PE GROUP/DELTACARE USA PLAN NUMBER

REFERRING ASSIGNED GENERAL DENTIST FACILITY

DELTACARE USA FACILITY NUMBER:

FACILITY NAME

FACILITY STREET ADDRESS

FACILITY CITY, STATE ZIP

FACILITY TELEPHONE

SPECIALIST FACILITY RECEIVING REFERRAL

DELTACARE USA FACILITY NUMBER (OR ENTER "NON-CONTRACTED")
0C0709

SPECIALIST NAME
Gary D. Sabbadini, DDS

SPECIALIST STREET ADDRESS
1500 Tara Hills Dr. Suite 100

SPECIALIST CITY, STATE ZIP
Pinole, CA 94564

SPECIALIST TELEPHONE
510-724-4400

NEEDED SPECIALTY SERVICE(S)

NEEDED SPECIALIST TYPE (check one):
❑ Endodontist ❑ Oral Surgeon ❑ Orthodontist ■ Pediatric Dentist ❑ Periodontist

SPECIALIST PLAN STATUS (check one):
❑ DeltaCare USA Contracted ❑ Non-Contracted

REFERRAL TYPE (check one)
❑ Direct Referral to a Contracted Specialist:
❑ DeltaCare USA Preauthorized Referral for Routine Specialty Service(s)
❑ DeltaCare USA Preauthorized Referral for Emergency Specialty Service(s) with DeltaCare USA Emergency Authorization Number :_____

RADIOGRAPH(S)/RECORD(S) FORWARDED WITH THIS FORM
❑ Radiographs How many?_____ ❑ to Plan ❑ to Specialist
❑ Full-mouth periodontal charting ❑ to Plan ❑ to Specialist
❑ Other:_____ ❑ to Plan ❑ to Specialist

COMMENTS:

PROCEDURE NUMBER	PROCEDURE DESCRIPTION	TOOTH NO. QUADRANT ARCH	SURFACES	ENROLLEE'S COPAYMENT	[RESERVED FOR SPECIALIST] DATE OF SERVICES	SPECIALIST FEE	
					TOTAL FEE		
					PATIENT PAYS		

REFERRING DENTIST SIGNATURE
In my professional judgment all services I have listed above are needed and beyond the scope of a general dentist. The information supplied herein is true and accurate.
Dentist Signature:_____ Date:_____

PREAUTHORIZING SPECIALIST SIGNATURE
The treatment listed above is necessary in my professional judgment and I request a predetermination of cost and authorization.
Signature:_____ Date:_____

SPECIALIST SIGNATURE FOR PAYMENT
The treatment listed above was completed on the date(s) of service listed. All information I have provided concerning this case is true and accurate.
Signature:_____ Date:_____

Note, all dental services listed above may not be covered under all DeltaCare USA plans and referrals are subject to an enrollee's eligibility and plan-specific benefits, limitations and exclusions. For further information, enrollees can refer to their DeltaCare USA Evidence of Coverage.