Auth. Code:_____

Nevada Dental Benefits, Ltd.®

a PRIMECARE℠ BENEFITS GROUP company

Date:_____

NEVADA DENTAL BENEFITS REQUEST FOR SPECIALTY REFERRAL: **ORAL SURGERY**

PROVIDER INFORMATION

Referring Provider Name: Practice Name:		Specialty Provider Name: Practice Name:	
Address:		Address:	
City: State:	Zip: Phone:	City: State:	Zip: Phone:

EMPLOYEE & PATIENT

Employee Name:		ID:	
Address:			
City:	State:	Zip Code:	Phone:
Patient Name:		Date of Birth:	Relationship:

REASON FOR REFERRAL

Please answer each question listed below.

Question	Answer
1. Indicate reason why this service cannot be performed in your office.	1.
2. Is there a medical condition that requires specialist care? If yes, explain.	2.
3. Describe oral pathology and its location.	3.

Mark with an "X" teeth to be extracted

			☐A	☐B	☐C	☐D	☐E	☐F	☐G	☐H	☐I	☐J				
☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10	☐11	☐12	☐13	☐14	☐15	☐16	
☐32	☐31	☐30	☐29	☐28	☐27	☐26	☐25	☐24	☐23	☐22	☐21	☐20	☐19	☐18	☐17	
			☐T	☐S	☐R	☐Q	☐P	☐O	☐N	☐M	☐L	☐K				

Required Documents

Check (√) to ensure required documents are attached:

- ☐ Current and readable copy of radiographs
- ☐ Copy of Progress Notes indicating any treatment completed leading to this request for referral

COMMENTS:

NOTE: Radiographs must be readable and show the entire crown and root structure. For panographs, indicate patient's left (L) or right (R) side.

THIRD MOLAR ASSESSMENT

THE REMOVAL OF 3rd MOLARS THAT ARE ASYMPTOMATIC OR NONPATHOLOGIC ARE NOT A COVERED BENEFIT

If request involves third molars, the following section must be completed. Please check YES or NO for each question and tooth.

Tooth #	Is a nonrestorable carious lesion present?	Is patient currently experiencing periocoronitis?	Are extractions requested due to an orthodontic treatment plan?	Are there other conditions indicative of oral pathology present? If yes, write comment in box above.	Has tooth experienced resorption?	Is the patient experiencing pain other than expected from normal eruption?
#1	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
#16	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
#17	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
#32	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

IF URGENT REQUEST, PLEASE ANSWER THE FOLLOWING QUESTIONS

Is the patient in pain now? ☐ Yes ☐ No	Is the patient swollen? ☐ Yes ☐ No	Have you prescribed / dispensed medication(s) to the patient? ☐ Yes ☐ No

When can the patient go to the specialist? ☐ Now ☐ Later Today ☐ Tomorrow

I verify that the information submitted on this form is a true representation of the clinical status of the patient.

Dentist signature required _____

REQUEST FOR SPECIALTY REFERRAL SUBMISSION INSTRUCTIONS

This form is to be completed by NDB Premier General Dentist Providers only. Specialty Premier (In-Network) Benefits are only available when referred by a NDB Premier General Dentist Provider.

1. Complete "Request for Specialty Referral" form, attach necessary documentation (x-rays, periodontal charting, narrative, etc.). Please refer to list of participating NDB Specialty Providers.

2. For non-urgent requests (retain copy for your records), mail to the following:

   Nevada Dental Benefits – PA
   P.O. Box 80117
   Las Vegas, NV 89180

3. You will receive a written response within 14 days. If you do not receive a response, please contact us at: (702) 478-2014.

For urgent requests for specialty referral, please follow the steps below:

General Dentist

1. Complete this form, attach necessary documentation (x-rays, periodontal charting, narrative, etc.). Please refer to list of participating NDB Specialty Providers.

2. Assist member in scheduling appointment with participating specialist and fax this form to specialist.

3. Give copy of this form and x-rays to member to take to specialist.

4. Fax this form to Nevada Dental Benefits: (702) 333-9140.

Specialist

1. Contact Nevada Dental Benefits at (702) 478-2014 to verify eligibility and indicate procedure to be performed to address urgent need.