



AETNA MANAGED DENTAL SPECIALTY REFERRAL FORM FOR DMO

DIRECT REFERRAL (Eligible only to participating Specialty Dentists) SPECIALTY APPROVAL

IF SUBMITTING A UNIVERSAL CLAIM FORM FOR PAYMENT OR SPECIALTY APPROVAL, THIS REFERRAL FORM MUST BE INCLUDED.

COMPLETE MEMBER/PATIENT INFORMATION	PART I EMPLOYEE INFORMATION					
	EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL) PLEASE PRINT			MEMBER IDENTIFICATION NUMBER	GROUP NUMBER OR CONTROL NUMBER	DATE OF BIRTH (MM/DD/YYYY)
	HOME ADDRESS			WORK PHONE	HOME PHONE	
	CITY	STATE	ZIP CODE	OTHER INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	IF YES, NAME OF PLAN _____					
	Is this member listed as a Late Entrant (LE) on your Monthly Roster? <input type="checkbox"/> YES <input type="checkbox"/> NO					

PART II COMPLETE ONLY IF CLAIM IS FOR A DEPENDENT						
PATIENT'S NAME (LAST, FIRST, MI) If a Dependent			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH (MM/DD/YYYY)	DEPENDENT STATUS <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	IF CHILD, IS HE/SHE WHOLLY DEPENDENT FOR SUPPORT & MAINTENANCE <input type="checkbox"/> YES <input type="checkbox"/> NO

PART III					
REFERRING DR. _____		PHONE # _____		OFFICE CODE # _____	
REFERRING TO DR. _____		PHONE # _____			
ADDRESS _____		CITY _____	STATE _____	ZIP CODE _____	
<input type="checkbox"/> IN Network <input type="checkbox"/> OUT of Network; if so, indicate reason _____					
DMO Plan Code _____					

ALL PROCEDURES BELOW, PRECEDED BY AN " * ", MUST BE APPROVED PRIOR TO REFERRAL.

PLEASE INDICATE PRIMARY REASON FOR PATIENT REFERRAL:

REFERRING DENTIST	ENDODONTICS - Include Pre-OP and Post-OP Periapical X-rays		ORAL SURGERY - Include Pre-OP X-ray/Panoramic X-ray (Bitewings are NOT acceptable) and provide rationale for each tooth requested.			
	<input type="checkbox"/> Consultation or problem focused examination (please explain below)		<input type="checkbox"/> Consultation or problem focused examination (please explain below)			
	<input type="checkbox"/> Molar root canal therapy Tooth # _____		<input type="checkbox"/> Single symptomatic and/or pathologically involved partial or full bony impaction Tooth # _____ Symptoms: _____			
	<input type="checkbox"/> Calcified/inaccessible canals (with conclusive radiograph evidence) Tooth # _____		<input type="checkbox"/> Five or more routine extractions to be performed in one visit (except for 3rd molars) Teeth #s _____ Symptoms: _____			
<input type="checkbox"/> Root canal retreatments Tooth # _____		<input type="checkbox"/> Alveoloplasty (in conjunction with three or more extractions in the same quadrant or in an edentulous area)				
<input type="checkbox"/> Other procedure(s) eligible for direct referral (see list on opposite side of form) _____		<input type="checkbox"/> Surgical removal of residual roots				
<input type="checkbox"/> Other * - Any other service requires approval. Please explain below.		<input type="checkbox"/> Other procedure(s) eligible for direct referral (see list on opposite side of form) _____				
PEDIATRICS - Direct referral eligible only for consultation/evaluation for children under age 7. Detailed narrative required for children age 7 or over.		PERIODONTICS - Include Periodontal charting, full mouth mounted Intraoral X-rays (Panoramic X-ray is NOT acceptable)				
<input type="checkbox"/> Medically compromised or developmentally disabled (please include a physician's statement of condition)		<input type="checkbox"/> Generalized moderate to severe periodontitis - consultation only				
<input type="checkbox"/> Presents a documented behavioral management problem (please indicate below any attempts made to manage patient)		<input type="checkbox"/> Indicate date(s) and quadrants Scaling and Root Planing completed				
<input type="checkbox"/> Has rampant caries, or		<input type="checkbox"/> Other * - Any other service requires approval. Please explain below.				
<input type="checkbox"/> Requires emergency care that is beyond the scope or ability of the Primary Care Dentist		ORTHODONTICS - Verify patient is eligible for Orthodontic benefits				
<input type="checkbox"/> Other * - Any other service requires approval. Please explain below.		<input type="checkbox"/> Consultation or problem focused examination only				
Clinical Indications / Rationale / Additional Comments: _____						
SIGNATURE OF REFERRING DR. _____ DATE _____						

ATTENDING SPECIALIST	PART IV EXAMINATION, TREATMENT PLAN, and/or SERVICES RENDERED								
	Tooth # or Letter	Surface	Description of Services	Date Service Performed			Procedure Number (ADA Code)	Fee	Copay Collected
				MM	DD	YYYY			
I hereby certify that the procedure(s) indicated by date have been completed and that the copay represents the actual copay collected.									
Treating Dentist's Signature _____ TIN/SSN _____ NPI _____									

Note: Approval is *not required* if a member requires **emergency care** from a **pediatric dentist** because the needed care is beyond the scope or ability of the Primary Care Dentist.

ADDITIONAL PROCEDURES ELIGIBLE FOR DIRECT REFERRAL - Please indicate selected procedure in the appropriate area on the front of the form.

PLEASE NOTE: A Primary Care Dentist may Directly Refer only to a participating Specialty Dentist. Any procedure not specifically listed as eligible for Direct Referral or referrals to non-participating Specialty Dentists must be approved in advance by the appropriate Aetna Dental Service Center prior to referral. When submitting requests for approval or reimbursement consideration, please ensure supporting diagnostic material is included. **FAILURE TO COMPLY WITH THESE INSTRUCTIONS MAY AFFECT YOUR COMPENSATION.**

ENDODONTICS - Include Pre-OP and Post-OP Periapical X-rays

- Severely dilacerated and/or sclerosed roots (with conclusive radiographic evidence)
- Tortuous and/or convoluted roots (with conclusive radiographic evidence)
- Complications encountered during treatment (please explain on other side)
- Hemisection
- Root amputation
- Apexification/recalcification

**ORAL SURGERY - Include Pre-OP X-ray/Panoramic X-ray
(Bitewings are not acceptable)**

- Complications mid-treatment
- Treatment needs due to cellulitis
- Frenectomy
- Exostosis removal
- Removal of foreign body from bone
- Sequestrectomy
- Closure of oral fistula
- Transplantation of tooth or tooth bud
- Sialolithotomy
- Excision of hyperplastic tissue per arch (in conjunction with fabrication of prosthetic device)
- Biopsy

SPECIALTY DENTIST: Additional approval is required for treatment beyond the approved directly referred procedure(s). Approval must be obtained from the appropriate Aetna Dental Service Center for treatment to be eligible for benefit consideration. **FAILURE TO COMPLY WITH THESE INSTRUCTIONS MAY AFFECT YOUR COMPENSATION.**

The Specialty Dentist may report examination, treatment plan approval, or services rendered as follows:

Complete the appropriate section of the Specialty Referral Form, attach supporting diagnostic material and submit to the appropriate Aetna Dental Service Center.

OR

Submit a completed ADA type claim form along with a copy of the Specialty Referral Form indicating prescribed treatment and supporting diagnostic material to the appropriate Aetna Dental Service Center.

DID YOU REMEMBER TO

- OBTAIN APPROVAL AS REQUIRED?
- Complete each box applicable on the form?
- Provide copies of payment or rejection statements from another group?
- Provide all required diagnostic information?
- Sign the form and secure patient's signature?
- Mail completed forms to Aetna Dental, P.O. Box 14094, Lexington, KY 40512-4094

Questions may be directed to 1-800-451-7715.