# Maryland Uniform Dental Consultation Referral Form

| **Date of Referral:** | | **Carrier Information:** |
|---|---|---|
| **Patient Information:** | | |
| Name: (Last, First, MI) | | Name: |
| Date of Birth (MM/DD/YY): | Phone: | Address: |
| Member #: | | Phone Number: |
| Site #: | | Facsimile/Data #: |

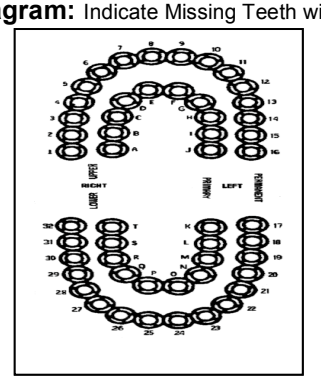
**Primary or Requesting Dentist**

| Name (Last, First, MI): | | Specialty: |
|---|---|---|
| Institution/Group Name: | Provider ID #: 1 | Provider ID #: 2 (If Required) |
| Address: (Street #, City, State, Zip) | | |
| Phone Number: | | Facsimile/Data #: |

**Specialist Dentist**

| Name: (Last, First, MI) | | Specialty: | |
|---|---|---|---|
| Dental Office Name: | Dental Office Code: | | Provider ID/License #: |
| Address: (Street #, City, State, Zip) | | | |
| Phone Number: | | Facsimile/Data #: | |

**Referral Information**

| Reason for Referral: | |
|---|---|
| Brief History, Diagnosis, and Test Results: | |
| | |
| | |
| **Services Desired:** Provide Care as Indicated:<br><br>[ ] Initial Consultation Only<br>[ ] Consultation with Specific Procedures (Specify)<br>[ ] Other: (Explain)<br><br>**Place of Service:**<br><br>[ ] Office<br>[ ] Hospital<br>[ ] Other: (Explain) | **Teeth Diagram:** Indicate Missing Teeth with an "X".<br>  |
| Authorization # (If Required): | Referral is Valid Until: (Date)<br>(See Carrier Instructions) |
| **Signature:** (Individual Completing This Form) | **Authorizing Signature:** (If Required) |

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Reverse and Carrier/Plan Manual for Specific Instructions