

CareOregon Dental Referral/Prior Authorization Form

This form is used for referral or prior authorization requests from CareOregon Dental providers who are not able to submit requests through the CareOregon Connect/OneHealth portal. All requests should be submitted online if possible. This form can be submitted to dentalaccessteam@careoregon.org or faxed to (503) 416-8108.



Date of Request*: _____

Reason for Fax/Email Form: No Internet Access CareOregon Connect or OneHealth Port offline
 Non-participating Provider (no Connect/OneHealth Port account) Other

Level of Service (Priority) *: Routine Urgent; **By selecting urgent, I certify that the request is for a dental urgency and includes a patient with severe swelling, infection, pain or other dental emergency situations that would jeopardize the life or health of the patient.**

Is this Request a....*

Referral (requesting approval of services and assignment to specialty provider by CareOregon Dental) OR
 Prior Authorization (requesting approval for requesting provider to perform services)

Patient Medicaid ID*: _____

Patient First Name*: _____

Patient DOB*: _____

Patient Last Name*: _____

Patient Main Phone Number*: _____ Patient Secondary Phone Number: _____

Parent/Guardian/Caregiver Name: _____ Parent/Guardian/Caregiver phone: _____

Interpreter Needed? No Yes, Language: _____

Is Patient Pregnant? No Yes

Service Type*: Endodontics Special Needs General Dentistry Hospital Dentistry
select one Orthodontics Oral Pathology Oral Surgery Prosthodontics
 Periodontics Pediatric Dentistry

Requested CDT Codes*	Quantity*	Teeth/Treatment Area*

All requests **must** include at least one CDT code that corresponds with the selected Service Type. Codes for different service types should be submitted as separate requests. Each code should have an associated Quantity and Treatment Area. Teeth or Oral Cavities may be used (i.e. Entire Oral Cavity).

Are there other requests being submitted for this member or related requests that should be considered alongside this request*? No Yes

Additional Information/Comments:

Please remember to include supporting documentation (Chart Notes, Complete Treatment Plan, Medical History, Recent Periodontal Charting, Radiographs, and/or Tooth Charting) as appropriate.

If you selected **Endodontics, Special Needs, Hospital Dentistry, or Prosthodontics** as the Service Type, please continue to **Additional Questions**.

Additional Questions: Please answer additional questions associated with the selected Service Type.

If you selected **Endodontics** as a service, please provide the following information:

Planned Final Restoration*: Composite Amalgam Stainless Steel Crown PFM/Cast Crown
 Other: _____

If you selected **Special Needs** as a service, please provide the following information:

Patient's Primary Care Provider*: _____ Primary Care Provider Phone*: _____

If you selected **Hospital Dentistry** as a service, please provide the following information:

Please explain the clinical justification for requesting hospital based dental care*:

If you selected **Prosthodontics** as a service, please provide the following information:

Select Type*:

Complete Denture (D5110, D5120)

Is patient's arch edentulous today? Yes No; **Reminder: Complete dentures are for edentulous patients only**

Immediate Denture (D5130, D5140)

Are you...

- Referring for Oral Surgery; **Reminder: Coordinate dentist and oral surgeon on behalf of patient** OR
- Extracting Teeth/delivering denture at your office; **Reminder: Coordinate surgery with dentist**

Resin Partial (D5211, D5212)

Reminder: Planned extractions must have already been completed

Teeth to be replaced: _____

Date restorations completed: _____ Date periodontal treatment completed: _____

Immediate Resin Partial (D5221, D5222)

Teeth to be extracted: _____ Teeth to be replaced by partial: _____

Date restorations completed: _____ Date periodontal treatment completed: _____

Are you...

- Referring for Oral Surgery; **Reminder: Coordinate dentist and oral surgeon on behalf of patient** OR
- Extracting Teeth/delivering denture at your office; **Reminder: Coordinate surgery with dentist**

Interim Partial (D5820, D5821)

All teeth to be replaced: _____

Other

Any additional information: