



Auth. Code: _____

Date: _____

NEVADA DENTAL BENEFITS REQUEST FOR SPECIALTY REFERRAL: **ENDODONTICS**

PROVIDER INFORMATION

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

EMPLOYEE & PATIENT

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

DIAGNOSIS

TOOTH # <input type="text"/>		TOOTH # <input type="text"/>	
Apical diagnosis: <input type="checkbox"/> Acute apical periodontitis <input type="checkbox"/> Chronic apical periodontitis <input type="checkbox"/> Other	Pulpal diagnosis: <input type="checkbox"/> Vital pulp <input type="checkbox"/> Reversible pulpitis <input type="checkbox"/> Irreversible pulpitis <input type="checkbox"/> Necrotic pulp <input type="checkbox"/> Other	Apical diagnosis: <input type="checkbox"/> Acute apical periodontitis <input type="checkbox"/> Chronic apical periodontitis <input type="checkbox"/> Other	Pulpal diagnosis: <input type="checkbox"/> Vital pulp <input type="checkbox"/> Reversible pulpitis <input type="checkbox"/> Irreversible pulpitis <input type="checkbox"/> Necrotic pulp <input type="checkbox"/> Other
Is this tooth restorable?		Is this tooth restorable?	
If retreat is requested, please complete the following: Date of Previous RCT: / / Provider who completed RCT: _____		If retreat is requested, please complete the following: Date of Previous RCT: / / Provider who completed RCT: _____	

URGENT/EMERGENCY EVALUATION

Please answer the following questions by checking the appropriate box:		Yes	No
Is the patient in pain now?		<input type="checkbox"/>	<input type="checkbox"/>
Is the patient swollen?		<input type="checkbox"/>	<input type="checkbox"/>
Have you prescribed / dispensed medication(s) to the patient?		<input type="checkbox"/>	<input type="checkbox"/>
Do you have x-rays to send with the patient to the specialist?		<input type="checkbox"/>	<input type="checkbox"/>
When can the patient go to the specialist?	<input type="checkbox"/> Now	<input type="checkbox"/> Later Today	<input type="checkbox"/> Tomorrow

REASON FOR REFERRAL

Provide narrative to support reason for referral:

DOCUMENTS REQUIRED

Check (√) to ensure the following required documents are attached:
 Current and readable copy of radiographs

FOR URGENT REQUESTS ONLY. If non-urgent, leave blank for NDB Administrative use.

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

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

Nevada Dental Benefits - PA
6543 S. Las Vegas Blvd., 2nd Floor
Las Vegas, NV 89119
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, narrative, etc.).
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.

