Auth. Code:_____

Nevada Dental Benefits, Ltd.®

a PRIMECARE℠ BENEFITS GROUP company

Date:_____

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

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:

PATIENT HEALTH & PERIODONTAL HISTORY

Does patient smoke? ☐ Yes ☐ No Is patient diabetic? ☐ Yes ☐ No	Date of last Periodontal Maintenance (D4910): / /
Date of first periodontal probing: / /	Were Oral Hygiene Instructions taught? ☐ Yes ☐ No
Date of last periodontal probing: / /	How is patient's home care? ☐ Good ☐ Fair ☐ Poor
☐ Patient has 4+mm pockets and/or bone loss four weeks post scaling and root planing	☐ Patient has had previous surgery that appears to be failing

INDICATE *CURRENT* PERIODONTAL STATUS BY CHECKING (√) MOST APPLICABLE FOR EACH QUADRANT

Upper Right Quadrant	☐ Slight (4-5 mm) ☐ Moderate (5-8 mm) ☐ Advanced (8-12 mm)	**Lower Left Quadrant**	☐ Slight (4-5 mm) ☐ Moderate (5-8 mm) ☐ Advanced (8-12 mm)
Upper Left Quadrant	☐ Slight (4-5 mm) ☐ Moderate (5-8 mm) ☐ Advanced (8-12 mm)	**Lower Right Quadrant**	☐ Slight (4-5 mm) ☐ Moderate (5-8 mm) ☐ Advanced (8-12 mm)

Missing Teeth:	☐ 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

REASON FOR REFERRAL

Please provide a narrative to support reason for referral:

DOCUMENTS REQUIRED

Check (√) to ensure the following required documents are attached:

- ☐ Current and readable copy of full mouth radiographs
- ☐ Current and readable copy of periodontal charting
- ☐ Copy of general dentist treatment plan for patient

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
   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, 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.