Avesis Medicaid Dental Specialty Referral Form

Authorization Number:			Authorization Expiration Date:	
Avesis Dental Consultant Signature:			Date:	___ Approved ___ Denied ___ Pending
This request is for: ☐ Endodontist ☐ Periodontist ☐ Orthodontist			Services Requested: ☐ Consultation with Treatment ☐ Consultation Only	
Member Information				
Name of Member:	Date of Birth:	Member ID #	Does Member have other Coverage? Plan #: Group #:	
Address:	City:	State:	Zip Code:	Telephone Number:
General/Pediatric Dentist Information	Signature:		Date:	Circle Prognosis: Good Fair Poor

Required information for referral:
Endodontics: Please submit tooth number and radiographs
Orthodontics: Please submit qualifying condition
Periodontics: Please submit probings and radiographs

Print Name of Referring General/Pediatric Dentist:	Avesis #:	Telephone #:	Fax #:
Address:	City:	State:	Zip Code:
Name of Specialist:	Avesis #:	Telephone #:	Fax #:
Address:	City:	State:	Zip Code:
Number of radiographs sent: _____ NEA Attachment Number: _____		Study models sent: ☐ Yes ☐ No	

Reason for Referral to include tooth number and treatment :

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____