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 ☐ Pregnancy	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

Periodontics: Please submit probings and radiographs

Orthodontics: Please submit qualifying condition

Pregnancy: Please submit DMA – 635

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 :

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