Health Net Dental Specialist Referral Form

Health Net DENTAL

340 Commerce, Suite 100

Irvine, CA 92602

☐ **Specialty Referral**

(Mail to Health Net with x-ray & documents)

☐ **Emergency Referral**

(Call: (800) 977-7307 or Fax to Health Net)

Provider		**Member**	
Provider #ID	Phone	Member Name	ID#
Name		Patient Name	Phone
Address		Address	DOB
City		City	

CHECK ALL THAT APPLY IN EACH CATEGORY:

☐ **Endodontics** (must submit PA & BWX)	☐ **Oral Surgery** (must submit PA or Pano)
☐ **Prognosis** _____	☐ Pain
☐ Pain	☐ Swelling
☐ Retreatment (date of original RCT ___)	☐ Periocornitis caused by exacerbated third molars
☐ Calcification (circle one)	☐ Non-restorable – caries/internal resorption
Canal involved M D B P	☐ Resorption of roots of adjacent teeth
☐ Curved Canal (circle one)	☐ Interference with prosthesis
Canal involved M D B P	of edentulous arches
☐ Internal/External Resorption	☐ Other _____
☐ Apicoectomy/Retrofiling	• In absence of Pathology extractions of
☐ Other _____	impacted teeth and roots are not a benefit

☐ **Periodontics** (must submit FMX & perio charting)	☐ **Pedodontics**
(circle one)	

Case Type I, II, III, IV Dates of Root Planing UR _____ LL_____ LR _____ LR _____ ☐Other _____ _____	☐ Uncooperative Date of treatment attempt _____ ☐ Medical Reason _____ ☐ See MD attached note ☐Other _____ _____
☐ **Orthodontics** Notes:	

TREATMENT REQUEST

Tooth #	**Surface**	**ADA Code**	**Description**	**Fee**	**Co-Pay**

Dentist Signature _____ **Date** _____

In office use only

Date Received _____ Eligibility _____ Plan # _____

Date Processed _____

Approved ☐ Denied ☐ Modified ☐

X-rays reviewed _____ Tracking # _____

Comments_____