Nevada Dental Benefits, Ltd.®

a PRIMECARE℠ BENEFITS company

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 #		**TOOTH #**	
Apical diagnosis: ☐ Acute apical periodontitis ☐ Chronic apical periodontitis ☐ Other	**Pulpal diagnosis:** ☐ Vital pulp ☐ Reversible pulpitis ☐ Irreversible pulpitis ☐ Necrotic pulp ☐ Other	**Apical diagnosis:** ☐ Acute apical periodontitis ☐ Chronic apical periodontitis ☐ Other	**Pulpal diagnosis:** ☐ Vital pulp ☐ Reversible pulpitis ☐ Irreversible pulpitis ☐ Necrotic pulp ☐ 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?		☐	☐
Is the patient swollen?		☐	☐
Have you prescribed / dispensed medication(s) to the patient?		☐	☐
Do you have x-rays to send with the patient to the specialist?		☐	☐
When can the patient go to the specialist?	☐ Now	☐ Later Today	☐ 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:

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, narrative, etc.).

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

   Nevada Dental Benefits – PA
   P.O. Box 80117
   Las Vegas, NV 89180

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.