Auth. Code:_____

Nevada Dental Benefits, Ltd.®
a PRIMECARE℠ BENEFITS company

Date:_____

NEVADA DENTAL BENEFITS REQUEST FOR SPECIALTY REFERRAL: ORTHODONTICS

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:

GUIDELINES FOR REFERRAL

Please answer each question listed below.

1. Class: I II III (Circle One)	
2. What is the primary reason for referral?	
3. Is patient 19 years old or older?	☐!Yes! ☐!No
4. Has all restorative work been completed?	☐!Yes! ☐!No
5. Has the patient demonstrated good oral hygiene practices?	☐!Yes! ☐!No
6. Have the 12 year molars erupted to full occlusion?	☐!Yes! ☐!No
6a. If answer "NO" to question #6 above, please provide narrative to support need for early referral:	

7. Does the patient present with one of the following qualifying conditions? (complete question 7 for Nevada Kids plans only)		☐!Yes! ☐!No
7a. Severe Overbite 7b. Posterior Crossbite 7c. Increased Overjet or Reverse Overjet	7d. Open Bite 7e. Impaction (excluding 3rd molars) 7f. Severe Crowding or Ectopic Eruption	
If answer is "NO" to question #7 above, please provide narrative to support medical necessity for orthodontic referral:		

DOCUMENTATION REQUIRED

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

☐! Completed Request for Specialty Referral Form

☐! **Current BW Radiographs** to demonstrate status of 12 year molars

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
   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, 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.