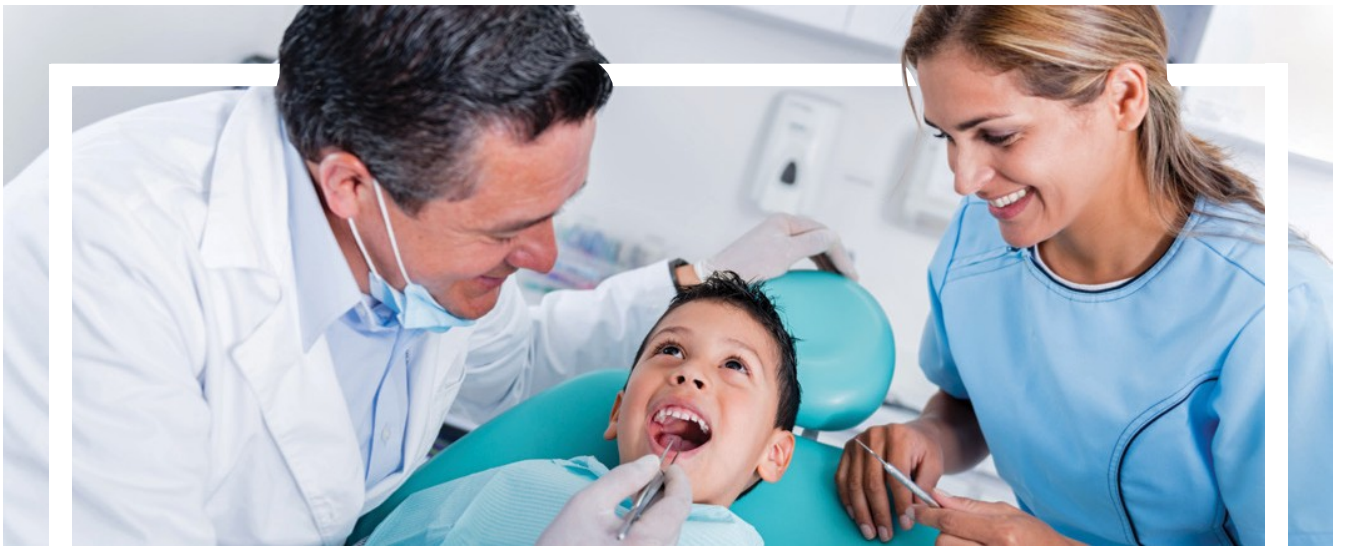
WellCare
Beyond Healthcare. A Better You.



Dentist Referral to Medical Provider

Completed by Dentist Only

Instructions:

1. **Complete this section**
2. **Make a copy for your records**
3. **Send copy to medical provider's office**
4. **Ask parent/guardian to take this form to a child's medical appointment.**
5. **Upon completing your section Fax or Email referral to:**
   Fax: (813) 865-6759 or Email: NJDentalServices@wellcare.com

Referral Date:_____ Patient's Name:_____ Member ID:_____ DOB:_____

Dentist Name:_____ Provider NPI: _____ Phone:_____

Address:_____ Fax:_____

City, State & ZIP code:_____ E-mail:_____

Medical Provider's Name:_____ Phone:_____

Address:_____ Fax:_____

City, State & ZIP:_____ E-mail:_____

Dental Treatment completed today:

❑ Oral hygiene ❑ Cleaning ❑ Restorative tx ❑ Exam/X-rays

❑ Sealants ❑ Fluoride Rx ❑ Fluoride Varnish/Topical Fluoride

Comments:_____

_____

_____

❑ tx completed ❑ Additional tx needed Approx. # of units needed_____

(continued on back)

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Medical Report to Dentist

Completed by Medical Provider Only

Medical Provider: _____ Date: _____

Provider NPI: _____

Instructions:

1. **Complete this section**
2. **Make a copy for your records**
3. **Upon completing your section Fax or Email referral to:**
   Fax: (813) 865-6759 or Email: NJDentalServices@wellcare.com

Suspected Problem: _____

Medical contraindications or recommendations: ❑ No ❑ Yes

Explain: _____

_____

ALERT: Please list if any of the following is applicable.

❑ Medications: _____

❑ Allergies: _____

Oral healthcare given by this provider:

❑ Fluoride Rx ❑ Recommended drinking fluoridated water

❑ Fluoride Varnish ❑ Recommended brushing with fluoridated toothpaste

Quality care is a team effort. Thank you for playing a starring role!

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