WellCare

Beyond Healthcare. A Better You.

Medical Provider Referral to Dentist

Completed by Medical Provider Only

Instructions:

1. **Complete this section**
2. **Make a copy for your records**
3. **Send copy to medical dental office**
4. **Ask a parent/guardian to take this form to a child's dental 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:_________

Medical Provider's Name:__________________________ Provider NPI:_____________ Phone:_______________________

Address: ____ Fax:_______________________

City, State & ZIP code:____ E-mail:_______________________

Dental Provider's Name:____ Phone:_______________________

Address: ____ Fax:_______________________

City, State & ZIP: ____ E-mail:_______________________

Reason for Referral: ❑ Age ❑ Routine ❑ Emergency

Suspected Problem: ____

Any Medical Precautions for Dental Treatment: ❑ No ❑ Yes

Explain: ____

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

❑ Medications: ___________________________ ❑ Allergies: ___________________________

Oral healthcare given by this provider:

❑ Fluoride Rx ❑ Fluoride Varnish

❑ Recommended drinking fluoridated water ❑ Recommended brushing with fluoridated toothpaste

(continued on back)

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Dental Report to Medical Provider

Completed by Dentist Only

Dental Provider:_________________________________ Date:____________________

Provider NPI: ____________________

Instructions:

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☐ 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 ____________________

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

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