Referral Extension Request Form

Provider or Clinic:_____ Phone:_____ Fax:_____

Patient Name:_____Medicaid ID #:_____DOB:____/ ___/____

Tooth #:_____CDT Code(s):_____Treatment Needed: _____

Estimated date of completion:____/___/____ Reason for extension: _____

_____

Extensions may be approved if:

1) Delay in first appointment due to low scheduling access or client slow to respond to initial appointment request.
2) Client is almost finished with treatment, but needs 1 or 2 more appointments to complete referral need.

Extension may be denied if:

1) Client does not complete needed treatment within 6 months of initial referral date. *Exceptions need to be approved by CareOregon Dental Access Coordinators, Mario Villavicencio or Geraldine Gilboy. Client needs to return to referring/primary dental clinic for continuing dental care or new referral (if necessary.)*

Today's Date: __/____/____ Referral Extension Expiration Date:____/____/____

Approved By:_____

Notes:_____

_____

CareOregon Dental
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Phone: 503-416-1444

Please email securely to
dentalaccessteam@careoregon.org