CareOregon Dental Referral/Prior Authorization Form

This form is used for referral or prior authorization requests from CareOregon Dental providers who are not able to submit requests through the CareOregon Connect/OneHealth portal. All requests should be submitted online if possible. Email this form to dentalaccessteam@careoregon.org or fax to (503) 416-8108 with documentation.

Date of Request*: _____

Reason for Fax/Email Form: ○ No Internet Access ○ CareOregon Connect offline/not working
○ Non-participating Provider or No Connect/OneHealth Port account

Requesting Provider*:_____ Requesting Clinic*:_____

Contact Name*:_____ Contact Phone Number/Email*:_____

Level of Service (Priority) *: ○ Routine ○ Urgent; By selecting urgent, I certify that the request is for a dental urgency and includes a patient with severe swelling, infection, pain or other dental emergency situations that would jeopardize the life or health of the patient.

Is this Request a….*

○ Referral (requesting approval of services and assignment to specialty provider by CareOregon Dental OR
○ Prior Authorization (requesting approval for requesting provider to perform services)

Patient Medicaid ID*: _____ Patient First Name*: _____

Patient DOB*: _____ Patient Last Name*: _____

Patient Main Phone Number*: _____ Patient Secondary Phone Number: _____

Parent/Guardian/Caregiver Name: _____ Parent/Guardian/Caregiver phone: _____

Interpreter Needed?* ○ No ○ Yes, Language: _____ Is Patient Pregnant?* ○ No ○ Yes

Service Type*: *select one*

○ Endodontics ○ Special Needs ○ General Dentistry ○ Hospital Dentistry
○ Orthodontics ○ Oral Pathology ○ Oral Surgery ○ Prosthodontics
○ Periodontics ○ Pediatric Dentistry

Requested CDT Codes*	Quantity*	Teeth/Treatment Area*

*All requests **must** include at least one CDT code that corresponds with the selected Service Type. Codes for different service types should be submitted as separate requests. Each code should have an associated Quantity and Treatment Area. Teeth or Oral Cavities may be used (i.e. Entire Oral Cavity).*

Are there other requests being submitted for this member or related requests that should be considered alongside this request*? ○ No ○ Yes

Additional Information/Comments:

Please remember to include supporting documentation (Chart Notes, Complete Treatment Plan, Medical History, Recent Periodontal Charting, Radiographs, and/or Tooth Charting) as appropriate.

If you selected Endodontics, Special Needs, Hospital Dentistry, or Prosthodontics as the Service Type, please continue to Additional Questions.

Additional Questions: Please answer additional questions associated with the selected Service Type.

If you selected Endodontics as a service, please provide the following information:

Planned Final Restoration*: ☐ Composite ☐ Amalgam ☐ Stainless Steel Crown ☐ PFM/Cast Crown

If you selected Special Needs as a service, please provide the following information:

Patient's Primary Care Provider*: _____ Primary Care Provider Phone*: _____

If you selected Hospital Dentistry as a service, please provide the following information:

Please explain the clinical justification for requesting hospital based dental care*:

If you selected Prosthodontics as a service, please provide the following information:

Select Type*:

☐ Complete Denture (D5110, D5120)

Is patient's arch edentulous today? ○ Yes ○ No; Reminder: Complete dentures are for edentulous patients only

☐ Immediate Denture (D5130, D5140)

Are you…

○ Referring for Oral Surgery; Reminder: Coordinate denturist and oral surgeon on behalf of patient OR

○ Extracting Teeth/delivering denture at your office; Reminder: Coordinate surgery with denturist

☐ Resin Partial (D5211, D5212)

Reminder: Planned extractions must have already been completed

Teeth to be replaced: _____

Date restorations completed: _____ Date periodontal treatment completed: _____

☐ Immediate Resin Partial (D5221, D5222)

Teeth to be extracted: _____ Teeth to be replaced by partial: _____

Date restorations completed: _____ Date periodontal treatment completed: _____

Are you…

○ Referring for Oral Surgery; Reminder: Coordinate denturist and oral surgeon on behalf of patient OR

○ Extracting Teeth/delivering denture at your office; Reminder: Coordinate surgery with denturist

☐ Interim Partial (D5820, D5821)

All teeth to be replaced: _____

☐ Other

Any additional information: