

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