HEALTHPLEX
THE DENTAL BENEFIT EXPERTS℠

SPECIALIST REFERRAL FORM

PROVIDER

Patient Name Last	First	MI	Relationship To Member ☐ Self ☐ Spouse ☐ Child ☐ Other	Patient Birthdate

Member Name Last	First	MI	Member ID#	Name of Group or Dental Program	Group #

Member Mailing Address	City	State

Referred by: _____ Provider Site #: _____

Tooth #, Letter, or Area	SERVICES REQUESTED	Healthplex Use Only

Additional Information:

I understand that only those services approved by Healthplex will be covered by my Dental Plan.

Signature of Patient: _____

HEALTHPLEX

Referral: ☐ Approved   ☐ Denied   ☐ Pending

Date Reviewed: _____

Remarks: _____

_____

_____

_____

For Healthplex Use Only:

SPECIALIST

Referred to Dr.: _____ Specialty: _____

Address: _____ Telephone #: _____

Copayment: $ _____ Referral Approval #: _____

PLEASE SUBMIT A CLAIM FORM REFERENCING THE REFERRAL APPROVAL # TO HEALTHPLEX FOR SERVICES RENDERED.

Referrals are not a guarantee of payment. Benefits are subject to eligibility & plan limitations at the time of actual treatment.

INSTRUCTIONS:

FOR NON-URGENT REFERRALS:
1. GP completes 'PROVIDER' section and submits form to Healthplex for review via mail, fax to 516-228-5025, or email to referrals@Healthplex.com.
2. Healthplex reviews the request and issues a determination via mail to the GP and member. Specialist will receive a copy if approved.
3. If the referral is approved, the patient should make an appointment with the specialist.
4. The specialist renders approved services and submits a claim to Healthplex.

FOR URGENT REFERRALS:
1. GP completes 'PROVIDER' section and calls Healthplex for a referral approval number and copayment information (to be placed in 'SPECIALIST' section).
2. The patient makes an appointment with the specialist and references the referral approval # given by Healthplex.
3. The specialist renders approved services and submits a claim to Healthplex.

RIGHT   MAXILLARY   LEFT

1 2 3 4 5 6 7 8   9 10 11 12 13 14 15 16

A B C D E   F G H I J
DECIDUOUS   DECIDUOUS
T S R Q P   O N M L K

32 31 30 29 28 27 26 25   24 23 22 21 20 19 18 17

MANDIBULAR