DELTA DENTAL Delta Dental of Washington

DeltaCare®
Administered by Delta Dental of Washington

Specialty Referral Form

(Does not apply to Orthodontic treatment)

Referred by_____ **Date**_____

Patient's Name:_____

Subscriber's Name:_____

Subscriber's Member ID Number:_____

Referred to Dr._____

Address _____ Phone _____

Please provide **only** the following treatment:

_____

_____

☐ Referral of capitated treatment has been pre-approved by Delta Dental

Collect patient co-payment of $_____

☐ Enclosed are available x-rays
☐ X-rays **are not** available
☐ If additional x-rays are required, please contact my office

Please note, benefits and limitations for these plans differ from other Delta Dental programs. Please contact the referring doctor if additional treatment is necessary. Treatment performed other than listed or approved by the referring dentist can result in non-payment.

Reminders:

- General anesthesia is only covered for groups 3850, 4100, 4102 & 4200. It is not a covered benefit for any other groups and is the patient's responsibility.
- For all groups (with the exception of 4100, 4102 & 4200) removal of impacted teeth MUST be symptomatic; prophylactic (asymptomatic/non-pathological) removal of impacted teeth is not a covered benefit. *Documentation is required*.
- Referral is valid for six months