

Advanced Specialty Education
University of Maryland Dental School
650 W. Baltimore Street 4 South 4319
Baltimore, MD 21201
410-706-8111

Date _____

Dear Doctor, Parent and Patient: **Endo MA Referral Form – for children w/MA <21yo**

Please complete the following for both the patient and the parent/guardian so we can submit this information to your insurance for pre-authorization. **Return this 1) completed form, 2) copy of the front & back of your child's insurance card & 3) the PERIAPICAL x-ray from your dentist to Ms. Angela Dudley to the address above. We cannot treat your child without ALL of this information--any INCOMPLETE PACKET WILL NOT BE PROCESSED and will be returned. Your cooperation is needed for the benefit of the patient and very much appreciated. Radiographs will not be returned so please send copies.**

Patient name: _____ Male _____ Female _____

Address: _____ City, State _____

Zip _____ Daytime Ph# _____ Date of Birth _____

SS# _____ Medical Assistance 11 digit # _____

Medical Assistance MCO Insurance Plan Name _____

Parent/Guardian name _____ Relation to Patient _____

Parent/Guardian DOB _____ Parent/Guardian SS# _____

Parent/Guardian Address & Daytime Phone # if different from child:

Name of Referring Dentist: _____

Address of Referring Dentist: _____

City, State _____ Zip _____

Dentist Phone # _____ Tooth # _____

Diagnosis & Symptoms (not tx requested) _____

BCDS Office Use Only:

Received _____ Assigned _____ PR# _____