UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

University of Maryland School of Dentistry
ASE Periodontics Referral Form – MA Referral Form

650 W. Baltimore St. Room #4319
Baltimore, MD 21201
Phone: 410-706-8111 Email: PGReferrals@UMaryland.edu

Dear Doctor, Parent and Patient:
Please complete this form in full and return to the Patient Care Coordinator (PCC), at the address above including:

- **a copy of the front & back of your insurance card and**
- **COPIES of all pertinent x-ray from the dentist (x-rays cannot be returned to you)****

All requested information and documentation must be submitted to your insurance company by UMSOD for pre-authorization of treatment ***PRIOR*** *to the start of treatment.* ***INCOMPLETE REFERRAL PACKETS CANNOT BE PROCESSED*** *and will be returned to the sender. We appreciate your attention to these directions. Thank you.*

Patient Name_____Male_____Female_____

Patient Address _____Zip_____

Ethnicity_____Race_____

Best Daytime Phone #_____Patient's Date of Birth _____

Patient's SS #_____Medical Assistance 11 Digit #_____

Medical Assistance MCO Insurance Plan Name _____

Best Email for Patient _____

Name of Parent / Guardian_____Relation to Patient_____

Parent / Guardian Date of Birth_____Parent/Guardian SS# _____

Referring Dentist _____

Referring Dentist's Address _____

_____Zip_____

Dentist's Phone #_____Diagnosis & Symptoms _____

_____

Date of Most Recent Hygiene Maintenance_____Date of Most Recent Panoramic X-ray _____

Date of Most Recent BW X-rays_____Date of Most Recent Full Series of X-rays _____

Referring Dentist's Signature_____Date_____

ASE Periodontics Clinic Use Only

Received_____Assigned_____PR# _____