SEVERE MALOCCLUSION PROGRAM - REFERRAL

CLIENTS LESS THAN 12 YEARS OF AGE

I would like to refer _____ for an
(Name of client)

orthodontic examination to _____.
(Name of orthodontist)

Pay-to Provider NPI: _____ Treating Providers NPI: _____

Client Date of Birth: _____/_____/ 20_____ Client Medicaid ID: _____
Month Day Year

Parent/Legal Guardian: _____

Address, City, Zip: _____

Phone: (_____)_____-_____

Dentist's Reason for Ref. (must contain medically necessary reason to evaluate before the age of 12):

Dentist's Signature: _____

Dentist's Name (Printed): _____

Address: _____
(Street/P.O. Box, City, State, Zip Code)

Telephone: _____ Date: _____

NPI: _____ Provider ID: _____

Please submit this form with your prior authorization request via Qualitrac. If you do not have access to the Qualitrac portal, please contact Telligen at (833) 610-1057 or wymedicaidum@telligen.com.