



PINAL COUNTY  
Wide open opportunity

PINAL/GILA LONG TERM CARE  
REQUEST FOR REFERRAL  
**DENTAL SERVICES FOR MEMBERS UNDER THE AGE OF 21**  
PLEASE FAX ALL REQUESTS TO (520) 866-6717

MEMBER NAME: \_\_\_\_\_ MEMBER ID: \_\_\_\_\_

DOB: \_\_\_\_\_ OTHER INSURANCE: \_\_\_\_\_ MEDICARE A  B

EPSDT eligible member? Yes  NO  CRS Eligible member? Yes  No

REQUESTED PROVIDER: \_\_\_\_\_ ID: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**URGENCY STATUS (see \* for definitions of status):**

Standard (Based on members' condition – Not to exceed 14 days)

Expedited – Urgent (within 3 days)

Date of Service: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

**Services Requested:**

Tooth Number	Requested CPT Code	Estimated Cost	Tooth Number	Requested CPT Code	Estimated Cost	Other Codes Requested	Estimated Cost

**Please answer the following questions:**

1. What is the diagnosis related to this request referral?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Reason for referral?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please attach the following: (Mandatory)**

1. PCP order
2. Physician progress notes, which describe dental condition.
3. Any other relevant documentation

**Referring Provider Information:**

Provider Name: \_\_\_\_\_ ID Number: \_\_\_\_\_ Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Date: \_\_\_\_\_

PCP/PCP Designee Signature: \_\_\_\_\_

**PCP Remember: It is your responsibility to assure a copy of this consult/treatment is present in your office/facility medical records.**

*\*Standard Authorization Request:* This is a request that P/GLTC provides a decision as promptly as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to reach a decision.

*Expedited Authorization Request:* A request that P/GLTC provide a decision to the member as promptly as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to come to a decision.

**Referral authorization is not guarantee of payment.**