Orthodontic Specialty Referral Form

REFERRAL #:	DATE:

CONTRACTHOLDER / PT. CHG. SCH.	REFERRING DR. / DENTAL OFF. #
SS # / PATIENT'S BIRTHDATE	SPECIALIST NAME
PATIENT	LICENSE # / DENTAL OFF. # / IN-HOUSE ☐ Yes ☐ No
RELATIONSHIP: ☐ Self ☐ Spouse ☐ Dependent	STREET
STREET	CITY / STATE / ZIP / PHONE ( )
CITY / STATE / ZIP	COMMENTS:
PHONE: Home ( ) Work ( )	
DOES PATIENT HAVE ANOTHER DENTAL COVERAGE? ☐ Yes ☐ No	
COMPANY *(Carrier)*	
POLICYHOLDER	

☐ **NEW CASE**	☐ **ORTHO IN PROGRESS CASE**
☐ Phase I (Interceptive) ☐ Phase II (Comprehensive)	Are new bands and/or appliances necessary? ☐ Yes ☐ No
TREATMENT PLAN DESCRIPTION:	**TREATMENT PLAN DESCRIPTION:**
☐ One Arch ☐ Both Arches	☐ One Arch ☐ Both Arches
FULL LENGTH OF TREATMENT AND COST:	**FULL LENGTH OF TREATMENT AND COST:**
Active: _____ / Month Treatment Fee: $ _____	Active: _____ / Month Banding Date: _____
Retention: _____ / Month Retention Fee: $ _____	Retention: _____ / Month Retention Fee: $ _____

PROCEDURE(S)	CODE(S)	DATE OF SERVICE	PATIENT CHARGE	CIGNA DENTAL PAYMENT
Pre-Orthodontic Treatment Visit	D8660			
Unspecified Orthodontic Procedure, By Report (Orthodontic Treatment Plan and Records)	D8999			
Interceptive Orthodontic Treatment of the Primary Dentition (Banding)	D8050			
Interceptive Orthodontic Treatment of the Transitional Dentition (Banding)	D8060			
Comprehensive Orthodontic Treatment of the Transitional Dentition (Banding)	D8070			
Comprehensive Orthodontic Treatment of the Adolescent Dentition (Banding)	D8080			
Comprehensive Orthodontic Treatment of the Adult Dentition (Banding)	D8090			
Periodic Orthodontic Treatment Visit (As Part of Contract)	D8670			
Children (Up to 19th Birthday)				
Adults				
Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	D8680			

I understand that only those services which meet Cigna Dental Care referral guidelines will be authorized for payment. Certain procedures may require a patient payment in accordance with the applicable Patient Charge Schedule for the group. I understand that the fees listed are based on current coverage. **All fees correspond to the Patient Charge Schedule in effect on the date the 8020 (treatment plan and records) is initiated, provided that the insertion date (8025/8026) occurs within 90 days of this date.** Payment responsibility may change if coverage terminates. Referral authorization is not a guarantee of payment.

SIGNATURE OF PATIENT	SIGNATURE OF REFERRING DOCTOR
SIGNATURE OF SPECIALIST	DATE

This form must be attached to the signed claim form and submitted within 12 months from the date of service.

SEND CLAIM TO: Cigna Dental, P.O. Box 188045, Chattanooga, TN 37422-8045

14430e Rev. 01-2012