Specialty Referral Form

CIGNA Dental
1.800.DIAL.CDH

CIGNA

REFERRAL TYPE: *(Check one)* ☐ EN ☐ OS ☐ PE ☐ PD	**REFERRAL #:**	**DATE:**

CONTRACTHOLDER	PT. CHG. SCH.
SS #	PATIENT'S BIRTHDATE
PATIENT	
RELATIONSHIP: ☐ Self ☐ Spouse ☐ Dependent	
STREET	
CITY	STATE / ZIP
PHONE: Home ( ) Work ( )	
DOES PATIENT HAVE ANOTHER DENTAL COVERAGE? ☐ Yes ☐ No	
COMPANY *(Carrier)*	
POLICYHOLDER	

REFERRING DR.	DENTAL OFF. #
SPECIALIST NAME	
LICENSE # / DENTAL OFF. # / IN-HOUSE ☐ Yes ☐ No	
STREET	
CITY / STATE / ZIP / PHONE ( )	
REASON FOR REFERRAL *(Include tooth # or area(s):* ***See Quick Reference Sheet for Referral***	

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. Payment responsibility may change if the Patient Charge Schedule changes or if coverage has terminated prior to the service treatment date. All fees correspond to the Patient Charge Schedule in effect on the date the procedure is initiated and pre-authorization is valid for a MAXIMUM of 90 days. Referral authorization is not a guarantee of payment.

SIGNATURE OF PATIENT	SIGNATURE OF REFERRING DOCTOR

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

SEND CLAIM TO: For States: CA, CO, OR, UT, WA, ID AND NM, send to: CIGNA Dental, P.O. Box 2125, Glendale, CA 91209-2125
For all other States, send to: CIGNA Dental, P.O. Box 189062, Plantation, FL 33318-9062

14420a Rev. 5-02

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