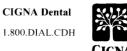
Specialty Referral Form



<i>yy</i>				1 000 DIAL CDII					
REFERRAL TYPE: (Check one)	ck one) REFERRAL #:		TE:	7	1.800.DIAL.CDH				
☐ EN ☐ OS ☐ PE ☐ PD			***					CIGNA	
			S. SCH.	REFERRING DR.			DENTAL OFF. #		
				ODECIALIOT NAME					
SS # PATIENT'S BIRTHDATE				SPECIALIST NAME					
PATIENT				LICENSE#	DENTAL (OFF.#	IN-HOUSE Yes No		
RELATIONSHIP: Self	STREET								
STREET				CITY	STATE	ZIP	PHONE ()		
CITY		STATE	ZIP	REASON FOR REFERRAL (Include tooth # or area(s):		*See Quick Re	eference Sheet for Refere	ral	
PHONE:									
Home ()	Work ()							
DOES PATIENT HAVE ANOTHER DENTA	AL COVERAGE?		Yes No						
COMPANY (Carrier)									
POLICYHOLDER									
I understand that only those sen payment in accordance with the responsibility may change if the Patient Charge Schedule in effect guarantee of payment.	applicable Patient Patient Charge Sch	Charge :	Schedule for the	group. I understand that the grage has terminated prior to pre-authorization is valid for	the fees listed the service a MAXIMUM	are based (treatment da	on current coverage ate. All fees corresc	e. Payment ond to the	
SIGNATURE OF PATIENT				SIGNATURE OF REFERRING DOCTOR					
SEND CLAIM TO: For States: CA	, CO, OR, UT, WA, ID	AND NM	, send to: CIGNA D	d submitted within 12 months Dental, P.O. Box 2125, Glendale antation, FL 33318-9062					
14420a Rev. 5-02									
Specialty Referral Form							CIGNA Dental	XVX	
				7			1.800.DIAL.CDH		
REFERRAL TYPE: (Check one) EN OS PE PD	REFERRAL #:	DA	TE:					CIGNA	
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REFERRAL TYPE: (Check one)	RAL TYPE: (Check one) REFERRAL #:					11000.21712	.0011	Cross
☐ EN ☐ OS ☐ PE ☐ PD								CIGNA
CONTRACTHOLDER		PT. CHG. SCH.	REFERRING DR.		DENTAL OFF. #			
SS # PATIENT'S BIR		IRTHDATE	SPECIALIST NAME					
			LICENSE # DENTAL OFF. # IN-HOUSE					
PATIENT		LICENSE #	DENTALO	·	1 -	Yes	□No	
	STREET							
RELATIONSHIP: Self Spouse Dependent			SIREET					
STREET			CITY	STATE	ZIP	PHONE		
STALE!						()		
CITY STATE ZIP			REASON FOR REFERRAL (Include tooth # or area(s): *See Quick Reference Sheet for Referral					al
PHONE:								
Home ()								
DOES PATIENT HAVE ANOTHER DENTA								
COMPANY (Carrier)								
(
POLICYHOLDER								
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