the children's program

Dental treatment referral form

Section 1 › Requestor information

Request date (mm/dd/yyyy)	Requestor name	Requestor title
Requestor email	Phone	Fax
Organization name		
Organization type (check one) ☐ School ☐ SBHC ☐ County health ☐ ER ☐ Pediatrician's office ***Referrals NOT accepted from parent/legal guardian; must come directly from authorized organization***		

Section 2 › Patient information

Patient last name	First		M.I.	
Date of birth (mm/dd/yyyy)	Is the child 5 to 18 years of age? ☐ Yes ☐ No		Gender ☐ Male ☐ Female	Primary language
Address				
City	State	ZIP code	County	
Parent or legal guardian last name	Parent or legal guardian first name		Phone	
Primary reason for referral ☐ Pain (abscess) ☐ Tooth pain (unknown cause) ☐ Restorative (cavity) ☐ Preventative				
Is the child a patient of record of a local dentist? ☐ Yes ☐ No ☐ Unknown	If yes, list dentist's name		If yes, list dentist's city	
Is the child covered under a dental plan? ☐ OHP ☐ Commercial ☐ None ☐ Unknown		Has the child been referred to this program in the past? ☐ Yes ☐ No ☐ Unknown		
Has the child's parent or legal guardian been notified of this referral? ☐ Yes ☐ No ***Referring party is responsible for notifying parent that child is being referred to The Children's Program***				

For office use only

Referral status ☐ Accepted ☐ Pending additional information ☐ Does not qualify (list reason)		
Member on file (previous referral) ☐ Yes ☐ No	Current coverage checked ☐ O ☐ F	Assigned ☐ ODS ☐ WDG ☐ KZ
Assigned dentist		Phone
Notifed referring organization ☐ Yes ☐ No	TCP referral processed (date & initial)	B&E referral processed (date & initial)

Ready to submit? Please fax the completed referral form to 503-243-3965 or 888-229-7140. Or email the completed form to childrensprogram@modahealth.com. For more information, please contact the Children's Program Coordinator at 503-265-5627 or 888-393-2772. Or email childrensprogram@modahealth.com.

The Children's Program provides access to basic dental services on an as-needed basis for uninsured children ages 5 to 18 who reside in Oregon. If eligible, each child will be assigned a dentist and may receive care during his or her eligibility period. The child's parent or legal guardian will receive a letter notifying them of the child's ID number and dentist's name and phone number so they may schedule an appointment. The assigned dental office will also receive a copy of the referral letter.

DELTA DENTAL
Delta Dental of Oregon & Alaska

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