

Health Plan of San Mateo Dental Referral Form



This form is used for referral requests from HPSM providers. All requests should be submitted via email dental@hpsm.org or fax to (650) 829-2071. For any questions, call (650) 616-1522.

Date of Request*: _____

Requesting Provider*: _____

Contact Name*: _____

Requesting Clinic*: _____

Contact Phone Number/Email*: _____

Level of Service (Priority) *: Routine Urgent

By selecting urgent, I certify that the request is for a dental urgency and includes a patient with severe swelling, infection, pain, or other dental emergency situations that would jeopardize the life or health of the patient.

Patient Medicaid ID*: _____ Patient First Name*: _____

Patient DOB*: _____ Patient Last Name*: _____

Patient Main Phone Number*: _____ Patient Secondary Phone Number: _____

Parent/Guardian/Caregiver Name: _____ Parent/Guardian/Caregiver Phone: _____

Interpreter Needed?* No Yes, Language: _____ Is Patient Pregnant?* No Yes

Service Type*: Endodontics Special Needs General Dentistry Hospital Dentistry
select one Orthodontics Oral Pathology Oral Surgery Prosthodontics
 Periodontics Pediatric Dentistry

Tooth Numbers

The diagram shows two rows of tooth illustrations. The top row represents permanent teeth, with 16 teeth on the right side and 16 teeth on the left side. Below each tooth is a small square checkbox. The teeth are numbered 1 through 16 from the center outwards on both sides. The bottom row represents deciduous teeth, with 10 teeth on the right side and 10 teeth on the left side. Below each tooth is a small square checkbox. The teeth are labeled with letters A through J on the right side and T through K on the left side.

HPSM will call/email you for additional supporting documentation.

Are there other requests being submitted for this member or related requests that should be considered alongside this request*? No Yes

Additional Information/Comments: