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

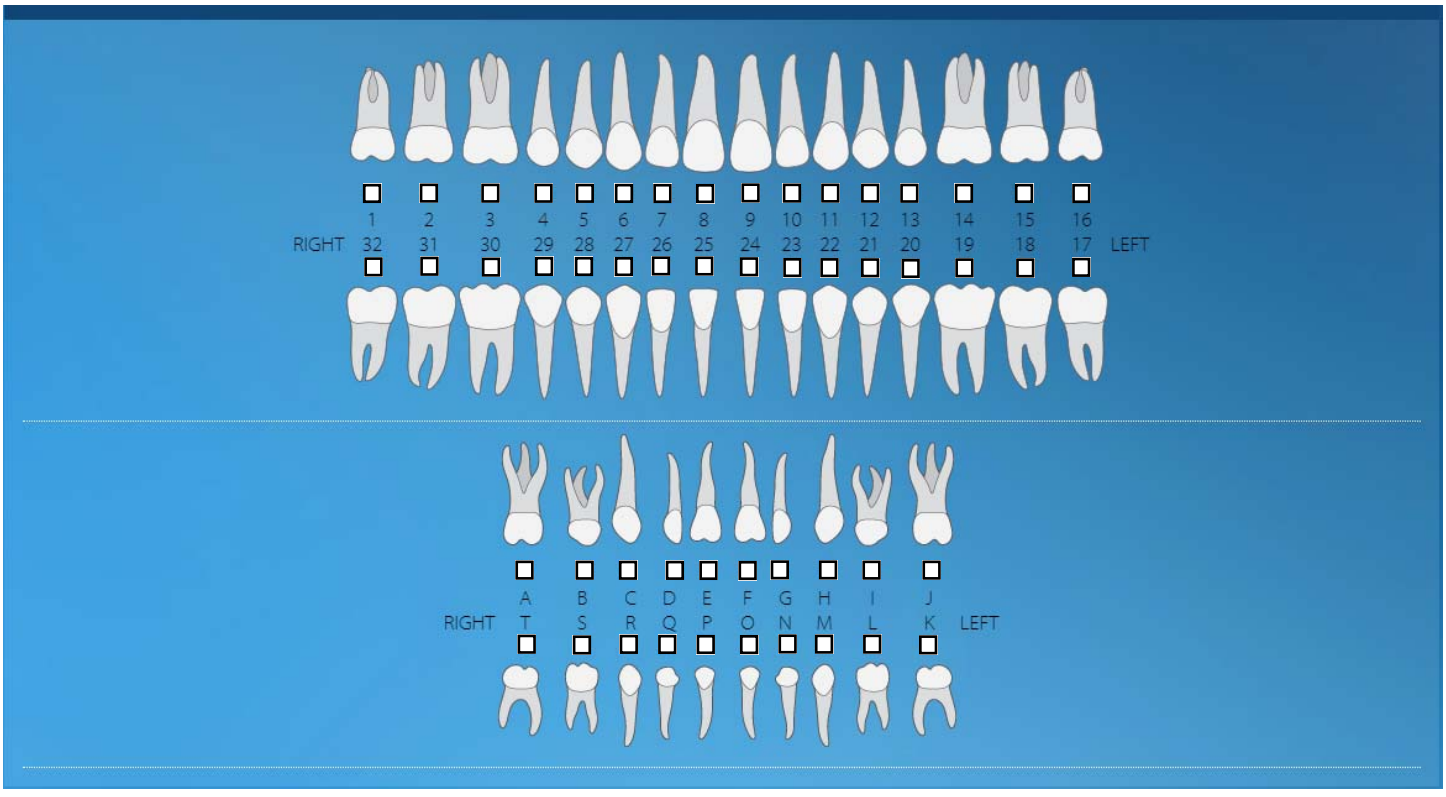
Service Type*: *select one*

◯ Endodontics ◯ Special Needs ◯ General Dentistry ◯ Hospital Dentistry

◯ Orthodontics ◯ Oral Pathology ◯ Oral Surgery ◯ Prosthodontics

◯ Periodontics ◯ Pediatric Dentistry

Tooth Numbers



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: