CareLink
Mobile Dentistry

## Dental Services Authorization/ Referral Form

Please print clearly using dark ink. Fax completed form to (401) 432-6687. File original in patient medical record.

## Section 1: Resident Information

Name: _____ Gender: ☐ Male ☐Female
Last First Middle Initial

Social Security Number: _____ Date of Birth: _____ Admission Date: _____

Facility Name, Address, RM/ APT number: _____ **UNIT:** _____

**Dentures: Y_____ N_____** **Has Natural Teeth Y_____ N_____**

☐ Yes, please enroll me in your dental program. ☐ No, I will make alternative arrangements for dental care.

## Section 2: Enrollment/ Billing Information

**Enrollee is responsible for billing and decision making of service?** ☐ YES ☐ NO **[ If no, please fill out Part A: Responsible Party Section]**

### Responsible Party Information

Name: _____
Last First Middle Initial

Address: _____
Number Street Name Apt / Unit

_____
City State Zip Code

Home Telephone: (____) _____ Work Telephone: (____) _____

Email Address: _____

Relationship to Resident: _____

### Insurance Information (Please attach a copy of each insurance card, front and back)

Medicaid #: _____

Medicare #: _____

Medicare Advantage Plan: _____ ID #_____

Other Insurance _____

Group Number: _____ Policy Number: _____

**Please read the following paragraphs, then sign and date where indicated.**

I hereby assign all health insurance benefits to The Wisdom Tooth's professional for services rendered for the above resident at the nursing facility. This assignment includes benefits payable by Medicaid and all other insurance programs of which I / the resident am / is a beneficiary. I authorize the release of all information from all sources necessary to secure payment for services rendered. I understand that I am responsible for any fees and/or co-payments not covered by insurance and agree to be billed at the address provided above for services rendered. By signing below, I also acknowledge that I have received The Wisdom Tooth's Notice of Privacy Practices included in this packet.

Private Pay? ☐ YES **[Enrollee or Responsible Party listed above are responsible for payments of services not covered by insurance]**

Responsible Party Signature: _____ Date: _____