UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

University of Maryland School of Dentistry
ASE Endodontic Referral Form – MA Referral Form

650 W. Baltimore St. Room #4319
Baltimore, MD 21201
Phone: 410-706-2860 Email referral and PA to: PGENDO@UMaryland.edu

Dear Doctor, Parent and Patient:
Please complete this form in full and return to the Patient Care Coordinator (PCC), at the address above including:

- **a copy of the front & back of your insurance card and**
- **a *COPY* of the Periapical x-ray from the dentist (x-rays cannot be returned to you)****

All requested information and documentation must be submitted to your insurance company by UMSOD for pre-authorization of treatment ***PRIOR*** *to the start of treatment.* ***INCOMPLETE REFERRAL PACKETS CANNOT BE PROCESSED*** *and will be returned to the sender. We appreciate your attention to these directions. Thank you.*

Patient Name_____**Male**_____**Female**_____

Patient Address_____**Zip**_____

Best Daytime Phone #_____**Patient's Date of Birth** _____

Patient's SS #_____**Ethnicity**_____**Race**_____

Medical Assistance 11 Digit #_____

Medical Assistance MCO Insurance Plan Name _____

Best Email for Patient _____

Name of Parent / Guardian_____**Relation to Patient**_____

Parent / Guardian Date of Birth_____**Parent/Guardian SS#** _____

Best Email for Parent / Guardian _____

Name of Referring Dentist _____**Phone #**_____

Referring Dentist's Address _____

_____**Zip**_____

Will the referring dentist be responsible for the restoration? Yes _____ **No** _____

Patient's Treatment Needs

****RCT Tooth #**_____**Diagnosis & Symptoms** ***(not Tx requested)*** _____

Referring Dentist Signature ***Date***

ASE Endodontic Clinic Use Only

Received_____**Assigned**_____**PR#** _____