Health Choice Arizona, Dental Specialty Referral Request Form

Print Form

Please print a copy of this form and Fax to 480-350-2217,
Send it to
HCHDentalDepartmentHCA@healthchoiceaz.com
or
Print a copy of this form and attach required supporting documentation and mail to the address listed to the left.

Mail to: Health Choice Arizona, Dental Prior Authorization
410 N. 44th Street, Suite 900, Phoenix, AZ 85008
Fax to: 480-350-2217

Complete all Member Information

Member Name:

Member ID #

Member Phone Number:

Member Date of Birth:

Member Address:

Complete all Dental Provider Information

Requesting Dentist Name:

Office Contact:

Office Phone Number:

Office Fax Number:

Provider ID #:

Office Address:

Services Requested

Refer member to:

- ☐ Oral Surgeon (3rd molars, mail with x-rays and chart notes)
- ☐ Endodontist, for mail with x-rays and documentation of arch integrity (opposing tooth)
- ☐ Periodontist, for mail with x-rays (FMX or pano), chart notes, and perio chart
- ☐ Other

Other Service Requested

Reason for Referral:

Medical Alert/ Special Needs:

Health Choice Arizona requires all non-contracted dentists to obtain a Prior Authorization before rendering treatment. Prior Authorization is not a guarantee of payment.

Notice to Patients and Providers: This referral is valid only when member is enrolled with Health Choice Arizona at the time service is delivered. Membership can be confirmed anytime through Health Choice Arizona. Referral is not valid if services do not commence within 30 days of date of referral. Unauthorized services, or services not specifically covered under this referral are not the responsibility of Health Choice Arizona.