Dental Referral Form

Mobile Dental Care

Please fax this completed referral form and the resident's current face sheet to **800.986.1139**

NOTE: Both pages 1 & 2 of the ORIGINAL, signed H1263B are required for all IME (Medicaid w/Applied Income) referrals prior to scheduling.

Date:	Facility Name:
Resident:	Room Number:

☐ Medicaid ☐ Private Pay — The RP will need to include Patient Information and Payment Forms

Hospice Provider:

Have x-rays been taken in the last twelve (12) months? ☐ YES ☐ NO ☐ UNKNOWN

Reason for referral: (please check all that apply)

☐ Routine Evaluation - Texas Admin Code 19.1401 (a)(2),
Evaluation of: ☐ broken teeth/loose teeth/decay, ☐ bleeding gums/infected gums/painful gums, ☐ loose dentures/broken dentures/lost dentures, ☐ weight loss/temperature/irritability/ restlessness/not eating, ☐ Other.

Specific dental complaint:

☐ Please include Facesheet with signed Referral form.

Person Making Referral (Print Name):	Date:
Signature: ☒	Title: (Nurse/SSD/Resident/RP)

Patient/Responsible Party Authorization

- I (patient/Responsible Party) authorize release of any and all information and appropriate medical, dental, financial, AI and RP be provided to Mobile Dental Care (MDC) from DADS, HHSC, the Facility; including any facility I may reside in in the future until the dental treatment and all financial considerations are completed. I authorize MDC to release dental treatment information to the Nursing Home staff and Department of Aging and Disability Services. I understand that I have the right to revoke the authorization in writing at any time.
- I understand that all private information obtained by MDC will be held in confidence and will only be made available to others as appropriate. I have been provided a copy of MDC's Notice of Privacy Practices, MDC notice of Privacy Practices is also available on www.mobiledentalcare.com and/or I have been informed that I may request a copy of MDC's Notice of Privacy Practices.
- For Medicaid AI Funding the IME/Medicaid program covers medically necessary dental charges. Mobile Dental Care's fee structure follows IME guidelines. Upon approval the Applied Income (AI) will be adjusted and notification (1259/4808) will be sent to the nursing home and the patient/Responsible Party. The AI adjustment will create a credit to be paid to MDC. I authorize the facility to make payment of these credits DIRECTLY TO MOBILE DENTAL CARE for dental services rendered. No portion of the AI adjustment shall be assigned another party, used to pay unpaid nursing home balance or other expenses. This authorization supersedes any other financial directive regarding the applied income until the dental bill is paid in full. I understand that the AI adjustment is only valid if the patient continues to live in a long-term care facility. Should the patient move from the long-term care facility, the patient/Responsible Party will be responsible for any outstanding balance.
- I give consent for new patient appointment, to include: comprehensive dental evaluation, x-rays, diagnostic debridement and fluoride. No additional procedures will be completed without my prior approval.
- In case of a risk event, I authorize an oral and/or blood test to determine infectious disease status of the patient.
- This release is valid as stated above unless restricted or revoked in writing to MDC. By signing this form I agree, as patient/Responsible Party, that the contract to provide dental services is between the patient/Responsible Party and Mobile Dental Care.

☐ I will send or have previous dentist of record send x-rays if taken within the past 12 months

Responsible Party Name	*Responsible Party email	*Responsible Party Cell
Address	City, ST ZIP	*Responsible Party Phone

☒ Relationship ( )

Patient or Responsible Party Signature — Date

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DALLAS ● LONGVIEW ● WICHITA FALLS ● ABILENE ● HOUSTON