Dental Claims Referral Form
Dental Essentials

PacificSource HEALTH PLANS

Date _____ **Please fax completed form to: 541-225-3632**

1. Primary care dental (PCD) provider information

Last name _____ First name _____

Contact person _____

Phone _____ Fax _____

Address _____

City _____ State _____ ZIP _____

Preference for receiving determination notices: ☐ No preference ☐ Fax ☐ Mail

2. Patient information

Last name _____ First name _____

Birth date _____ Member No. _____

3. Specialist information

Last name _____ First name _____

Specialty _____ Tax ID _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

4. Referral Information

Reason for referral and description _____

Requesting additional visits on referral already in place? ☐ Yes ☐ No If yes, please note all dates used:

Dental Claims Department
PO Box 7068, Springfield, OR 97475-0068
Phone: ***541-225-1981*** *or toll-free* ***866-373-7053,*** *Confidential Fax: 541-225-3632*
Email: ***psdental@pacificsource.com***