Dental Claims Referral Form
Dental Essentials

PacificSource HEALTH PLANS

Date _____ (Referral is valid for one year from this date)

1. Primary care dental (PCD) provider information

Last name _____ First name _____

Contact person _____

Phone _____ Fax _____

Address _____

City _____ State _____ ZIP _____

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 _____

_____

_____

Please fax completed form to: 541-225-3632

Or mail to:

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