United Healthcare | Dental Benefit Providers®

RIte Smiles Medical Access Request

Dear Provider,

To request scheduling assistance on behalf of an eligible Rite Smiles patient in need of medically necessary dental treatment that must be performed in a Rhode Island medical facility, please complete this RIte Smiles Medical Access Request form and the Dental Referral Form. Please email your request to UnitedHealthcare Dental, Attention: Dental Team Coordinator at dccri@uhc.com.

This form should be used if you have made attempts to schedule time with a Rhode Island medical facility and have been unable to do so. Efforts should be continued by your office to locate appropriate medical access during the process outlined below.

UnitedHealthcare Dental will review the completed forms and will engage with Rhode Island medical facilities to support the request.

All fields below must be completed:

Please provide primary contact information to receive scheduling guidance or for questions regarding this request:

Date of Request:

Provider Name: Phone #: Email:

Primary Office Contact: Phone #: Email:

Best time to be contacted:

RIte Smiles Patient Name: DOB: RI MID#:

Member's Medical Insurer (MCO):

☐ UnitedHealthcare Community Plan ☐ Neighborhood Health Plan of Rhode Island
☐ Rhode Island Together, Tufts Health Public Plan

Please select the most appropriate category to describe the reason for treating patient in a medical facility:

☐ Complicated Dental Procedure ☐ Complex Medical and/or Behavioral Needs

Please describe the medical necessity for treating patient in a medical facility (attach additional pages if needed):

☐ I do not have hospital privileges.
☐ I am credentialed and/or have hospital privileges to provide medically necessary treatment at the following facilities:

Please list the attempts you have made to schedule treatment with a medical facility.

In order to support placement of a Rite Smiles member to an appropriate provider, please complete the mandatory Dental Referral Form attached. Include clinical documentations, radiographs (x-rays) and medical history.

Please note, if all documentation is not received, outreach will be made back to your office to provide required documentation.

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DENTAL REFERRAL FORM

Patient Name: _____ **Date of Birth:** _____
Address: _____
Referring Doctor: _____ **Referring Doctor Phone Number:** _____

Reason for Referral:
❒ 1st Dental Visit ❒ Tooth Pain ❒ Decay ❒ Special Needs ❒ Trauma
❒ Sedation/GA ❒ Other: _____
_____

Treatment Barriers/Challenges (Check all the apply):
❒ Age-appropriate uncooperative behavior
❒ Extreme apprehension
❒ Extensive treatment needs including, but not limited to, early childhood caries (ECC) or severe ECC.
❒ Documented medical condition _____
❒ Documented behavioral disorder _____
❒ Documented failed nitrous oxide analgesia and behavior guidance (in office visit)

WE REQUIRE ALL RADIOGRAPH, CLINICAL AND MEDICAL DOCUMENTATION IN ORDER TO SCHEDULE THE PATIENT.

Please evaluate the following teeth. Circle those needing treatment.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
RIGHT				A	B	C	D	E	F	G	H	I	J				LEFT
				T	S	R	Q	P	O	N	M	L	K				
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

For Staff Use Only:
Schedule with _____ Unable to Schedule _____ Unable to Reach Pt _____
Initial _____ Reviewed By _____ Date: _____