Community Case Management Corp.
P.O. Box 2818
Aiea, Hawaii 96701

EMAIL: dental@ccmcorp.net
PHONE: 792-1070; Toll-Free: 1-888-792-1070
FAX: 792-1062; Toll-Free: 1-888-792-1062

Specialist Referral Form

Date: _____ **Refer to:** ☐ Pedodontist ☐ Endodontist ☐ Oral Surgeon

_____
Referring Dentist Name

_____
Address

_____

_____ _____
Fax Phone

_____
Email

☐ Male ☐ Female

_____
Patient Last Name, First Name, M.I.

_____ _____
Medicaid I.D. Number Date of Birth

_____
Parent or Legal Guardian's Name

_____
Phone Numbers (home, cell, work)

Clinical Diagnosis /Treatment Requested (please EMAIL current x-ray images & clinical notes to include detailed information why this referral is required):

Tooth Number(s): _____

Reason for Referral (include medical conditions): _____

***CCMC referral does not guarantee Medicaid reimbursement for above treatment. Must comply with Chpt. 14.**

_____
Referring Dentist's Signature

To be filled out by Specialist. Please fax or e-mail to CCMC when completed.

Appointment Date: _____

Procedure Completed / Recommendation:

_____ _____ _____
Specialist's Signature Print Name Specialist's Phone/Fax

***Chpt. 14 – Medicaid Provider Manual**