



Maryland Specialist Referral Procedures

Participating Standing Referrals (Select/DHMO Plans Only):

1. A Dominion Member may receive a standing referral if the Member's Participating Dentist determines, in consultation with a Plan Specialist that:
 - a. the Member needs continuing care from a Plan Specialist, or the Member has a disease or condition that is life threatening, degenerative, chronic, or disabling, and requires specialized care;
 - b. the Plan Specialist has expertise in treating the life-threatening, degenerative, chronic, or disabling disease or condition; and
 - c. the services required to treat the Member's condition are covered services under the Member's Plan.
2. A standing referral shall be made in accordance with a written treatment plan for a covered service developed by:
 - a. the Participating Dentist;
 - b. the Plan Specialist; and
 - c. the Member or the Member's Representative.
3. A treatment plan may:
 - a. limit the number of visits to the Plan Specialist;
 - b. limit the period of time in which visits to the Plan Specialist are authorized; and
 - c. require the Plan Specialist to communicate regularly with the Member's Participating Dentist regarding the treatment and dental health status of the Member.
4. Participating Dentists can locate Plan Specialists on Dominion's website at DominionNational.com by selecting "Find a Provider," then "Dental," and then completing the fields to conduct a search.
5. The Member's Participating Dentist will complete a referral form for the treatment plan. Maryland Participating Dentists must complete the Maryland Uniform Dental Consultation Referral Form by accessing the "Specialist Referral Procedures (Maryland only)" link on Dominion's provider search page at DominionNational.com.
6. There is no pre-authorization of the referral required by the Plan.
7. The Plan Specialist will submit the referral form to the Plan with his/her claim, if applicable. Specialists only submit claims under certain Select Plans including those with an "S" or "XS" plan code and medically necessary Pediatric Services.
8. The foregoing information is included in Dominion's *Specialty Care Referral Guidelines*, which are made available to all Participating Dentists and Plan Specialists.

Nonparticipating Referrals (All Plans):

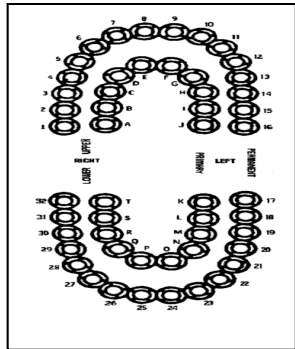
1. A Dominion Member may receive a referral to a nonparticipating specialist if:
 - a. the Member is diagnosed with a condition or disease that requires treatment by a specialist;
 - b. Dominion does not have, or cannot provide reasonable access to without unreasonable delay or travel, a Plan Specialist with the professional training and expertise to treat the Member's condition or disease; and
 - c. the services required to treat the Member's condition are covered services under the Member's Plan.
2. Before requesting a referral to a nonparticipating specialist, the Member should contact Customer Service at (888) 518-5338 or (703) 518-5338 for assistance in locating a Plan Specialist.
3. If Customer Service is unable to identify a Plan Specialist to treat the Member without unreasonable delay or travel, the Member will be advised to have their Participating Dentist complete a referral form. Maryland Participating Dentists must complete the Maryland Uniform Dental Consultation Referral Form by accessing the "Specialist Referral Procedures (Maryland only)" link on Dominion's provider search page at [DominionNational.com](https://www.dominionnational.com). Customer Service will provide instructions for submission of the referral form. The Participating Dentist must include the reason for the referral with the applicable ADA procedure codes under the "Reason for Referral" in order for the Plan to process the referral request.
4. In reviewing the referral request, the Plan will determine reasonableness of access to a Plan Specialist in accordance with its network access standards.
5. The Plan will make a determination of whether to approve the referral request within two working days of receipt of the properly completed referral form, and will promptly notify the Participating Dentist requesting the referral. If the referral is approved by the Plan, the notification will include instructions for submission of the claim. A copy of the referral form must be submitted with the claim.
6. The Member, Member's Representative or Participating Dentist may file an appeal of the Plan's denial of a request for a referral to a nonparticipating specialist by following the process described in the Appeals, Complaints and Grievances section of the *Individual Dental Policy* or *Group Certificate of Coverage*. If the referral is denied based on a finding that the proposed service is not medically necessary, appropriate, or efficient, the denial will constitute an Adverse Decision.
7. Upon receipt of the claim, for purposes of calculating any deductible, copayment amount, or coinsurance payable by the Member, Dominion will treat the request as if the services were provided by a Plan Specialist.

Maryland Uniform Dental Consultation Referral Form

Date of Referral:		Carrier Information:	
Patient Information:			
Name: (Last, First, MI)			
Date of Birth (MM/DD/YY):	Phone:		
Member #:			
Site #:		Name:	
		Address:	
		Phone Number:	
		Facsimile/Data #:	

Primary or Requesting Dentist			
Name (Last, First, MI):		Specialty:	
Institution/Group Name:	Provider ID #: 1	Provider ID #: 2 (If Required)	
Address: (Street #, City, State, Zip)			
Phone Number:		Facsimile/Data #:	

Specialist Dentist			
Name: (Last, First, MI)		Specialty:	
Dental Office Name:	Dental Office Code:	Provider ID/License #:	
Address: (Street #, City, State, Zip)			
Phone Number:		Facsimile/Data #:	

Referral Information	
Reason for Referral:	
Brief History, Diagnosis, and Test Results:	
Services Desired: Provide Care as Indicated: <input type="checkbox"/> Initial Consultation Only <input type="checkbox"/> Consultation with Specific Procedures (Specify) <input type="checkbox"/> Other: (Explain)	Teeth Diagram: Indicate Missing Teeth with an "X". 
Place of Service: <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Other: (Explain)	
Authorization # (If Required):	Referral is Valid Until: (Date) (See Carrier Instructions)
Signature: (Individual Completing This Form)	Authorizing Signature: (If Required)

Referral certification is not a guarantee of payment. Payment of benefits is subject to a member's eligibility on the date that the service is rendered and to any other contractual provisions of the plan/carrier.

White: Carrier; Yellow: Primary or Requesting Provider; Pink: Consultant/Facility Provider; Goldenrod: Patient

See Reverse and Carrier/Plan Manual for Specific Instructions