MaineCare X-ray Referral Form

Date:

Dear ______________________,

This explains what you need to know about the dental x-rays we took for you on_______ and what will happen next.

• Dr. _____________ will look at the x-rays and help us decide if you need follow-up care.

• We’ll let you know if you need follow-up care. If you do, we will give you Dr. _____________’s phone number and address at that time. You may also choose a different dentist other than Dr. _____________ for that follow-up care.

• If you choose to go to a different dentist and s/he wants to take a second set of x-rays, MaineCare may **NOT** pay for the second set.

Thank you,

_____________________________________________________________

Independent Dental Hygienist     Signature                Date

My signature below means I have read and understand this notice.

_____________________________________________________________

Member or parent /guardian    Signature     Date
MaineCare Temporary Filling Written Agreement Form

1. Independent Practice Dental Hygienist Section

By signing this form, I attest that I have entered into a written agreement with a dentist that meets the conditions of Chapter 101, MaineCare Benefits Manual, Chapter II 25.07-5(E)(2)(b).

The effective dates of this agreement are:

_________________________  ________________________
Start date                   End date

I will maintain a copy of this written agreement so that MaineCare may verify its terms and existence.

_________________________  ________________________
Name (print or type)                        NPI            Signature          Date
Independent Practice Dental Hygienist

2. Dentist Section

By signing this form, I attest that I have entered into a written agreement with a dentist that meets the conditions of Chapter 101, MaineCare Benefits Manual, Chapter II 25.07-5(E)(2)(b).

_________________________  ________________________
Name (print or type)                        NPI            Signature          Date
Dentist
MaineCare Temporary Filling Information & Referral Form

Date:

Dear ______________________,

Today I will be giving you one or more temporary fillings.

It is very important that you understand that this is not a permanent fix to the dental problem that you have. You need to go to a dentist for the proper care. If you do not see a dentist, your condition could get much worse.

Dr. _______________ is a dentist who has agreed to follow-up with you on your temporary filling(s) within 60 days.

You may also choose to see a dentist other than Dr._______.

Dr. ___________'s phone number and address are: (___)___-____

_______________________________________________
_______________________________________________
_______________________________________________

Thank you,

_______________________________________________
Independent Dental Hygienist     Signature                Date

My signature below means I have read and understand this notice.

_______________________________________________
Member or parent /guardian    Signature     Date