BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Dental Specialty Referral Request Form

Print Form

Mail to: BCBSAZ Health Choice, Dental Prior Authorization
8220 N. 23rd Avenue, Phoenix, AZ 85021
Fax to: 480-350-2217

Please print a copy of this form, attach required supporting documentation, and fax to 480-350-2217, send it to

HCHDentaldeptHCA@azblue.com
or
mail to the address listed to the left.

Complete all Member Information

Member Name: | Member ID #

Member Phone Number: | Member Date of Birth:

Member Address:

Complete all Dental Provider Information

Requesting Dentist Name: | Office Contact:

Office Phone Number: | Office Fax Number: | Provider ID #:

Office Address:

Services Requested

Refer member to:

- ☐ Oral Surgeon, submit with x-rays and chart notes)
- ☐ Endodontist, submit with x-rays, chart notes and documentation of arch integrity (opposing tooth)
- ☐ Periodontist, submit with x-rays (FMX or pano), chart notes, and perio chart
- ☐ Other

Other Service Requested

Reason for Referral:

Medical Alert/ Special Needs:

BCBSAZ Health Choice requires all non-contracted dentists to obtain a Prior Authorization before rendering treatment. Prior Authorization is not a guarantee of payment.

Notice to Patients and Providers: This referral is valid only when member is enrolled with BCBSAZ Health Choice at the time service is delivered. Membership can be confirmed anytime through BCBSAZ Health Choice. Referral is not valid if services do not commence within 90 days of date of referral. Unauthorized services, or services not specifically covered under this referral are not the responsibility of BCBSAZ Health Choice.