

Medicaid Program

Referral For Pregnancy Related Dental Services

(Must Be Completed By The Medical Professional Providing Pregnancy Care)

Part I: All Items Must Be Complete

Name of Pregnant Woman: _____

Street Address: _____ City: _____ Zip Code: _____

Medicaid Recipient ID #: _____

Estimated Date of Delivery (MM/DD/YYYY): _____

Referred for pregnancy related dental services: YES NO

Part II: Check (✓) All Conditions That Apply

- | | |
|---|---|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Pain associated with teeth or gums |
| <input type="checkbox"/> Swollen, puffy gums | <input type="checkbox"/> Bad breath odor that does not go away with normal brushing |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Spaces between the teeth that were not there before |
| <input type="checkbox"/> Teeth with obvious decay | <input type="checkbox"/> Inability to chew or swallow properly |
| <input type="checkbox"/> Teeth that appear longer | <input type="checkbox"/> Tender gums that bleed when brushing |

Are there any medical or perinatal complications that the dentist should be aware of prior to the delivery of dental services? YES NO If **yes**, please describe below:

Is pre-medication or other medication required prior to dental treatment? YES NO
(If **yes**, please attach a photocopy of the prescription.)

Part III: Check (✓) Any Services That Are Contraindicated

- | | |
|---|--|
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Restoration(s) |
| <input type="checkbox"/> Radiograph(s) | <input type="checkbox"/> Gum Treatment – Ultrasonic Cleaning and/or Scaling Below the Gum Line |
| <input type="checkbox"/> Teeth Cleaning | <input type="checkbox"/> Extraction(s) |

Part IV: Please include other comments and/or recommendations below:

I have confirmed the pregnancy with diagnostic testing for the above-named patient.

Medical Professional Signature (**Required**)

Provider Type & License #

Office Telephone #

Date

**To locate a Medicaid enrolled dentist, you may contact the
Medicaid Referral Assistance Hotline toll-free at 1-877-455-9955.**