

# Dental Provider – Dental Care Follow-up Request Form

## Child Health and Disability Prevention (CHDP) Program

Fax this form to the Local CHDP Program – fax number (831) 763-8410

Patient will be contacted. CHDP will provide a follow-up report regarding the outcome of the request.

For questions or mailed submissions, please call CHDP Program (XXX) XXX-XXX

Date of Request:

A. Patient Information:			B. Medi-Cal Dental Provider Information:	
Patient Name (Last) (First) (Initial)		Business Name		
Responsible Person Name (Last) (First)		Phone Number		
CIN Number		Foster Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Fax Number	
Birthdate (MM/DD/YYYY)	Sex M/F <input type="checkbox"/> M <input type="checkbox"/> F	Preferred Language		Address
Address			City, Zip	
City, Zip			Business NPI Number	
Telephone # (Home/Cell)		Alternate Phone # (Work/Other)		Rendering Provider Name & NPI Number

**C. Reason for Request: (Check all that apply)**

<input type="checkbox"/> Facilitation of 1 <sup>st</sup> dental visit	<input type="checkbox"/> Needs follow-up for diagnosed problem Explain:	<input type="checkbox"/> Specialty or hospital dentistry needed Explain:
<input type="checkbox"/> Transportation assistance		
<input type="checkbox"/> No show		
<input type="checkbox"/> Lost to care mid-treatment	<input type="checkbox"/> Needs follow-up for emergent problem Explain:	
<input type="checkbox"/> Needs follow-up for possible problem (CHDP/MD referral, not yet evaluated/ diagnosed)		

**D. Reasons Dental Office Unable to Bring Patient into Care (Check all that apply)**

<input type="checkbox"/> Phone disconnected	<input type="checkbox"/> Wrong phone number	<input type="checkbox"/> Mail/e-mail/text returned undeliverable
<input type="checkbox"/> No response to mail/email/text	<input type="checkbox"/> Specialty dental care needed – unable to accommodate	<input type="checkbox"/> Hospital dentistry needed
<input type="checkbox"/> Other, Explain:		

**E. Requesting Dental Office – Continued Patient Relationship**

Office would like to continue to see patient  Patient would be better served at another office

### For Local CHDP Use Only – Result of CHDP Follow Up Outcome

Date Request Received:	Contact Made <input type="checkbox"/> Assisted patient with appointment Date & Time:	No Contact Made – Request Closed <input type="checkbox"/> Attempt #1 Method: Date and Time:
Date Request Closed:	<input type="checkbox"/> Patient/family moved out of county/state Date & Time:	<input type="checkbox"/> Attempt #2 Method: Date and Time:
Update/Resolution to Dental Provider Date and Time:	<input type="checkbox"/> Patient/family refused assistance Date & Time:	<input type="checkbox"/> Attempt #3 Method: Date and Time:
	<input type="checkbox"/> Linked patient with another provider Date & Time:	
	<input type="checkbox"/> Patient/family wants to delay care/treatment Date & Time:	