TRANSITION OF CARE REQUEST

Form should be returned to:
EmblemHealth Plans
PO Box 2838, NY, NY 10116-2838

PATIENT NAME:	EmblemHealth ID #:
SUBSCRIBER NAME:	PATIENT PHONE #:

Check requested service(s) below:

_____ Orthodontia

_____ Oral Surgery

_____ Other

TREATING/ORDERING DENTIST NAME:	
DENTIST ADDRESS:	
DENTIST PHONE:	SPECIALTY:
TRANSITIONAL SERVICES BEING REQUESTED:	

A Letter of Necessity from your Dentist is required for all services. Letter should include past dental history, current status, services being requested (including number of visits, duration of treatment if applicable) as well as any other relevant information. X-rays will be required upon request.

By signing below I am authorizing EmblemHealth to contact my dentist to obtain any necessary clinical information. I further authorize the disclosure to EmblemHealth and providers and others to whom access is permitted by law of all clinical information involved in the provision or payment of services.

______________________________ ______________________________

Name Date