RIte Smiles Dental Case Management

Provider Referral Form

Email the completed form to dccri@uhc.com

REFERRAL INFORMATION	
Date of Referral	
Office Name / Location	
MEMBER INFORMATION	
First Name	
Last Name	
Date of Birth	
Contact Phone	
PARENT / CAREGIVER INFORMATION	
Full Name	
Relationship	

RECOMMENDATIONS

- ☐ Restorative (fillings, crowns, etc.)
- ☐ Extraction
- ☐ Root Canal Therapy
- ☐ Sealants
- ☐ Fluoride Treatment
- ☐ Oral Surgery Needed
- ☐ Urgent Appointment Needed
- ☐ Dental Abscess/Infection

NOTES