AmeriHealth Caritas™
District of Columbia

School-Based Dental Sealant Program
Referral Form

Date: _____

Member Information	
Member name:	Date of birth:
Member ID number:	Phone number:
Parent or guardian name (if applicable):	

Dental Provider Information	
Dentist's name:	Group name:
NPI number:	Group TIN:
Phone number:	Fax number:
Office contact name:	

Please check the appropriate intervention(s):

- ☐ Patient has urgent dental need
- ☐ Patient has an abscess
- ☐ Inappropriate and/or disruptive behavior
- ☐ Patient is in pain
- ☐ Refer to Integrated Care Management
- ☐ Other: _____

Additional information or comments:

_____

_____

_____

_____

Please fax this completed form to 1-888-607-6405.

Follow-up performed: _____

Comments: _____

Please address your questions regarding this communication to AmeriHealth Caritas District of Columbia at 1-877-759-6224.

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR