SUBMIT

Dental Provider – Dental Care Follow-up Request Form

Shasta County Child Health and Disability Prevention (CHDP) Program

Fax this form to the Local CHDP Program – fax number (530) 225-5017

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 (530) 225-5122

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** ☐Yes ☐No	**Fax Number**
Birthdate (MM/DD/YYYY)	**Sex M/F** ☐M ☐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)

- ☐ Facilitation of 1st dental visit
- ☐ Transportation assistance
- ☐ No show
- ☐ Lost to care mid-treatment
- ☐ Needs follow-up for possible problem (CHDP/MD referral, not yet evaluated/ diagnosed)
- ☐ Needs follow-up for diagnosed problem
- ☐ Needs follow-up for emergent problem
- ☐ Specialty or hospital dentistry needed

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

- ☐ Phone disconnected
- ☐ No response to mail/email/text
- ☐ Other, Explain:
- ☐ Wrong phone number
- ☐ Specialty dental care needed – unable to accommodate
- ☐ Mail/e-mail/text returned undeliverable
- ☐ Hospital dentistry needed

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:

Date Request Closed:

Update/Resolution to Dental Provider
Date and Time:

Contact Made

- ☐ Assisted patient with appointment
  Date & Time:
- ☐ Patient/family moved out of county/state
  Date & Time:
- ☐ Patient/family refused assistance
  Date & Time:
- ☐ Linked patient with another provider
  Date & Time:
- ☐ Patient/family wants to delay care/treatment
  Date & Time:

No Contact Made – Request Closed

- ☐ Attempt #1
  Method:
  Date and Time:
- ☐ Attempt #2
  Method:
  Date and Time:
- ☐ Attempt #3
  Method:
  Date and Time: