California Medi-Cal Dental Program

Denti-Cal Bulletin

Volume 25, Number 13, April 2009
www.denti-cal.ca.gov

PO Box 15609 Sacramento, CA 95852-0609
(800) 423-0507

Medi-Cal Dental Patient Referral Service

Medi-Cal Dental Program (Denti-Cal) providers can take advantage of a free referral service for accepting Denti-Cal patients. This referral service can be an excellent resource for enrolled Denti-Cal providers to build, maintain, or increase their patient base while making available the highest level of dental service for the state's medically needy.

If you are a provider interested in this service, or need to update the information currently on file, please fill out the attached Medi-Cal Dental Patient Referral Service Form (see the attached form) and mail it to:

California Medi-Cal Dental Program
Attn: Enrollment Department
PO Box 15609
Sacramento, CA 95852-0609

For additional information or questions regarding the Medi-Cal Dental Patient Referral Service, please call the Denti-Cal Telephone Service Center at (800) 423-0507.

Denti-Cal

California Medi-Cal Dental Program

Medi-Cal Dental Patient Referral Service

Dear Doctor:

The Medi-Cal Dental Program (Denti-Cal) offers a voluntary patient referral service that serves the dental community statewide. Please consider our request to include your office on our referral list for Denti-Cal patients.

Complete this form and return it to Denti-Cal in the enclosed envelope.

If you have any questions about the Medi-Cal Dental Patient Referral Service, please do not hesitate to call Denti-Cal toll-free at (800) 423-0507.

Sincerely,

Provider Services

Medi-Cal Dental Program

Denti-Cal

☐ Yes I would like Denti-Cal patients referred to my office. Please add my name to your referral list. I understand I may request removal of my name from this list at any time.

☐ No I do not want Denti-Cal patients referred to my office. Please do not include my name on your referral list.

Provider Name: _____ Billing Provider ID: _____ Service Office #: _____

Business Name: _____

Fictitious Name: _____

Office Address: _____

Office Telephone: ( ) _____ Is your office wheelchair accessible? ☐ Yes ☐ No

What other languages are spoken in your office?

List any dental specialties or services offered in your office (i.e., endodontic, periodontal, oral surgical procedures, general anesthesia, etc.): _____

What age group of children does your office see? ☐ 5 & under ☐ 6 – 12 ☐ 13 & older

Billing Provider Signature: _____ **Date:** _____