Keystone First

EPSDT Dental Referral Notification

Date: ____________________

PROVIDER

Provider identification

Provider name:

Keystone First provider ID number:

Phone number:

Providers can submit up to five separate referrals at a time using this form.

MEMBER

Member identification

Member name (first, middle, last):

Keystone First member ID number:

Date of EPSDT visit:

Does the member need assistance locating a dental provider?	Does the member need assistance making an appointment?
◯ Yes ◯ No	◯ Yes ◯ No

MEMBER

Member identification

Member name (first, middle, last):

Keystone First member ID number:

Date of EPSDT visit:

Does the member need assistance locating a dental provider?	Does the member need assistance making an appointment?
◯ Yes ◯ No	◯ Yes ◯ No

MEMBER

Member identification

Member name (first, middle, last):

Keystone First member ID number:

Date of EPSDT visit:

Does the member need assistance locating a dental provider?	Does the member need assistance making an appointment?
◯ Yes ◯ No	◯ Yes ◯ No

MEMBER

Member identification

Member name (first, middle, last):

Keystone First member ID number:

Date of EPSDT visit:

Does the member need assistance locating a dental provider?	Does the member need assistance making an appointment?
◯ Yes ◯ No	◯ Yes ◯ No

MEMBER

Member identification

Member name (first, middle, last):

Keystone First member ID number:

Date of EPSDT visit:

Does the member need assistance locating a dental provider?	Does the member need assistance making an appointment?
◯ Yes ◯ No	◯ Yes ◯ No

Submitted by: ____________________ Phone number: ____________________

Fax the signed and completed form to **1-215-937-7314.** (Incomplete or illegible forms will be returned for correction.)

If you have any questions or concerns, please call Provider Services at **1-800-521-6007**.