AmeriHealth Caritas Pennsylvania

Coverage by AmeriHealth First.

AmeriHealth Caritas Northeast

EPSDT Dental Referral Notification

Date: ____________________

PROVIDER

Provider identification

Provider name:

◯ AmeriHealth Caritas Pennsylvania ◯ AmeriHealth Caritas Northeast

Plan-assigned 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):

◯ AmeriHealth Caritas Pennsylvania ◯ AmeriHealth Caritas Northeast

Member ID number:

Date of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit:

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

Does the member need assistance making an appointment?
◯ Yes ◯ No

MEMBER

Member identification

Member name (first, middle, last):

◯ AmeriHealth Caritas Pennsylvania ◯ AmeriHealth Caritas Northeast

Member ID number:

Date of EPSDT visit:

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

Does the member need assistance making an appointment?
◯ Yes ◯ No

MEMBER

Member identification

Member name (first, middle, last):

◯ AmeriHealth Caritas Pennsylvania ◯ AmeriHealth Caritas Northeast

Member ID number:

Date of EPSDT visit:

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

Does the member need assistance making an appointment?
◯ Yes ◯ No

MEMBER

Member identification

Member name (first, middle, last):

◯ AmeriHealth Caritas Pennsylvania ◯ AmeriHealth Caritas Northeast

Member ID number:

Date of EPSDT visit:

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

Does the member need assistance making an appointment?
◯ Yes ◯ No

MEMBER

Member identification

Member name (first, middle, last):

◯ AmeriHealth Caritas Pennsylvania ◯ AmeriHealth Caritas Northeast

Member ID number:

Date of EPSDT visit:

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

Does the member need assistance making an appointment?
◯ 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** for AmeriHealth Caritas Pennsylvania or **1-888-208-7370** for AmeriHealth Caritas Northeast.

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