BHSF Form 9-M
Issued 12/03

Medicaid Program

Referral For Pregnancy Related Dental Services

(Must Be Completed By The Medical Professional Providing Pregnancy Care)

Part I: All Items Must Be Complete

Name of Patient: _____

Street Address: _____ City: _____ Zip Code: _____

Medicaid Recipient ID #: _____

Estimated Date of Delivery (MM/DD/YYYY): _____

Part II: Check (☑) All Conditions That Apply

- ☐ Bleeding Gums
- ☐ Swollen, puffy gums
- ☐ Loose teeth
- ☐ Teeth with obvious decay
- ☐ Teeth that appear longer
- ☐ Pain associated with teeth or gums
- ☐ Bad breath odor that does not go away with normal brushing
- ☐ Spaces between the teeth that were not there before
- ☐ Inability to chew or swallow properly
- ☐ Tender gums that bleed when brushing

Are there any medical or perinatal complications that the dentist should be aware of prior to the delivery of dental services? ☐ YES ☐ NO If **yes**, please describe below:

_____

_____

Is pre-medication or other medication required prior to dental treatment? ☐ YES ☐ NO
(If **yes**, please attach a photocopy of the prescription.)

Part III: Check (☑) Any Services That Are Contraindicated

- ☐ Local Anesthetic
- ☐ Radiograph(s)
- ☐ Teeth Cleaning
- ☐ Restoration(s)
- ☐ Gum Treatment – Ultrasonic Cleaning and/or Scaling Below the Gum Line
- ☐ Extraction(s)

Part IV: Please include other comments and/or recommendations below:

_____

_____

I have confirmed the pregnancy with diagnostic testing for the above-named patient.

_____	_____	( ) _____	_____
Medical Professional Signature **(Required)**	Provider Type & License #	Office Telephone #	Date

To locate a Medicaid enrolled dentist, you may contact the Medicaid Referral Assistance Hotline toll-free at 1-877-455-9955.