

Robbins AFB DTF REFERRAL FORM

Date Referred: _____ From: Robbins AFB, GA Dental Clinic Phone: (478) 327-8056	Treating Office: _____ Date Completed: _____	Robins Dental Clinic/SGD 655 7 th Street Robins AFB, GA 31098-2227 Fax: (478) 327-8100 DSN Fax: 497-8100																																
<p align="center"><u>Treatment Authorized:</u></p> <p>Dental care (restorative, endodontic, periodontic, prosthodontic, oral surgery, etc.) as specified on chart below, and any necessary radiographs (bitewing or periapical) as needed to perform treatment.</p> <table border="0"> <tr><td>#1 _____</td><td>#17 _____</td></tr> <tr><td>#2 _____</td><td>#18 _____</td></tr> <tr><td>#3 _____</td><td>#19 _____</td></tr> <tr><td>#4 _____</td><td>#20 _____</td></tr> <tr><td>#5 _____</td><td>#21 _____</td></tr> <tr><td>#6 _____</td><td>#22 _____</td></tr> <tr><td>#7 _____</td><td>#23 _____</td></tr> <tr><td>#8 _____</td><td>#24 _____</td></tr> <tr><td>#9 _____</td><td>#25 _____</td></tr> <tr><td>#10 _____</td><td>#26 _____</td></tr> <tr><td>#11 _____</td><td>#27 _____</td></tr> <tr><td>#12 _____</td><td>#28 _____</td></tr> <tr><td>#13 _____</td><td>#29 _____</td></tr> <tr><td>#14 _____</td><td>#30 _____</td></tr> <tr><td>#15 _____</td><td>#31 _____</td></tr> <tr><td>#16 _____</td><td>#32 _____</td></tr> </table> <p>Other procedure(s): _____ (biopsy, quadrant SCRPs, or other procedures not identified by tooth number)</p>		#1 _____	#17 _____	#2 _____	#18 _____	#3 _____	#19 _____	#4 _____	#20 _____	#5 _____	#21 _____	#6 _____	#22 _____	#7 _____	#23 _____	#8 _____	#24 _____	#9 _____	#25 _____	#10 _____	#26 _____	#11 _____	#27 _____	#12 _____	#28 _____	#13 _____	#29 _____	#14 _____	#30 _____	#15 _____	#31 _____	#16 _____	#32 _____	<p align="center"><u>Civilian providers:</u></p> <p>For changes or adjustments to listed treatment or other questions please contact:</p> <p align="center">Col (Dr) Doug Ammon, Col (Dr) Andrew Kious or Lt Col (Dr) Arroyo-Kemp at (478) 327-8056</p> <hr/> <p>Within 7 Days of provided care: Please mail, fax or have the patient hand carry a narrative summary of your treatment to the Robins Dental Clinic at the above address.</p> <hr/> <p align="center"><u>Claims Processing:</u></p> <p>Upon completion of each phase of treatment, <u>mail</u>:</p> <ol style="list-style-type: none"> 1. A copy of this Referral Form 2. Standard ADA Dental Claim Form 3. MMSO Dental Information Sheet <p>To: Military Medical Support Office Attn: Dental Claims P.O. Box 886999 Great Lakes, IL 60088-6999</p> <p>For claims processing questions contact: MMSO Customer Service 1-888-647-6676</p>
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Patient's Name: Last, First, MI	Rank	SSAN																																
Patient's Address	Work Phone	Home Phone																																