AUGUSTA UNIVERSITY
DENTAL COLLEGE OF GEORGIA

Referral/CMN Form
Clinic for Anaplastology

Once completed, please return this form via fax number or mailing address below.

Patient Information

Name: ____**Date of Birth:** ________________

Address: ____

Insurance ID or SS#:_________________________

Phone: ____________________ **Fax:** ____________________ **Email:** ________________________

Prosthesis Need Information

Diagnosis or Condition Necessitating the Prosthesis: ____

ICD-10 Code: ____

Prosthesis Type: ____

Method of Retention: ____

Prescription Applies: ☐ For a Lifetime ☐ From _______________ To ________________

Expected Replacement Frequency: Per Physician request or based on patient condition

Physician Making the Referral

Name: ____

Address: ____

Phone: ____________________ **Fax:** ____________________ **Email:** ________________________

Website: _________________________________ **National Provider Identification #:** _____________

Unique Physician Identification #: _______________ **Physician Medicaid Provider #:** _______________

Statement of Medical Necessity: *I certify the medical necessity of the above-mentioned prosthesis for this patient. This form has been completed or reviewed by me, and has been signed by my own hand.*

Physician's Signature: ____ **Date:** ___________________

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