COUNTY OF ORANGE HEALTH CARE AGENCY

RYAN WHITE - DENTAL REFERRAL FORM

Ryan White (RW) Dental Referral to (check one only):

☐ 17th Street Dental: 1725 W. 17th Street, Santa Ana (714) 834-8408: **Accepts RW and Denti-Cal**

For 17th Street Dental Referrals: Fax referral directly to 17th Street Dental: (714) 834-8377

1. ☐ Alicia Parkway Dental: 24482 Alicia Parkway #B-3, Mission Viejo (949) 586-9800: **Accepts RW only**
2. ☐ AltaMed: 1814 W. Lincoln Ave. Suite A, Anaheim (714) 500-0350: **Accepts RW, Denti-Cal, Assurant, and Liberty**
3. ☐ Bristol Family Dental: 2618 S. Bristol Street, Santa Ana (714) 540-7101: **Accepts RW and Denti-Cal**
4. ☐ Dr. Carlos Garcia: 362 Third St. Laguna Beach (949)494-2111: **Accepts RW and Denti-Cal**

For the Four Other Dental Providers: Fax referral to Specialty Coordinator: (714) 834-8418

Client's ARIES ID:_____ (☐Share /☐ Non-Share[1]) **AND** Client's Medi-Cal ID:_____ **OR** ☐N/A

Client Name (print): _____ _____ _____ DOB: _____

First MI Last

Client's Address: _____

City: _____ ZIP Code: _____

Client's Preferred Phone: (_____) _____ Call Discretion? ☐Yes / ☐No

Special Needs (wheelchair, impaired vision, cognitive issues, other): _____

ALL THREE (3) CRITERIA MUST BE MET IN ORDER FOR THE REFERRAL TO BE ACCEPTED:

1. Client signed authorization which allows referring provider to disclose patient protected health information (PHI) to Health Care Agency (HCA) and Dental provider is attached. Clients shall be informed of their right to: confidentiality in accordance with state and federal laws and informed consent.
2. I have ensured that eligibility has been verified in ARIES.

   Eligibility expiration date: _____ Or **Client Referred to Eligibility** (30-day grace ends): _____
3. I have reviewed the client's insurance (check appropriate insurance below).
   - ☐ No Insurance: Client is eligible for Ryan White-funded dental care
   - ☐ Denti-Cal (check if client has Medi-Cal): Services must be billed to Denti-Cal unless service is not covered by DentiCal
   - ☐ Private Dental Insurance: Services must be billed to private insurance unless service is not covered by private insurance

---

Person/Agency Referring

Person Making Referral (Print) _____ Today's Date: _____

Signature of Person Making Referral _____

Referring Agency: _____ Agency's Phone: (_____) _____

Orange County Health Care Agency Use Only

_____ _____

Referral Authorization Number Date

_____

[1] ARIES non-share clients require submission of ARIES consent form and EVF Supplemental form with the initial referral and thereafter upon ARIES consent expiration for HCA ARIES data entry requirements.