South Dakota Medicaid At-Risk Referral Form Instructions

Purpose

The Medicaid At-Risk Referral Form is a tool for dental clinics to identify individuals who are considered at-risk and may benefit from Dental Care Coordination.

Dental Care Coordinators will use the information provided to support access to dental care for Medicaid recipients.

Definition

"At-risk" may indicate recipients have significant health concerns and are in need of immediate or extensive dental care, are burdened with substantial barriers to receiving treatment, or have a history of missed appointments which may lead to being dismissed from the dental clinic.

Completion of this Form

Please fill in as much as possible regarding the Medicaid recipient's contact information, including that of any parent, guardian, or other caregiver.

Several scenarios indicating a patient is at-risk are available from the dropdown menu:

- 01 Patient at risk of dismissal from dental office due to missed appointment history
- 02 Patient has a barrier(s) to keeping an upcoming Operating Room appointment
- 03 Patient has approved Ortho treatment plan but is not compliant with appointments and/or office is unable to contact
- 04 Patient has approved pre-determined treatment plan but is not compliant with appointments and/or office is unable to contact
- 05 Patient has outstanding account balance and office will not see patient until balance is paid in full
- 06 Patient move during a treatment plan (ortho or other)
- 07 Other (Please provide explanation)

If the Medicaid recipient has a history of missed appointments or "no shows," include the date(s) and any information you have regarding the reason why the individual did not arrive as scheduled.

All completed forms should be emailed to: sdmedicaid@deltadentalsd.com

South Dakota Medicaid At-Risk Referral Form

PROVIDER INFORMATION

Provider Name _____ Phone Number _____

Clinic Name _____ Submitted By _____

Tax ID Number _____ Email Address _____

MEDICAID PATIENT INFORMATION

Recipient ID# _____ Parent/Guardian _____

Last Name, First Name _____ Patient Type New Patient

Phone Number _____ Appointment Type Preventative

Why is the patient at risk?

01-At risk of dismissal from dental office due to missed appointment history

Other:

Date(s) of missed appointment(s):

Has a new appointment been scheduled?

○ No ○ Yes - If yes, when?

What are the potential barrier(s) for this patient?

- ☐ Transportation
- ☐ Previous No Shows
- ☐ Affordability
- ☐ Completing Pre-Op Physical
- ☐ Anxiety/Fear
- ☐ Physical Needs
- ☐ Family Dynamics
- ☐ Other:

If unable to contact patient, indicate why:

- ☐ Voicemail full
- ☐ Number disconnected
- ☐ Message left/no return call
- ☐ No voicemail
- ☐ Wrong number
- ☐ Returned mail / Email undeliverable
- ☐ Hung up
- ☐ Other:

Steps your dental office has taken to reduce the risk of a missed appointment(s):

- ☐ Text to patient
- ☐ Call to patient
- ☐ Email to patient
- ☐ Sent mail to patient
- ☐ Provided education to patient about office missed appointment policy
- ☐ Provided information to patient on transportation/other community resources
- ☐ Engaged other community providers (i.e. case manager)
- ☐ Explained what was going to take place at appointment
- ☐ Other:

Please tell us more about the situation. How do you think Care Coordination could benefit this patient?

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