Molina Dental Coordination Referral Form

Send completed referral via secure email: **ca_dental_coordination_mhc@MolinaHealthcare.com**

Molina Dental Coordination Referral Form	
Referral Date:	
Member Name:	**DOB:**
Medi-Cal ID:	**Preferred Language:**
Referral Source:	
Referral Contact:	
Contact Name:	**Relationship:**
Contact Phone Number:	
Reason for Referral:	
Preventative ☐ **Urgent** ☐	
Is the member currently receiving dental care? **Yes** ☐ **No** ☐	
If member is receiving dental care please include the following: **Dentist Name:** **Address:** **Phone Number:**	
Notes:	

MHC Dental Coordinator 05/10/22

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