

# Form Instructions: Beneficiary Dental Exception (BDE)

If you are having problems scheduling a dental appointment for yourself or your child in Sacramento County, please follow the instructions below.

For **DENTAL EMERGENCY** (pain, swelling, and/or bleeding),

Call the **BDE Toll-Free number at 1(855) 347-3310** for help.

BDE Hours are Monday - Friday, 8:00 a.m. to 5:00 p.m.

## Filling out the BDE Form:

Enter Benefits Identification Card Number as shown.



State of California—Medi-Cal Dental Services Program Department of Health Care Services

### Beneficiary Dental Exception (BDE) Form

For **DENTAL EMERGENCY** (pain, swelling, and/or bleeding),  
Call the **BDE Toll-Free number at 1(855) 347-3310** for help.  
BDE Hours are Monday - Friday, 8:00 a.m. to 5:00 p.m.

**Patient Information**

Name (first and last): \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Benefits Identification Card Number (BIC): \_\_\_\_\_

Best Contact Number: \_\_\_\_\_

**Parent or Guardian Information (Must be filled out if patient is under 18 years old)**

Name (first and last): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Best Contact Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Please Check any Box(es) that Apply to the Patient:**

For "Dental Emergencies", call the **BDE Toll-Free number at 1(855) 347-3310**.

Not able to get an "urgent" appointment within 72 hours (3) days.

Not able to get a "routine" appointment within four (4) weeks.

Not able to get a "specialist" appointment within 30 days from authorized request.

Other: \_\_\_\_\_

**Signature and Date** (Parent/Guardian **must** sign if the patient is under 18 years old)

Signature: \_\_\_\_\_ Date (mm/dd/yyyy): / /

**Please return this form by using one of the following ways:**

**Mail:** Dental Managed Care BDE  
PO Box 997413, MS 4900  
Sacramento, CA 95899-7413

**E-Mail:** dentalmanagedcare@dhcs.ca.gov  
Subject: Dental Managed Care BDE

**FAX:** Dental Managed Care BDE  
(916) 464-3783

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Patient information is required.

Parent or Guardian information is needed only if patient is under 18 years old.

Check all boxes that apply. If "other", please explain.

Signature and Date (Parent must sign if patient is under 18 years old.)

Please mail, e-mail or fax form to Dental Managed Care.

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