LIBERTY Dental Plan Specialty Care Referral Request

P.O. Box 26110
Santa Ana, CA 92799
Email: claims@libertydentalplan.com Fax: 949-253-0096

Eligibility Verified: Yes No
Verifiers Initials:
Date & Time:

Specialty Referral (Mail to LDP with x-ray & documents) Emergency Referral (Call (800) 268-9012)

Provider	**Referring Specialist**
Name:	Specialist Name:
Phone: ID#:	Phone: ID#:
Address:	Address:
City, State, Zip:	City, State, Zip:

Member		
Member Name:	ID #:	Eligibility Verified: ☐Yes ☐No
Patient Name:	DOB:	Verifiers Initials:
Address:	Phone:	Date & Time:
City, State, Zip:		

Treatment Request

CDT Code	Procedure Code Description	Tooth #	Surface

PLEASE CHECK ALL THAT APPLY IN EACH SPECIALTY CATEGORY:

Endodontics (MUST submit PA & BWX)	Prognosis: ☐Good ☐Poor Reason for Referral: _____ _ _____
Oral Surgery (MUST submit PA or Pano)	Reason for Referral _____ Additional Information _____ *In absence of Pathology extractions of impacted teeth and roots are not a benefit
Pediatric Dentistry	Reason for Referral (Please document behavioral problems): _____ Date(s) _____ Age of Child _____
Periodontics	Referral limited to D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician Case Type (circle one) I, II, III, IV Dates of Root Planing (SRP) UR _____ UL _____ LR _____ LL _____ Additional Information _____
Orthodontics	Notes:

I hereby certify that the above noted treatment request has met the criteria for specialty referral and acknowledge that the final claim for payment is subject to clinical review.
Dentist Signature: _____ Date: _____

Dental plan use only □ Approve □ Deny □ Pend Dental Consultant Signature _____

Comments _____