LIBERTY DENTAL PLAN.

NJ FAMILYCARE: ATTESTATION OF COMPLETED PREVENTIVE & RESTORATIVE DENTAL TREATMENT

Provider Office

Provider Name:				Office ID#:
Address:				Office Phone:
City:	State:	Zip:		Office Fax:

Member

Member Name:				Member ID#:
Address:				Date of Birth:
City:	State:	Zip:		Phone:

PLEASE SELECT ONE. PROVIDER SIGNATURE IS REQUIRED TO AFFIRM REQUIREMENTS:

The Primary Care Dentists (PCD) must certify that all preventive and/or restorative dental treatment needs have been met.

I hereby attest that the above member's active orthodontic treatment has been completed with a favorable outcome and case is ready for retention.

Provider Name

Provider Signature

Date (mm/dd/yyyy)

PLEASE NOTE: It is the responsibility of the rendering orthodontist to submit an attestation from the referring or treating primary care dentist that all preventive and dental treatment services have been completed. This attestation may be submitted in lieu of a written narrative on the PCD's letterhead.