LIBERTY Dental Plan Specialty Care Referral Request

P.O. Box 401086
Las Vegas, NV 89140
Phone: 888-401-1128 Fax: 888-401-1129

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

☐ Specialty Referral (Mail to LDP with x-ray & documents) ☐ Emergency Referral (Call 888-359-1087)

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 (circle one): good / poor
☐ Reason for Referral
Additional Information _____

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 occurring at initial exam):
Date(s) _____
☐ Age of Child _____
Additional Information _____

Periodontics

Referral limited to D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician
(circle one)
Case Type I, II, III, IV
Dates of Root Planing
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 _____