Liberty Dental Plan Ambulatory Surgical Center (ASC)/Hospital Assessment Form

LIBERTY DENTAL PLAN

This assessment is for LIBERTY Dental Plan (LDP) to determine the need for treatment in an Ambulatory Surgical Center (ASC) or Hospital setting.

Please circle the answers that apply by using a blue or black pen. Complete one form **for each LDP enrollee**. If you have questions, please call LIBERTY, toll free at**1.833.276.0850**. A representative is available to speak with you Monday through Friday, between 8:00 am and 5:00 pm. TDD/TTY users should dial **1.877.855-8039**. Upload this form with the preauthorization for treatment in the ASC or Hospital. Include a full narrative to support the member assessment or findings and for any affiliated codes.

***If prior authorization is approved the authorization number will cover the rendering dentists' professional services, the ASC/Hospital facility fee, and sedation/anesthesia. ***

Standard for Treatment in an ASC or Hospital to be submitted by Rendering Dentist (Must Be Contracted With LIBERTY)

Date:	
1. Rendering Provider Name:	**Rendering Dentist FL Medicaid ID:**
2. Facility (ASC/Hospital) Name:	**Facility (ASC/Hospital) Medicaid ID:**
3. Member's Name:	**Member FL Medicaid Number:**
Member's Date of Birth:	

TREATMENT PLAN REQUIRED: ***Rendering Dentist Must submit a Treatment Plan*** **If a treatment plan is NOT being submitted provide a detailed narrative of when/how a treatment plan will be developed. Please indicate obstacles of why a treatment plan could not be developed.***	**Treatment Plan Provided Circle Yes or No**	
SECTION 1 Select only one response per question		
Age of Patient (Select One)		
2 – 5 years old	Y	N
6-10 years	Y	N
> 10 years	Y	N
Treatment Required (Carious and/or Abscessed Teeth) (Select One)		
Less than 4 teeth	Y	N
4+ Anterior Teeth	Y	N
4 + Posterior Teeth	Y	N
5 – 8 Teeth	Y	N
> 8 teeth	Y	N

	Ability to Cooperate in a normal dental setting (Select One)			
	Major dental anxiety/Prohibitive/Actively Resistant Unable to cooperate for x-rays and exam due to physical or emotional maturity Physically resistant prohibiting being touched for treatment/ exam		Y	N
	Moderate Dental Anxiety/Inhibitive /Allows Examination Refuses an x-ray or exam but can be coaxed. Verbally expresses dental fears/objections Will allow exam but grabs doctor's hands or requires restraint.		Y	N
	Mild Dental Anxiety/Inhibitive /Allows Examination Allows for x-rays, exam with mirror only, and mild treatment such as prophy but unable to cooperate for more advanced treatment such as sealants or exam with explorer.		Y	N
	SECTION 2 (select all that apply)			
	Failed Moderate Sedation Attempt		Y	N
	Failed Nitrous Oxide Attempt		Y	N
	Failed Attempt at treatment in the chair (without sedation or nitrous)		Y	N
	SECTION 3 Special Circumstances and Criteria (select all that apply)			
	Pathology **Abscess, fistula, swelling, or other oral pathology requiring immediate attention**		Y	N
	Extreme Social/Environmental circumstance *** .		Y	N
	Medically compromised (e.g. special health care considerations)		Y	N
	Severe Behavioral Condition (e.g. Autism spectrum)		Y	N

Please provide a narrative of medical necessity, medical or behavioral diagnosis and indicate if any failed treatment attempts in the dental chair including nitrous or sedation.

I find the above assessment to be true according to clinical exam and information gathered from parents. A full narrative of my findings will be submitted with this form as part of the preauthorization process and will be documented in the patient's chart.

Provider	**Date Signed:**

I agree with the examining dentist's assessment of my child. I understand this guideline is no guarantee of procedure acceptance and is used as a tool to determine the medical necessity of treatment in an ASC or hospital setting for the planned dental treatment at this time and is subject to change based on the patient's circumstances.

Guardian/Parent/Patient Signature:	**Date Signed:**