

## LIBERTY Dental Plan Specialty **Care Referral Request**

P.O. Box 401086

Eligibility Verified: Yes No Verifiers Initials:

Date & Time:

Las Vegas, NV 89140 Phone: 888-401-1128 Fax: 888-401-1129

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:			
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:							
<b>Endodontics</b> (must submit PA & BWX)	<ul> <li>Prognosis</li> <li>Reason</li> <li>Additional Information</li> </ul>	-	one): for	good	/	poor Referral	
<b>Oral Surgery</b> (must submit PA or Pano)	Reason for Referral Additional Information *In absence of Patholo	l					
Pediatric Dentistry	<ul> <li>Reason for Referral (Pl Date(s)</li> <li>Age of Child</li> <li>Additional Information</li> </ul>			-	·		
Periodontics	Referral limited to D9310 requesting dentist or phys (circle one) Case Type I, II, III, IV Dates of Root Planing UR LR LR Additional Information	ician UL LL	diagnostic service pro			ner than	
Orthodontics	Notes:						
I hereby certify that the above no payment is subject to clinical revi Dentist Signature:	ew.			-	e that the final		

Dental plan use only

□ Approve □ Deny □ Pend

Dental Consultant Signature

Comments