LIBERTY Dental Plan
Specialty Care Referral Request

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

Referral #_____

☐ 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** (must submit FMX & perio charting)	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 _____