



Orthodontic Treatment Status Form

Patient Name: _____

Subscriber/Insured's Name: _____

Subscriber/Insured's ID Number: _____

Treating Orthodontist: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Phone: _____ FAX: _____

Please provide the following information on the above named patient:

1. Original diagnosis/treatment plan: _____

2. Date treatment initiated: _____
3. Summary of treatment remaining for completion: _____

4. Estimated completion date: _____
5. Remaining financial obligation (patient amount/insurance amount): _____
6. Is there another insurance payment anticipated prior to Liberty Dental Plan's coverage effective date? _____ If so, amount expected: _____

Please attach a copy of the patient's chart, including patient ledger, and FAX or mail with this form to:

LIBERTY Dental Plan
3200 El Camino Real, Suite 290
Irvine CA 92799-6110
Attn: Professional Services

FAX: 949.223.0011

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Patient or Guardian:

In accordance with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically regarding Protected Health Information (PHI) please authorize with your signature the release of your or your dependent's patient records to LIBERTY Dental Plan.

Patient or Guardian Signature

Date