LIBERTY DENTAL PLAN

P.O. Box 26110
Santa Ana, CA 92799-6110
(888) 703-6999
Fax: (949) 253-0096

☐ **Specialty Referral**
(Mail to LDP with xray & documents)

☐ **Emergency Referral**
(Call or Fax to LDP)

Provider		**Member**	
Prov #ID	Phone	Member Name	ID#:
Name		Patient Name	Phone
Address		Address	DOB
City		City	

CHECK ALL THAT APPLY IN EACH SPECIFIC CATEGORY:

☐ **Endodontics** (must submit PA & BWX)

☐ **Prognosis** _____
☐ Pain
☐ Retreatment (date of original RCT _____)
☐ Calcification (circle one)
Canal involved M D B P
☐ Curved Canal (circle one)
Canal involved M D B P
☐ Internal/External Resorption
☐ Apicoectomy/Retrofilling
☐ Other _____

☐ **Oral Surgery** (must submit PA or Pano)

☐ Pain
☐ Swelling
☐ Periocornitis caused by exacerbated third molars
☐ Non-restorable- caries/internal resorption
☐ Resorption of roots of adjacent teeth
☐ Interference with prosthesis of edentulous arches
☐ Other _____

* In absence of Pathology extractions of impacted teeth and roots are not a benefit

☐ **Periodontics** (must submit FMX & perio charting)
(circle one)
Case Type I, II, III, IV
Dates of Root Palnning

UR _____ LL _____
LR _____ LR _____
☐ Other _____
_____

☐ **Pedodontics**

☐ Uncooperative (2) attempts
Dates _____ & _____
☐ Medical Reason_____
☐ See MD attached note
☐ Other _____
_____

☐ **Orthodontics** Notes:

TREATMENT REQUEST

Tooth #	Surface	ADA Code	Description	Fee	Co-Pay

Dentist Signature _____ **Date** _____

In office use only
Date Received _____ Eligibility _____ Plan # _____
Date Processed _____
Approved ☐ Denied ☐ Modified ☐ By _____ Admin. _____
X-rays reviewed_____ Tracking #:_____
Comments _____

revised 9/18/03