Ambulatory Surgical Center (ASC)/Hospital Assessment Form

Purpose: This assessment is for Liberty Dental Plan (LDP) to determine the need for non-emergency dental treatment to be completed in an Ambulatory Surgical Center (ASC) or Hospital setting.

Instructions: ASC/Hospital Assessment Form Instructions for Dental Providers

Liberty Dental Plan requires that providers complete the ASC/Hospital Assessment form to determine the medical necessity of rendering dental services in an Ambulatory Surgical Center (ASC) or hospital setting. Please ensure that you follow the instructions carefully and submit all required information for timely processing.

Complete All Required Fields: Ensure that all fields marked with an asterisk (*) are filled out completely. These fields are necessary for processing the request. If any required field is missing, the form will not be processed.

Treatment Plan Submission: Please submit a comprehensive treatment plan for the member. If you are unable to provide a treatment plan, clearly explain the reason for the omission in Section 4.

X-rays and Supporting Documentation: Submit relevant radiographs and/or photographs to support the request for services to be performed in an ASC or hospital setting. This documentation must accompany the ASC/Hospital Assessment form.

One Form Per Member: Only one ASC/Hospital Assessment form should be submitted per member. Multiple forms for the same member will not be accepted.

Form Submission: This form must be included as part of the regular pre-authorization submission process. It can be submitted along with the ADA form via paper, EDI, or through the web portal.

Eligibility for Submission: Only providers who have completed a site application with Liberty Dental Plan and have ASC or hospital privileges are authorized to complete/submit this form.

Assistance with Site Application: If you have not yet completed the site application or need assistance, please contact the Provider Relations Department for support in completing the application.

Provider Attestation: Wet or Digital signature is required. Stamp Signatures are accepted as long as an attached copy of the dentist's clinical notes contain a wet or a digital signature.

Scheduling: Do not schedule the member to have services rendered at an ASC or Hospital until a pre-authorization is approved.

By following these instructions, you will help us process your request quickly and accurately. Thank you for your cooperation and commitment to providing the highest quality care to Liberty Dental Plan members.

Process: If pre-authorization is approved, Liberty will generate a pre-authorization number. This authorization number must be included when submitting the claim for the rendering dentist's professional services. The same authorization number must be used by the ASC/Hospital to cover the facility fee, as well as for anesthesia services. **The ASC or Hospital does not need to submit a pre-authorization request to Liberty Dental Plan for code CPT 00170 or facility services.** We encourage you to share this number with these entities to ensure efficient coordination of care for the member. Authorization is valid for 6 months from approval date. Pre-authorization will be processed within the clean claims processing standards.

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Members	
*First Name:	*Last Name:
*Date of Birth:	*Member ID:
Rendering Provider	
*First Name:	*Last Name:
*NPI:	*Medicaid ID:
Facility	
*Name:	
*Address:	
TIN (optional):	*Medicaid ID:

SECTION 1: Member Oral Health Information (Select only one response)		
Member Age Range		
2 – 5 years old ☐	6-10 years ☐	> 10 years ☐
Treatment Required (Carious and/or Abscessed Teeth)		
Less than 4 teeth ☐		
4+ Anterior Teeth ☐		
4 + Posterior Teeth ☐		
5 – 8 Teeth ☐		
> 8 teeth ☐		

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Ability to Cooperate in a normal dental setting	
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.	☐
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.	☐
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.	☐
SECTION 2: Sedation Attempts (select all that apply)	
Failed Moderate Sedation Attempt	☐
Failed Nitrous Oxide Attempt	☐
Failed Attempt at treatment in the chair (without sedation or nitrous)	☐
SECTION 3: Special Circumstances and Criteria (select all that apply)	
Severe Behavioral Condition (e.g. Autism spectrum)	☐
Abscess, fistula, swelling, or other oral pathology requiring immediate attention	☐
Medically compromised (e.g. special health care considerations)	☐
Extreme Social/Environmental circumstance	☐
SECTION 4: Narrative	
Please provide a detailed narrative outlining the medical necessity (e.g. specific airway anatomy or special health care needs) for rendering services in an Ambulatory Surgical Center (ASC) or hospital setting. Include the patient's medical or behavioral diagnosis and specify if any treatment attempts were made in the dental chair, including the use of nitrous oxide or sedation, and the outcomes of those attempts. Attach a separate page if needed.	

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SECTION 5: Rendering Provider Attestation

By completing and submitting this ASC/Hospital Assessment form, I, the undersigned provider, attest that all information provided is true and accurate to the best of my professional knowledge. I confirm that the assessment, including the clinical examination and information gathered from the member's parent or guardian, accurately reflects the medical necessity of rendering dental services in an ASC or hospital setting.

I understand that this form is part of the member's record and must be kept on file in accordance with Florida's record-keeping requirements. I also acknowledge my responsibility to retain a copy of this form for my records.

By submitting this form, I certify that the information provided is complete and aligns with the standards set forth by Liberty Dental Plan and the state of Florida.

*Signature:	*Date:

SECTION 6: Member, Parent or Guardian Attestation

I, the undersigned, hereby agree with the examining dentist's assessment of the patient, as outlined in the provided documentation. I understand that this guideline is not a guarantee of procedure acceptance but is used solely as a tool to determine the medical necessity of rendering dental treatment in an ASC or hospital setting at this time. I further acknowledge that this assessment is subject to change based on the patient's circumstances.

In the event that this request is denied, I understand that the dental services can still be completed using other forms of sedation and will not require teatment in an ASC or hospital setting.

I certify that I have been informed and understand the above conditions related to the request for dental services.

*Signature:	*Date: