LIBERTY Dental Plan Specialty Care Referral Request

P.O. Box 15149
Tampa, FL 33684-5149
Phone: 888-352-7924 Fax: 888-700-1727

Eligibility Verified: Yes No
Verifiers Initials:
Date & Time:

☐ Specialty Referral (Mail to LDP with x-ray & documents) ☐ Emergency Referral (Call 888-352-7924)

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	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 _____