**LIBERTY Dental Plan Specialty**  
**Care Referral Request**  
P.O. Box 401086  
Las Vegas, NV 89140  
Phone: 888-401-1128  
Fax: 888-401-1129

<table>
<thead>
<tr>
<th>Provider</th>
<th>Referring Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Specialist Name:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>ID#:</td>
<td>ID#:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
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<tr>
<td>City, State, Zip:</td>
<td>City, State, Zip:</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Member</th>
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<tbody>
<tr>
<td>Member Name:</td>
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</tbody>
</table>
|         | Eligibility Verified:  
|         | □ Yes □ No |
| Patient Name: | DOB: |
| Address: | Phone: |
| City, State, Zip: | |

<table>
<thead>
<tr>
<th>Treatment Request</th>
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<tbody>
<tr>
<td>CDT Code</td>
</tr>
<tr>
<td>Tooth #</td>
</tr>
</tbody>
</table>

**PLEASE CHECK ALL THAT APPLY IN EACH SPECIALTY CATEGORY:**

**Endodontics (must submit PA & BWX)**
- □ Prognosis (circle one):  
  - good / poor  
  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) ____________
  Additional Information

- □ Age of Child ____________
  Additional Information

**Periodontics**
- Referal 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 ___________________________

Rev. 11/2015