LIBERTY Dental Plan
Specialty Care Referral Request

P.O. Box 26110
Santa Ana, CA 92799-6110
Phone: 888-703-6999 Fax: 949-253-0096
Referrals@libertydentalplan.com

Referral #____________

☐ Specialty Referral (mail to LDP with x-ray & documents) ☐ Emergency Referral (fax or email with x-ray & documents)

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** (must submit FMX & perio charting)	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 ____