LIBERTY DENTAL PLAN

SPECIALTY CARE REFERRAL REQUEST

P.O. Box 401086
Las Vegas, NV 89140
Phone: 888-352-7924 Fax: 888-700-1727 Email: referralfax@libertydentalplan.com

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

Provider		**Requested 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 FMX or radiograph illustrating all conditions of dentition)	Prognosis (circle one): good / poor _____ ☐ Reason for Referral _____ ☐ Additional Information _____
Oral Surgery (Must submit PA or Pano)	☐ Reason for Referral _ Additional Information _____
Pediatric Dentistry	☐ Reason for Referral (Please document behavioral problems occurring at initial exam): Date(s)_____ & _____ ☐ Age of Child _____ Additional Information
Periodontics (Must submit FMX & 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: _____

Comments _____