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:

Specialty	Details
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 _____