



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 LIBERTY with x-ray and 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:
City, State, Zip:			Time:
Treatment Request			
CDT Code	Procedure Code Description	Tooth #	Surface

PLEASE CHECK ALL THAT APPLY IN EACH SPECIALTY CATEGORY:

Endodontics <i>Must submit FMX or radiograph illustrating all conditions of dentition</i>	Prognosis (select one): good poor Reason for Referral _____ Additional Information _____
Oral Surgery <i>Must submit PA or Pano</i>	Reason for Referral _____ Additional Information _____
Pediatric Dentistry	Reason for Referral (Please document behavioral problems occurring at initial exam): Date(s) _____ and _____ Age of Child _____ Additional Information _____
Periodontics <i>Must submit FMX and Charting</i>	Referral limited to D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician Case Type (select one): I II III IV Dates of Root Planing: UR LR UL LL Additional Information _____
Orthodontics	Notes:

Comments:

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: _____