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 *Must submit FMX or radiograph illustrating all conditions of dentition*	☐ Prognosis (select 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) _____ and _____ ☐ Age of Child _____ Additional Information _____
Periodontics *Must submit FMX and Charting*	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:** _____