Health Net
Specialty Care Referral Request

P.O. Box 26110
Santa Ana, CA 92799-6110
Phone (888) 273-2713 Fax (949) 253-0096
Referrals@libertydentalplan.com

☐ **Specialty Referral** (Mail to Health Net with x-ray & documents) ☐ **Emergency Referral** (fax or email with x-rays & documents)

Provider		**Referring Specialist**	
Name:		Specialist Name:	
Phone:	ID#:	Phone:	ID#:
Address:		Address:	
City, State, Zip:		City, State, Zip:	

Member	
Member Name:	ID #:
Patient Name:	DOB:
Address:	Phone:
City, State, Zip:	

Treatment Request

CDT 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
☐ **Pedodontics**	☐ If child is over 4 years old and uncooperative, please note attempts to treat (Children under 4 require only one attempt if uncooperative): Dates _____&_____ ☐ Age of Child _____ ☐ Reason for Referral _____ 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: _____