Transition of Care Request Form

The below information must be submitted between **January 1, 2024** and **January 31, 2024**.
A qualifying treatment must have started prior to your eligibility with LIBERTY Dental Plan.
Please work with your dental provider to complete the information below.

Subscriber's Name:		Subscriber ID#:
Patient's Name:		Patient's Effective Date:
Patient's Date of Birth:		Patient's Phone Number:
Home Address: Street City State Zip		
Choose one of the following qualifying conditions if the patient started treatment for a specific tooth/teeth that is in progress and not complete. ☐ Bridge ☐ Crown ☐ Full/Partial Denture ☐ Implant ☐ Root Canal ☐ Orthodontia		
Treating Dentist:		
Address:		
Phone Number:		Fax Number:
Date treatment initiated: (mm/dd/yyyy)	Estimated completion date: (mm/dd/yyyy)	Patients allowable benefit with previous carrier:
Remaining financial obligation: (patient amount/insurance amount)	Original diagnosis/Treatment Plan: (please include tooth numbers where applicable)	
Summary of treatment remaining for completion:		
Previous insurance payments, prior to LIBERTY Dental Plan effective date:		

Please mail, fax or email this form along with a copy of the previous insurance Evidence of Payment (EOP), Evidence of Benefits (EOB) or Pre-authorization to: LIBERTY Dental Plan, Attn: Claims – TOC, P.O. Box 15149 Tampa, FL 33684-5149, Fax: **(949) 270-0103** or Email: **claims@libertydentalplan.com**. Call Member Services at **(800) 764-5393**, Monday – Friday 7:30am to 9:00pm, (EST) if you have any questions.

Patient or Guardian: In accordance with the requirements and standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically regarding Protected Health Information (PHI), please authorize with your signature, the release of you or your dependent's patient records to LIBERTY Dental Plan.

Patient or Guardian Signature: _____ Date: _____

LIBERTY DENTAL PLAN | KAISER PERMANENTE