



Transfer Request Form

HFP                       LAPHP

Date \_\_\_\_\_

Member Name \_\_\_\_\_ Dental Provider Number \_\_\_\_\_

Member Telephone \_\_\_\_\_ Office Telephone Number \_\_\_\_\_

Reason for request:

- Member is repeatedly verbally abusive to provider, auxiliary or staff or other plan members.
- Member physically assaults the provider or staff person or threatens another individual with a weapon on provider's premises. (Provider must file a police report against the member.)
- Member is disruptive to provider's office operations.
- Member has allowed the fraudulent use of his or her coverage under the plan, which includes his or her allowance of others to use his or her membership card to receive services from the plan's providers.
- Member has failed to follow prescribed treatment (including failure to keep appointments). This is not, in and of itself, good cause for a request to transfer member unless the provider can demonstrate that, as a result of the failure, the provider is exposed to a substantially greater and unforeseeable risk than otherwise contemplated under the plan and the rate-setting assumptions.

List missed appointments (if applicable): \_\_\_\_\_

Additional comments for transfer \_\_\_\_\_

\_\_\_\_\_  
Dentist Signature

\_\_\_\_\_  
Date

Submit request by mail to:

**HEALTH NET DENTAL**  
**C/o LIBERTY Dental Plan of California, Inc.**  
**3200 El Camino Real, Suite 290**  
**Irvine, CA 92602**

**For Office Use Only**

**Name of person receiving complaint:** \_\_\_\_\_

**Date of action:** \_\_\_\_\_