

## Appeal Form

If you would like Dental Select to reconsider your benefit determination, please complete this appeal form. This form isn't required for a benefit determination to be reconsidered, but it is helpful for us to conduct our review.

Name of Person Filing Appeal		Status <input type="checkbox"/> Provider <input type="checkbox"/> Member		Telephone #	
Address			City	State	Zip
Patient Name				Subscriber ID #	
Name of Provider		Provider Address			Provider Telephone #
Date(s) of Service			Claim Number(s)		

Please provide a description of why you are appealing our initial decision. Please provide supporting documentation, such as provider narratives or letters, x-rays, clinical notes, etc. Attach additional pages if needed.

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What is your preferred outcome?

\*Please note this does not guarantee your preferred outcome will be met.

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I certify that the above information is correct.

Signature X_____	Date _____
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**Ready to submit?** Mail to Dental Select Attn: Appeals PO Box 851917 Richardson, TX 75085

**Questions?** Contact a Customer Care Representative at 800-999-9789