DELTA DENTAL®

Appeal Request Form: ASO (Self-funded groups only)

You may use this form to tell your benefits administrator you want to appeal a denial decision.

Insured Member's Name _____ Member ID _____

Name of representative pursuing appeal, if different from above _____

Mailing Address _____

City _____ State _____ Zip Code _____

Claim Number _____

Type of Denial ☐ Denied Claim ☐ Denied Service Not Yet Received

Explain what you want your benefits administrator to authorize or pay for and why you believe the claim or service should be covered: _____

_____

_____

_____

_____

(Attach additional sheets of paper, if needed.)

Make sure to attach everything that shows why you believe your benefits administrator should cover your claim or authorize a service, including:

☐ Dental records ☐ Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.)

Upon request, Delta Dental of Arizona can provide you copies of documents, records and other information relevant to your claim for benefits free of charge.

_____

Signature of insured or authorized representative Date

Forward appeal request to:

Delta Dental of Arizona
Appeals Department
14850 N. Scottsdale Rd., Suite 400
Scottsdale, AZ, 85254

Fax: 602.548.5089