



## DENTAL APPEAL REQUEST FORM

**Please submit this form and supporting information to:**

United Concordia Dental - Customer Service Unit  
Appeals and Grievance Coordinator  
P.O. Box 69420  
Harrisburg, PA 17106-9420

Person completing form:     SUBSCRIBER                       DEPENDENT  
    AUTHORIZED DELEGATE  
    PARENT/GUARDIAN    (AN AUTHORIZED DELEGATE FORM MUST BE COMPLETED AND ATTACHED)

MEMBER INFORMATION			
NAME _____			
STREET ADDRESS _____			
CITY _____			STATE _____
HOME TELEPHONE NUMBER _____			DATE OF BIRTH _____
MEMBER CONTRACT NUMBER _____	MEMBER GROUP NUMBER _____	TYPE OF CONTRACT <input type="checkbox"/> Individual <input type="checkbox"/> Group	

APPEAL INFORMATION	
DATE(S) OF SERVICE 1. _____ 2. _____ 3. _____	SERVICE PROVIDER(S) INFORMATION (Dentist, physician, etc) 1. Name _____ Address _____ Telephone Number (Including area code) _____ 2. Name _____ Address _____ Telephone Number (Including area code) _____ 3. Name _____ Address _____ Telephone Number (Including area code) _____
PROCEDURE OR TYPE OF SERVICE(S) DENIED _____ _____ Amount Appealed _____ _____ <b>Please attach any supporting clinical documentation you may be able to provide.</b>	
REASON FOR APPEAL <input type="checkbox"/> No Precertification / No Prior-Authorization <input type="checkbox"/> Other _____ <input type="checkbox"/> Not a covered benefit/policy exclusion	
DESCRIPTION OF THE APPEAL / SUPPORTING INFORMATION (Please use additional pages as needed) _____ _____ _____ _____	

MEMBER / AUTHORIZED DELEGATE SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_