DELTA DENTAL OF CONNECTICUT, INC.

REQUEST FOR EXTERNAL REVIEW

1. **Participating Dentist:**

   Name _____

   Office Name _____

   Provider I.D. No. _____

   License No. _____

   Address _____

   _____

   Telephone No. _____

   Facsimile No. *(Optional)* _____

   E-mail Address *(Optional)* _____

2. **Claim (the "Claim"):**

   Member Name _____

   Social Security Number _____

   Date of Birth _____

   Patient Name _____

   Patient Social Security Number _____

   Patient Date of Birth _____

   Claim No.[2] _____

3. Date of Internal Review Decision: _____
   (Attach copy of decision.)

4. Describe in detail why you believe that the external review organization should reverse or change Delta Dental's internal review decision, and the specific decision that you request.

   _____

   _____

   _____

   _____

   _____

5. Identify whom Delta Dental and/or the external review organization should contact if the reviewer has questions concerning your appeal.

   _____

   _____

6. Attach your check in the amount referred to in Section 4.B. of the External Appeals rules payable to the American Arbitration Association and enter your check number and date here:

   _____

[2] **Attach a copy of the claim with attachments (if applicable) and a copy of the claim determination for which external review is requested.**