DELTA DENTAL OF CONNECTICUT, INC.

REQUEST FOR INTERNAL 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.[1] _____

3. Identify any communications you have had with any Delta Dental representative concerning the claim for which you are seeking internal review and attach copies of all documents you have sent to and/or received from Delta Dental concerning this claim.

   _____

   _____

   _____

4. Describe in detail why you believe that Delta Dental should change its initial decision on the claim, and the specific decision that you request. You may enclose information and/or documentation not originally submitted with the claim.

   _____

   _____

   _____

   _____

   _____

5. Identify whom Delta Dental should contact if the reviewer has questions concerning your appeal.

   _____

   _____

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