DentalSelect

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 ☐ Provider ☐ 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.

_____
_____
_____

I certify that the above information is correct.

Signature	Date
X_____	_____

Ready to submit? Mail to Dental Select Attn: Appeals PO Box 851917 Richardson, TX 75085

Questions? Contact a Customer Care Representative at 888-999-9789