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.

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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 800-999-9789