DELTA DENTAL®

Request for Appeal

Please fill out this form in its entirety if you wish to appeal a previously processed claim.

Dentist Information: ☐ Please check if this dentist is submitting the appeal

Dentist name:	License number:
Office name:	Phone number:
Address:	
Email:	Fax number:

Patient Information: ☐ Please check if this patient/member is submitting the appeal

Patient name:	Patient date of birth:
Delta Dental ID number:	Delta Dental group number:
Member name (if different than patient):	Member date of birth:
Phone number we can reach you at regarding this appeal:	

Claim Information:

Claim number:	Date of service:

Explain in detail why you believe Delta Dental should reconsider our initial processing of this claim:

Supplemental information will need to be submitted with this form.
Please attach any additional diagnostics, narratives, X-rays, etc., that support your request for re-review. Please note: X-rays and photos cannot be faxed.

Once completed, please return to Delta Dental:

Mail:
Delta Dental of New Jersey
PO Box 15132
Little Rock, AR 72231

Fax:
973-944-4543

Questions?
Please call Customer Service at **800-452-9310**
Monday - Thursday: 8:00 a.m. to 6:30 p.m. ET
Friday: 8:00 a.m. to 5:00 p.m. ET