

**DELTA DENTAL OF NEW JERSEY, 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.<sup>2</sup> \_\_\_\_\_

**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:** \_\_\_\_\_

<sup>2</sup> **Attach a copy of the claim with attachments (if applicable) and a copy of the claim determination for which external review is requested.**