

**DELTA DENTAL OF NEW JERSEY, 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.<sup>1</sup> \_\_\_\_\_

**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.**

\_\_\_\_\_  
\_\_\_\_\_

<sup>1</sup>**Attach a copy of the claim with attachments (if applicable) and a copy of the claim determination for which internal review is requested.**