DELTA DENTAL OF NEW JERSEY, INC.

REQUEST FOR EXTERNAL REVIEW

1. **Participating Dentist:**

   Name ______________________________

   Office Name ______________________________

   Provider I.D. No. ______________________________

   License No. ______________________________

   Address ______________________________

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   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.[2] ______________________________

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.

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5. Identify whom Delta Dental and/or the external review organization should contact if the reviewer has questions concerning your appeal.

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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: ______________________________

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[2] Attach a copy of the claim with attachments (if applicable) and a copy of the claim determination for which external review is requested.