DELTA DENTAL OF NEW JERSEY, INC.

REQUEST FOR INTERNAL 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.[1] ______________________________________

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.

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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.

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5. Identify whom Delta Dental should contact if the reviewer has questions concerning your appeal.

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