BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

HMO Louisiana, Inc.

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DENTAL APPEAL REQUEST FORM

Please submit this form and supporting information to:
United Concordia Dental - Customer Service Unit
Appeals and Grievance Coordinator
P.O. Box 69420
Harrisburg, PA 17106-9420

Person completing form: ❑ SUBSCRIBER ❑ DEPENDENT
❑ AUTHORIZED DELEGATE
❑ PARENT/GUARDIAN (AN AUTHORIZED DELEGATE FORM MUST BE COMPLETED AND ATTACHED)

MEMBER INFORMATION

NAME			
STREET ADDRESS			
CITY		STATE	ZIP CODE
HOME TELEPHONE NUMBER		DATE OF BIRTH	
MEMBER CONTRACT NUMBER	MEMBER GROUP NUMBER	TYPE OF CONTRACT ❑ Individual ❑ Group	

APPEAL INFORMATION

DATE(S) OF SERVICE

1. _____
2. _____
3. _____

PROCEDURE OR TYPE OF SERVICE(S) DENIED

_____

_____

Amount Appealed

_____

Please attach any supporting clinical documentation you may be able to provide.

SERVICE PROVIDER(S) INFORMATION (Dentist, physician, etc)

1. Name _____
   Address _____
   Telephone Number (Including area code) _____
2. Name _____
   Address _____
   Telephone Number (Including area code) _____
3. Name _____
   Address _____
   Telephone Number (Including area code) _____

REASON FOR APPEAL
❑ No Precertification / No Prior-Authorization
❑ Not a covered benefit/policy exclusion
❑ Other _____
_____

DESCRIPTION OF THE APPEAL / SUPPORTING INFORMATION (Please use additional pages as needed)

_____

_____

_____

_____

_____ _____ _____

MEMBER / AUTHORIZED DELEGATE SIGNATURE DATE