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Appeal Request Form

TheStandard®

The Standard Life Insurance Company of New York Employee Benefits / P.O. Box 82629, Lincoln, NE 68501-2629 / Group Division

You may provide additional information in an attachment to explain why you are disputing our handling of the claim. You must be specific about billing codes and reason for dispute.

The following should be submitted with your appeal *(copies only)*:

- The relevant claim form
- The relevant Explanation(s) of Benefits
- A statement specifying the line items that you are appealing
- Information we previously requested that you have not yet submitted, if available
- Pertinent correspondence between you and us on this matter
- A description of pertinent communications between you and us on this matter that were not in writing
- Other documents you may believe support your position in this dispute (this may include medical records)

Who is requesting the appeal?

☐ Member/Patient ☐ Provider ☐ Other:_____

Member Information

Member Full Name: _____ Date of Birth:_____

Member ID Number:_____ Group/Policy Number:_____ Group Name:_____

Phone Number:_____ Email Address: _____

Mailing Address: _____ State:_____ Zip:_____

Patient Information (if different from member)

Patient Full Name:_____ Date of Birth:_____

Relationship to Insured: _____

Provider Information

Treating Provider Name: _____ Federal Tax Identification Number:_____

Phone Number:_____ Email Address: _____

Mailing Address: _____ State:_____ Zip:_____

Important: Each Appeal Request Form may only be used for one claim. Do not list multiple claim numbers on a single form. To appeal multiple claims, submit a separate Appeal Request Form and supporting documentation for each claim.

Claim Information

Type of Denial: ☐ Denied Claim ☐ Denied Benefit for Service Not Yet Received

Claim Number:_____ Date of Service:_____

Total Amount Billed:_____ Amount in Question:_____

Appealed Procedure Code(s) and related tooth/arch/quadrant:

Reason for Appeal *(required)*

Please explain in detail why you believe this claim should be reconsidered: *(attach additional documents if needed)*

Supporting Documentation

Please check all items you are including with this appeal:

- ☐ Copy of Explanation of Benefits (EOB)
- ☐ Letter from treating provider
- ☐ Medical records
- ☐ Plan document references
- ☐ Intra-Oral Photographs
- ☐ X-ray(s)
- ☐ Periodontal Charting
- ☐ Patient Clinical Notes
- ☐ Lab Bills
- ☐ Surgical Notes
- ☐ Other: _____

Authorization

I certify that the information provided is true and accurate to the best of my knowledge.

X _____ _____

Signature Date

Submission Instructions

Submit completed form and all supporting documentation to:

Quality Control
P.O. Box 82629
Lincoln, NE 68501-2629

For urgent care appeals, please call 888-418-6811 (Toll Free) for expedited review.

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