

# Provider Dispute/Appeal Request Form



**LIBERTY DENTAL PLAN**

Making members shine, one smile at a time™

Office/Provider Information	Patient/Member Information
Name:	Name:
Address:	Address:
Contact Person:	ID No.:
Phone:	DOB:
Fax:	Phone:

Denial Information		
Auth/Claim No.:	Request Date:	Denial Date:
Services Provided? Y or N:	Date of Service:	

Clinical Appeals Only		Claims Dispute Only	
<input type="checkbox"/>	Lack of Medical/Dental Necessity	<input type="checkbox"/>	Inclusive with another procedure
<input type="checkbox"/>	Lack of Necessary Information	<input type="checkbox"/>	Application Exclusion or Limitation
<input type="checkbox"/>	No Prior Authorization on File	<input type="checkbox"/>	Invalid ADA Procedure Code
<input type="checkbox"/>	No Out-of-Network Benefits	<input type="checkbox"/>	Untimely Claim Filing
<input type="checkbox"/>	Benefits are Exhausted	<input type="checkbox"/>	Secondary Insurance Coverage
<input type="checkbox"/>	Not a Covered Benefit/Service	<input type="checkbox"/>	Unbundling of Procedures
<input type="checkbox"/>	Claim Not Billed as Authorized	<input type="checkbox"/>	Bundling of Procedures
<input type="checkbox"/>	Exceeds Authorization	<input type="checkbox"/>	Other
<input type="checkbox"/>	Other		

This form is to be used when you want to appeal a claim or authorization denial. Fill out the form completely and make sure you keep a copy for your records. Send this form and **all** the necessary medical and/or dental documentation to support your request to the following address: **LIBERTY Dental Plan, Attn: Grievances and Appeals, P.O. Box 26110, Santa Ana, CA 92799-6110** or you can **fax** us at: **1-833-250-1814** or **email** us at: [GandA@libertydentalplan.com](mailto:GandA@libertydentalplan.com)



### Reason/Narrative for Dispute/Appeal

\*If you do not provide a reason/narrative, your dispute/appeal may be returned for additional information.

Unless your contract allows otherwise, LIBERTY will pay the Medicaid allowable fees, depending on the member's plan, for the services performed if we overturn our previous decision. By signing this form, you agree to these terms and will not bill the member, except for applicable copayment.

<b>Signature:</b>	<b>Date Signed:</b>
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### IMPORTANT INFORMATION

#### **Filing on Behalf of a Member/Patient:**

Appeals submitted on behalf of a member/patient that are associated with medical necessity, out-of-network services benefit denials or services for which the member/patient can be held financially liable must be accompanied by an Appointment of Representative Form or other office documentation signed and dated by the member you are appealing on behalf of, unless you are an attorney, power of attorney, court appointment guardian or health care proxy agent with associated documentation.

#### **Expedited Review Request:**

Qualifying cases involved imminent and serious threat to the health of the member including, but not limited to, severe pain, potential loss of life, and cases where, in the professional opinion of the treatment provider, taking time for a standard resolution could seriously jeopardize the member's/patient's life, health or ability to attain, maintain or regain maximum function. All cases that meet the expedited review criteria will be resolved within **72 hours** from the time of receipt. All standard requests will be resolved within **30 calendar days** from the time of receipt.

**Documentation Required: All Medical and/or Dental Information Needed to Determine Medical/Dental Necessity.**

#### **Examples:**

- **Radiology: Radiographs, Intra-Oral Photographs, Reports, Referring MS script.**
  - **NOTE: Faxed Radiographs Will Not Be Accepted**
- **Consultations: Consultation Reports, Progress Notes, Lab Reports**
- **Procedures: Progress Notes, Procedure Reports, Supporting Consultation Reports, PCP Progress Notes**
- **Timely Filing: Billing Notes, Fax Confirmation, Web Portal Confirmation Certified and Signed Mail Card.**