



Delta Dental of Massachusetts
PO Box 75688
Seattle, WA 98175

Subscriber Appeals Form

Should a claim be denied, in whole or in part, you or an authorized representative may request an appeal of the adverse benefit determination. The request to have a denied claim reviewed must be submitted within 180 days from the date the claim was processed. A final benefit determination will be made within 30 days, following receipt of this appeal.

Please submit this appeal and any supporting documentation by email to appealsandgrievances@deltadentalmass.com, or mail the form to the address below:

Delta Dental of Massachusetts
Attn: Appeals Coordinator
465 Medford St, Ste 400
Boston, MA 02129

Complete the following information in full.

1. MEMBER ID NUMBER*:			
2. LAST NAME* (Subscriber):		3. FIRST NAME* (Subscriber):	
4. LAST NAME (Patient)		5. FIRST NAME (Patient)	
6. PHONE NUMBER*:		7. SUBSCRIBER EMAIL*:	
9. HOME ADDRESS*:		10. CITY*:	11. STATE*:
			12. ZIP*:

Claim number and/or date of service:

Reason for appeal (please elaborate on the situation you are appealing: If additional space is needed, please attach another sheet.

Subscriber Signature

Date

Subscriber Name

Date

If you are an authorized representative looking to submit an appeal on behalf of a member, please submit an Authorized Representative form.