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	
☐	**Lack of Medical/Dental Necessity**	☐	**Inclusive with another procedure**
☐	**Lack of Necessary Information**	☐	**Application Exclusion or Limitation**
☐	**No Prior Authorization on File**	☐	**Invalid ADA Procedure Code**
☐	**No Out-of-Network Benefits**	☐	**Untimely Claim Filing**
☐	**Benefits are Exhausted**	☐	**Secondary Insurance Coverage**
☐	**Not a Covered Benefit/Service**	☐	**Unbundling of Procedures**
☐	**Claim Not Billed as Authorized**	☐	**Bundling of Procedures**
☐	**Exceeds Authorization**	☐	**Other**
☐	**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 15149, Tampa, FL 33684** or you can **fax** us at: **1-833-250-1816** or **email** us at: **FLGandA@libertydentalplan.com**

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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.

Signature:	Date Signed:

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.**