Health Plan Appeal Request Form

To ask for a health plan appeal, you can call us at 1-800-516-0165 (TTY: 711), or you can fill out this form and mail or fax it to us.

Mail: DentaQuest
Attn: Appeals
P.O. Box 2906
Milwaukee, WI 53201-2906

Fax: 800-936-0913

You must request an appeal by <date of letter+60 days>.

If you want to continue your services during your appeal, you must make your request by <date of letter+10 days>.

Mark the appeal you want:
Only select one.

___ Health Plan Appeal

___ Emergency Health Plan Appeal*

*Emergency health plan appeals should only be requested if you believe your health will be seriously harmed by waiting for your health plan appeal decision.

Denial Reference Number: <Authorization Number>

Do you want your services to continue? ___ Yes ___ No

You must request for your services to continue by **<date of letter+10 days>**.

You can make this request by phone. Call us at 1-800-516-0165 (TTY: 711) if you think this form will not reach us by mail before the deadline.

Your Personal Information*

Member Name:	Parent or authorized representative:

Member Medicaid ID and subscriber number:	Preferred phone number:

*If any of your contact information has changed, call the enrollment broker at 800-964-2777 or DentaQuest at 1-800-516-0165 (TTY: 711).

Your Authorized Representative's or Parent's Information

You can represent yourself. If you would like someone to represent you, such as, parent, relative or friend, complete the following information. By completing this section, you are authorizing your designated representative to appeal and obtain information on your behalf.

Name:
Address:
Phone number:

Reason for the Appeal

This section is optional. You can fill it out to tell us about your services under appeal and why you think they're needed.

Services under appeal:
Why you need them:

Sign this form:

By signing this form, you or your authorized representative are requesting an appeal and giving your health plan, DentaQuest, authorization to get your medical records and to contact your appeal representative if you listed one.

Member/Authorized representative signature

Printed name

Date