Dental Benefit Plan
Independent Review Request Form

Only claims which meet all requirements set forth in La-RS 46:460.90 are eligible for Independent Review. Claims payment disputes involved in litigation, arbitration or not associated with a Dental Benefit Plan member are not eligible.

Please complete this form and mail it to the following address:

LDH/Program Operations and Compliance
P.O. Box 91283, Bin 32
Baton Rouge, LA 70821-9283
ATTN: Dental Benefit Plan Independent Review

Make sure to include copies of all documentation that supports your complaint. You will be copied on our correspondence regarding this matter.

Alternatively, you may submit an Independent Review request online at:
https://ldh.force.com/Reporting/s/independentreview

PROVIDER INFORMATION

required field

Provider Name*: NPI #*:

Street Address:

City: State: Zip Code:

Phone Number: Fax Number:

Email Address:

Provider Representative*: Phone Number:

Email Address:

Provider Type:

- ☐ General Dentist
- ☐ Endodontist
- ☐ Prosthodontist
- ☐ Orthodontist
- ☐ Pedodontist
- ☐ Periodontist
- ☐ Oral/Maxillofacial Surgeon

DENTAL BENEFIT PLAN INFORMATION

My Complaint is against:

- ☐ MCNA
- ☐ DentaQuest

Are you an In-network provider with this Dental Benefit Plan?

- ☐ Yes
- ☐ No

Explain if needed:

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Please give a written description of the problem *(Attach additional pages if needed)*:

- Description may include, but is not limited to: reason given for denial and your position explaining why the Dental Benefit Plan should pay the claim. Include all pertinent information.
- Attach copies of pertinent documentation, including correspondence from the plan and remittance advice.

AGGREGATED CLAIMS INFORMATION

Do you request your claims to be aggregated?

☐ Yes ☐ No

NOTE: Claims being aggregated must be against the same dental benefit plan and involve a common question of fact or law. The fact that a claim is not paid does not create a common question of fact or law. If you wish to aggregate your claims, please explain the commonality:

Total number of claims:

Total number of Enrollees:

Reason(s) for Complaint:

☐ Untimely Filing ☐ Claim recoupment error ☐ Claim paid incorrectly

☐ Medical Necessity ☐ Neither paid nor denied ☐ Lack of authorization

☐ Level of care ☐ Other:

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Independent Review Request Form

ENROLEE/CLAIM INFORMATION

Complete this page for each case being submitted for independent review. Additional copies can be found at the end of this document.

Enrollee Name: Enrollee DOB:

Member ID:

Claim Number(s):

Beginning Date of Service: Ending Date of Service:

Total Amount Billed: Total Amount Paid:

Denied Date(s) of Service:

Date of Initial Claim Submission to DBPM:

Date of Initial DBPM Claim Denial or Recoupment:

Date Provider Submitted Written Reconsideration Request to DBPM:

Date Provider Received Reconsideration Decision from DBPM:

Please identify all supporting documents included in this submission for the case listed above by checking the appropriate boxes.

- ☐ Claim form, required
- ☐ Remittance advice, claim denial letter, and/or recoupment letter, required*
  - ☐ *Check this box if no remittance advice, claim denial letter, and/or recoupment letter was received from the DBPM
- ☐ Independent review reconsideration submitted to DBPM, required
- ☐ Independent review reconsideration determination letter, required*
  - ☐ *Check this box if no response was received from the DBPM
- ☐ Authorization information, if applicable
- ☐ Appeal information, if applicable
- ☐ All correspondence from the DBPM

DO NOT SEND MEDICAL RECORDS. The independent reviewer will request medical records from you.

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ACKNOWLEDGMENT OF FEE OBLIGATION

By my signature below, I hereby request Independent Review of the above claim(s), pursuant to La-RS 46:460.90. I also confirm that the above mentioned disputed claim(s) will not be raised as an issue in litigation or arbitration until the reviewer issues his decision. Any provider who brings a lawsuit or initiates arbitration involving a claims payment dispute raised in an independent review request before the independent reviewer renders a decision, must ultimately pay the independent reviewer's fee. I also understand that there is a mandatory fee of $250.00 per Independent Review request and if I have a contract with the Dental Benefit Plan, the Dental Benefit Plan is initially responsible for paying the fee. I further understand that if the reviewer determines the Dental Benefit Plan correctly denied payment of this disputed claim(s), then I must reimburse the Dental Benefit Plan for the reviewer's fee as established by the Selection Panel for reviewers.

If you are not the aggrieved provider, what is your relationship to the provider?

I declare that the information I've furnished is true and accurate.

Signature: Date:

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