[Dental Plan Letterhead] "Overturn"

[Dental Plan Tracking Number]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Dentist's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You or *[Name of requesting dentist or authorized representative]*, on your behalf, appealed the *[denial, modification, or termination]* of *[Service requested]. [Dental Plan]* has reviewed the appeal and has decided to overturn the original decision. This request is now approved. This is because *[Insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity]*.

[Dental Plan] has 72 hours from the date the service request is received to give you the service.

You may appeal this decision. The enclosed "Your Rights Under Dental Managed Care" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The cut-off date to ask for an appeal is *[cut-off date]*. You may get help from your dentist or call us at *[Dental Plan's Member Services telephone number]*.

[Dental Director's Name]
Enclosed: "Your Rights Under Dental Managed Care"

(Enclose notice with each letter)