[Dental Plan Letterhead]

"Uphold"

[Dental Plan Tracking Number-Optional]

NOTICE OF APPEAL RESOLUTION

[Date]

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

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

Identification Number

RE: *[Service requested]*

You or *[Name of requesting provider 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 uphold the decision. This request is still denied. 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]*.

You may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call *[Dental Plan name]* at *[telephone number]*.

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]

cc: DHCS
Enclosed: "Your Rights Under Dental Managed Care"

(Enclose notice with each letter)