



DENTAL APPEAL FORM

If you would like GEHA to reconsider our initial decision on your benefit claim, please complete this appeal form. You must write to us within 6 months of the date of our decision.

You can mail, fax or email your request to GEHA:

- Mail your request to GEHA, PO Box 455, Independence, MO 64051-0455;
- Fax your request to the Appeals Department at (816) 257-3256; or
- Email your request to GEHAappeals@geha.com

Patient name: _____

Dental plan: Connection Dental Federal (FEDVIP) CONNECTION Dental *Plus*

Plan ID number: _____

Claim number(s): _____

Your name: _____

Your status: Covered person Patient Authorized representative

If an authorized representative, explain your relationship to the patient:

Your mailing address:		

(Street address)	(City)	(State) (ZIP code)
Your phone number: () -	Your email address:	Prefer response by: <input type="checkbox"/> Letter <input type="checkbox"/> Email

Please explain why you believe our initial decision was wrong, based on specific benefit provisions in your plan brochure:

Attach additional sheets, if needed. Supporting documents may be necessary for review, such as dentist's letters, provider narratives, X-rays and explanation of benefit (EOB) forms. The review may be delayed if supporting documents must be requested by GEHA.

I confirm that the above information is correct.

Signature: _____

Date: _____

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