AmericianAirlines®

EMPLOYEE BENEFIT COMMITTEE (EBC)

APPLICATION FOR SECOND LEVEL APPEAL: ADVERSE BENEFIT DETERMINATION UNDER DENTAL COVERAGE

THIS APPLICATION FOR SECOND LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING YOUR DENTAL COVERAGE, SUCH AS DENTAL COVERAGE LIMITATIONS AND EXCLUSIONS, DENTAL CLAIM DENIAL, ALTERNATE TREATMENT/BENEFIT DETERMINATIONS, 5-YEAR REPLACEMENT LIMITATIONS, ETC.

IMPORTANT NOTICE:

YOU MUST COMPLETE THIS FORM AND PROVIDE ALL REQUESTED INFORMATION; OTHERWISE, YOUR APPEAL CANNOT BE ACCEPTED FOR REVIEW BY THE EBC.

In order for the EBC to carefully review the facts and give every consideration to your issue, you must include all of the information requested below. Failure to provide all pertinent documentation may affect the outcome of this review. It is essential that you keep, for your records, copies of all documentation you submit in support of your Second Level Appeal. The information you submit is provided at your own expense. You must file this Second Level Appeal within 180 days of the date you receive notice of the First Level Appeal determination from the Dental Claim Processor; otherwise, your right to further appeal is waived.

Your appeal must include the following:

- Complete, date, and sign this APPLICATION FOR SECOND LEVEL APPEAL (both employee and patient, other than a minor, must sign this Application)
- Attach a copy of the First Level Appeal determination letter you received from the Dental Claim Processor
- Explain, in detail, why you believe your issue in question should be approved by the EBC
- Include all information and documents that you believe support your appeal
- Attach all Explanation of Benefit Statements (EOBs) and all correspondence relating to this issue
- If you experienced any extenuating circumstances that you believe have a bearing on your appeal, include complete and specific details of such circumstances, and provide documentation to support the existence of such circumstances, and how they affected your case
- Other____

Additionally, if your appeal involves:

- Dental Usual and Prevailing Fee Limits, you must include itemized bills and any and all procedure/operative reports that you believe warrants additional allowances
- Dental Necessity, you must include recent dated, pre-operative x-rays, copies of the clinical records and procedure reports from your treating dentist, and any other clinical documentation on your case
- Time Limits for Replacement of Crowns or Other Restorations, you must include dental records or other documentation of prior placement, if any, and the reason for replacement of the prior restoration
- Alternate Treatment Benefit Allowance, you must send recent dated dental x-rays of the affected tooth, arch or full mouth series, as applicable. You must also provide copies of the clinical records from your treating dentist, including treatment plan, and documentation of why your dentist's selected method of treatment was required (as opposed to a less expensive method of treatment)
- Necessity of Dental Implants, you must provide clinical dental records of all missing teeth in the affected arch or arches (identified by tooth numbers), including dental x-rays. Please have your treating dentist provide records of the prior restorative placement, if any, and the reason for replacement with dental implants. Please have your treating dentist provide the post-implant restorative treatment plan, and an explanation of the necessity of these implants
- Plan Exclusions, please explain in detail why you believe that the service or supply that was declined qualifies for coverage, providing dental records and clinical documentation that you believe support your case.
- Other____

Your failure to provide all pertinent documents may affect the outcome of your appeal review.

THIS WILL BE YOUR **FINAL** ADMINISTRATIVE REVIEW; THEREFORE, INCLUDE ALL FACTS AND CIRCUMSTANCES THAT YOU WANT THE EBC TO CONSIDER WHEN IT REVIEWS YOUR APPEAL. AFTER THE EBC RENDERS A DECISION ON YOUR APPEAL, ADDITIONAL OR NEW INFORMATION WILL **NOT** BE CONSIDERED. THEREFORE, IT IS IMPERATIVE THAT YOU INCLUDE ANY AND ALL PERTINENT INFORMATION WHEN YOUR APPEAL IS SUBMITTED.

EMPLOYEE'S SECOND LEVEL APPEAL:

The benefit(s) to which I believe I am entitled is/are as follows (describe the type of benefit and the circumstances involving your case, being as specific as you can). Please refer to the specific Plan provision from your **Employee Benefits Guide**, which you believe entitles you to the benefit(s) you are claiming (attach additional pages if needed.):

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TOTAL AMOUNT OF APPEAL (IF KNOWN) $____

By signing this form, I attest to the validity of all information I have provided, and authorize the release of all clinical records and/or information pertinent to the evaluation of my appeal to the Dental Claim Processor, the EBC at American Airlines, Inc., and its agents, including any health care professional selected by the EBC to assist with the appeal review. American Airlines, Inc. is the sponsor and administrator for the group health and welfare benefit plans.

PLEASE PRINT, SIGN, AND DATE THE FOLLOWING:

EE Name:	**Benefit ID#:**
EE#:	**EE Signature:**
SS#:	**Patient Signature:**
Address:	**Date:**
Address:	**Home Phone:**
City:	**Work Phone:**
State:	**Cell Phone:**
Zip:	**Email:**

MAIL (or use express delivery) COMPLETED FORM AND SUPPORTING MATERIALS TO:

FOR USPS REGULAR MAIL DELIVERY	**FOR EXPRESS DELIVERY**
Employee Benefit Committee	**Employee Benefit Committee**
American Airlines, Inc.	**American Airlines, Inc.**
PO BOX 619616 MD #5134-HDQ1	**4333 Amon Carter Blvd. MD #5134-HDQ1**
DFW Airport, TX 75261-9616	**Fort Worth, TX 76155**
817-967-1412	**817-967-1412**