American Airlines

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.

In order for the Dental Network/Claim Administrator 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 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 Network/Dental Claim Processor; otherwise, your right to both levels of 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 child, must sign this Application
- Explain, in detail, why you believe your issue in question should be approved by the Dental Network/Claim Administrator
- 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
- If this appeal is being filed by your authorized representative on your behalf, include a copy of your signed and dated authorization documenting your permission for the authorized representative to act on your behalf

Additionally, if your appeal involves:

- Dental Usual and Prevailing Fee Limits, you must include any and all itemized bills and procedure/operative reports that you believe warrant additional allowances
- Dental Necessity, you must include recently 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, if appropriate. 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 explanation of the dental necessity and reasons for replacement with dental implants. Please have your treating dentist provide the post-implant restorative treatment plan
- 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.

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 DENTAL NETWORK/DENTAL CLAIM PROCRESSOR TO CONSIDER WHEN IT REVIEWS YOUR APPEAL. AFTER A DECISION IS RENDERED 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) $_____

In signing this form, I attest to the validity of all information I have provided and authorize the release of all medical records and/or other information pertinent to this appeal to the American Airlines, Inc., Plan Sponsor, and Administrator of the American Airlines, Inc. benefit plans, the Network /Claim Administrator and its agents/delegates, including any health care professional.

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 COMPLETED FORM AND SUPPORTING MATERIALS TO: MetLife Group Claims Review
PO Box 14589
Lexington, KY 40512
Fax: 859-389-6505
Phone 866-838-1072