

# Complaint and appeal form



Delta Dental of Oregon & Alaska

## Section 1: Patient and provider information

Name of person filing complaint		Telephone no.		
Address		City	State	ZIP
Member name	Patient name		Member ID no.	
Name of provider involved	Address		Telephone no.	
Name of provider involved	Address		Telephone no.	
Date(s) of service (mm/dd/yyyy)				

## Section 2: Complaint or appeal

Please write your complaint or appeal in the space below and on the back of this page. Attach additional pages if needed. You may include any document such as explanation of benefits (EOBs), correspondence, or invoices which will help us investigate your complaint or appeal. **Please sign and date this form.**

I certify that the above information is accurate and complete to the best of my knowledge. I have attached the most recent EOB from my previous carrier for each member listed on this form.

Signature X	Date (mm/dd/yyyy)
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**Ready to submit?** Mail this form to Delta Dental:  
Attn: Appeal unit, P.O. Box 40384, Portland, OR 97240  
or fax to 503-412-4003 or 866-923-0412.

**Questions?** Contact a customer service representative at 855-294-1668.

**DeltaDentalAK.com | DeltaDentalOR.com**

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon.  
Dental plans in Alaska provided by Delta Dental of Alaska. 62184379 HCS-1443 (6/20)