Connecticut State Dental Association

This form is only intended for use by dentists and dental office staff

1. Date:
2. Dentist Name:
3. State:
4. Third-Party Payer Name:
5. Dentist contracted with plan:

Yes ☐
No ☐

6. If your complaint is about a specific claim(s), how was the claim filed:

Paper ☐
Electronic ☐

7. What type of complaint or problem applies to you? (Check All That Apply)

- Coordination of benefits__
- Explanation of benefit (EOB) language __
- Downcoding (changed code to a less complex or lower cost procedure) __
- Bundling (combining distinct procedures that results in a reduced benefit) __
- Review by non-dentist___
- Utilization review (a system to evaluate procedure utilization frequency/plan abuse) ___
- Delayed payment__
- Denial of claim or pre-authorization__
- No direct pay to non-participating provider__
- Denial of payment after pre-authorization__
- Lost claims, x-rays or other documentation by carrier__
- Extensive or additional documentation requested__
- Interference with the doctor-patient relationship__
- Inability to reach authoritative insurance company__
- Other__

Please give a brief description of the problem (Use back side of this form if necessary):

May the CSDA contact you regarding this issue?

Yes ☐
No ☐

This form is intended for information gathering purposes only. No individual follow up is intended. Please complete and fax to 860) 378-1807.