Dental Claim Dispute Resolution

[Your Name]

[Your Address]

[City, State, ZIP]

[Email Address]

[Phone Number]

[Date]

[Insurance Company Name]

[Claims Department Address]

[City, State, ZIP]

Subject: Dispute of Dental Claim [Claim Number]

Dear Claims Department,

I am writing to formally dispute the adjudication of my dental claim, which was processed under the claim number [Claim Number]. I believe that the claim was incorrectly denied/partially paid based on [brief reason for dispute].

Details of the claim:

- **Patient Name:** [Patient Name]
- **Date of Service:** [Date of Service]
- **Provider Name:** [Provider Name]
- **Total Amount Billed:** [Total Billed Amount]
- **Amount Paid:** [Amount Paid]

According to my understanding of my policy, the treatment provided falls within the covered services. I have attached all relevant documentation, including the original claim, the explanation of benefits (EOB), and any additional supporting documents to further substantiate my position.

Kindly review the attached documents and reconsider the claim in light of the information provided. I appreciate your attention to this matter and look forward to your response within the standard timeframe.

Thank you for your assistance.

Sincerely,

[Your Name]