TennCare Dental Provider Appeal Form

Member name: _____

Member ID number: _____

Date of service: _____

Date EOB received: _____

Authorization number: _____

Date authorization was received: _____

Provider Name: _____

Location Number: _____

Office Contact: _____

Office Phone Number: _____

Reason for Appeal: _____

_____

_____

_____

_____

Outcome office is requesting: _____

_____

_____

Submit to:
DentaQuest - TennCare
Attn: Provider Appeals
PO Box 2906
Milwaukee, WI 53201-2906
Fax: 262-834-3452