Appeals Process Overview

At HRI, our Member Services team is here to support you with any questions about your claim, including how to file an appeal. Often, a quick call to our office can help clarify why a decision was made and provide the answers you need.

HRI offers different appeals processes depending on your type of plan and the state your plan is based in. If this feels confusing, don't worry — we're here to help guide you every step of the way.

All clinical claim reviews at HRI are conducted exclusively by licensed dentists, ensuring that determinations are based on professional dental expertise. If you're appealing a denial based on medical necessity, your case will be reviewed by a different licensed dentist—one who was not involved in the original decision—to ensure a fair and impartial evaluation.

Employer-Sponsored or Individual Dental Coverage (Marketplace/Exchange)

If you've received a partial or full denial of a claim, you have the right to formally appeal the decision within 180 calendar days from the date of determination. Appeals can be submitted by you or your dentist, especially if you believe the denied claim was medically necessary.

You may also appeal if you believe your claim was incorrectly processed due to:

- Medical Necessity determination.
- Eligibility decisions.
- Plan benefit features (e.g., co-insurance, deductible, plan maximums).

Once your appeal is submitted, HRI will assign a dedicated reviewer to evaluate your case and generally will issue a decision within 30 days. If you have the need for an expedite appeal due to a serious health risk, HRI will ensure you get an answer within 48 hours.

For members in Kentucky seeking an external review of an appeal decision, please complete [this form].

Michigan members may request an external review through the Michigan Department of Insurance and Financial Services. Details are located here: Appealing a Decision Made by Your Health Insurer.

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Medicare Advantage Plans

HRI or your Medicare Advantage Plan can assist with appeals. You have up to 65 days from the date of denial to request a Level 1 Standard Reconsideration/Redetermination. If you're not satisfied with the result, you may request an external review by an impartial third party as a Level 2.

Health Plan (your plan includes dental benefits)

Antidote Health (Arizona)
You have up to two years to file an appeal after a denial based on medical necessity.
Your plan allows for an initial appeal, a secondary internal review, and an external review by an impartial third party.

Antidote Health (Ohio)
You have up to 180 days to file an appeal after a denial based on medical necessity.
You may also request an external review.

Paramount Health Plan
You have up to 180 days to file an appeal after a denial based on medical necessity.
You may also request an external review.

Ready to file an appeal?

HRI prefers to receive appeals in writing to ensure we have all the necessary facts and details. You can also contact our office and file the appeal over the phone.

When submitting your appeal, please include:

- Your full name.
- Your member number.
- A clear explanation of why you believe the claim was processed incorrectly.

If your appeal needs to be expedited due to a serious health risk — such as a threat to life or potential loss of normal bodily function — please indicate this clearly in your submission. Be sure to include specific details explaining why you believe an expedited review is necessary.

Appeals can be submitted in any of these manners:

Secure Message: https://portal.insuringsmiles.com/Account/Login
Phone: 800-727-1444
Email: Claims@insuringsmiles.com
Mail: PO Box 659
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